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How Do Poles Perceive Health? The Social Representation of Health and its Importance for the Social Order

Abstract: In this article, the social representation of health shared by Poles is presented in the context of its function in society. The theory of social representations and its use in health research is introduced. The results of research are used to consider how perceptions of health shape a social order in which medicine is still a large institution of social control.

The above-mentioned research included 30 in-depth interviews and a nationwide survey of a representative sample. As a result, three dimensions of the social representation of health were identified: the 'ability to function independently', which involves mental well-being and the ability to fill social roles; 'absence of disease'—lack of ailments, a feeling of zest and a lack of diagnosed illness; and the 'biological reserves of the organism'—the resources for resisting disease. Analysis of the data has led to the conclusion that the first dimension serves to preserve identity and integration of the social group, the second contributes to maintaining medical social control, while the third motivates individuals to take steps to protect or improve their health. In addition, the last two dimensions serve the interests of groups profiting from medicalization.

Keywords: social representation, lay perception of health, Claudine Herzlich, medical social control, medicalization.

In contemporary developed societies an increasingly large role is played by health, both as the aim of personal and collective efforts, and as a point of reference for various kinds of activities or appraisals (cf. Domaradzki 2013a; Crawford 1980, 2006). Concentration on health (on attaining and preserving it) could be considered in categories of an ideology whose functions include supporting group interests and maintaining the social order (cf. Mannheim 1992; Crawford 1980, 2006). In this connection, how people understand health could also be of importance for the social order. The theory of social representations is useful for describing ways of understanding health and their consequences for the social order. In contrast to the collective representations typical of traditional societies, which are ascribed the status of 'social facts', social representations, that is, lay theories on the subject of reality, continually evolve in the process of communication and are more apt for describing modern societies characterized by 'a type of ideological war'—the existence of alternative, rival visions of reality (Howarth 2006). Howarth calls the theory of social representations a mod-

ern theory of social change (or a theory of social knowledge) because its subjects include how contrary representations of the same objects can coexist; what the consequences of 'using' or 'resisting' a representation may be; how people deal with the uncertainty and unpredictability of such a varied and fluid system of knowledge; what resources are employed in a conflict; and who is the winner and who the loser 'in the battleground of social representation' (Howarth 2006). In Howarth's opinion, social representations can serve to maintain the relations of power in a society, and people can simultaneously use them to resist those relations and preserve their own identity. It is not without reason that representations are sometimes equated with ideology—ideology is defined as a 'system of representations' (Howarth 2006).

The creator of the theory of social representation is Serge Moscovici, who defined social representation as

> a system of values, ideas and practices with twofold function; first, to establish an order which will enable individuals to orientate themselves in their material and social world and to master it; and secondly to enable communication to take place among the members of a community by providing them a code for social exchange and a code naming and classifying unambiguously the various aspects of their world and their individual and group history (Moscovici 1973: xiii).

Because social representations are created and modified as a result of communication processes, they integrate the individuals in a group. Groups are understood here in a specific sense, because it is precisely social representations that define their boundaries, which often do not coincide with the boundaries delimited by socio-demographic traits. Representations are thus shared by members of a given group, which means they similarly understand and evaluate behavior and events occurring in their surrounding world (cf. Mosovici 1973; Trutkowski 1999). As Howarth writes,

> Social re-presentations, as a socio-cognitive practice, is something we do in order to understand the worlds in which we live and, in doing so, we convert these social representations into a particular social reality, for others and for ourselves (Howarth 2006: 69).

Social representations not only reflect reality and inform us about it, they also constitute it, giving it sense and reconciling us to it.

In modern societies characterized by competing visions of reality, in which each requires legitimation, the question of the relation between social representations and the social order becomes important. As Howarth claims, various social groups have differing access to the creation of social reality and in consequence the social representations protecting the interests of one social group over the interests of others. On the other hand, social representations provide the tools to resist the dominant vision of reality, particularly when the group identity needs to be defended, which, in Howarth's opinion, is the central aspect of a social representation. As research has shown, people use social representations to establish their place in the world, their claim to a common identity, and for self-defence against stigmatizing or marginalizing practices. Howarth (2006) produced a set of functions of the social representations of various subjects identified in various studies. The set indicates that the representations of madness, sex, health, injustice, AIDS, and society

have such functions as defending identity, preserving social inequality, and maintaining social exclusion. In addition to preserving and supporting the relations of domination in society and maintaining identity, other researchers also perceive such functions of representation as the 'mythical' function serving the legitimation and motivation of group enterprises, the 'attitudinal' function (connected with making judgments and choices), and the function of planning deliberate activities[1] (Bauer and Gaskell 1999).

The majority of the above-mentioned functions are related to this aspect of social representation, thanks to which the ideology is called a 'system of representations' (Howarth 2006). It would seem that social representations could be understood as ideology in the broad sense, that is, as 'a general process of creating meaning and ideas' (see Fiske 1999: 206), and also as ideology in the more narrow sense, defined as the product of a social group for the purpose of supporting the social order and defending group interests (see Olechnicki and Załęcki 1998; Mannheim 1992).

In societies where an important role is played by health and its control, social representations of health could fill important ideological functions in terms of maintaining the social order. The aim of this article is to describe the social representations of health shared by Poles and to consider them from the angle of their functions in society.

Lay Knowledge and Social Representations of Health

Analysing social representations of health is part of a fairly long tradition in the sociology of medicine of studying lay knowledge: a field that grew out of the study of health beliefs. Lay knowledge could be defined as the ideas and notions by which social actors interpret the experience of health and disease in daily life (Gabe, Bury, Elston 2006). It is individualistic and utilitarian in nature. Researchers generally—though not always—refer to conceptions in this area when they are interested in the perspective not only of medical professionals but also of the recipients of various kinds of activities aimed at treating or preventing diseases, promoting health, and so forth: for instance, the cause of behavior that negatively impacts health could be sought by this means (Neilson, Jones 1998). What is important is consideration of the differences between lay and expert approaches to matters of health and illness, treatment, prevention, and health promotion. Discovering these differences—that is, the experts' understanding of the lay perspective—is usually intended to serve specific aims, such as being able to influence 'ordinary' people more effectively. And thus, for instance, research into health beliefs was intended to help understand the perspective of ordi-

[1] The question of the relation between social representations and practices is a controversial aspect of the theory of social representations. According to Moscovici and other scholars (see Howarth 2006), social practices could be part of social representations, and some representations can be grasped solely through the medium of practice. On the other hand, it is considered that real conditions, which are transformed in representations, influence the behaviour of individuals. Thus it should be recognized, in keeping with Howarth, that representations not only influence people's ordinary practices, but also constitute them, that is, practices are part of the representation.

nary people primarily in order better to encourage them to behave in ways considered proper within the frame of expert medical knowledge (Mokounkolo, Mullet 1999; Callaghan 1999; Kirscht, Haefner, Kegeles and Rosenstock 1966). A Health Belief Model is used in the health promotion and health education to describe the relation between the perception of a disease and the adoption of recommended preventive behaviors, as well as the perception of barriers and guidelines for such behaviors (Cockerham 1998; McAllister, Farquhar 1992; Harvey, Lawson 2009). 'Lay epidemiology' refers to lay conceptions of the causes of disease, which are expressed in the 'typing' of potential patients on the basis of their socio-demographic traits, appearance, or lifestyle (Davison, Smith, Frankel 1991; Lawlor, Frankel, Show, Ebrahim, Smith 2003; Macdonald, Watt, Macleod 2013). Popular epidemiology, which is also part of this field (Brown 1992; Brown 1993), describes the process by which 'ordinary' people seek to clarify and resolve health problems by collecting knowledge of various kinds, including expert knowledge. Because this happens in spite of official definitions and appraisals of their problems, it can lead to the creation of social movements. Lay knowledge has often been contrasting with expert knowledge; for instance, in considering the proper degree to which patients and other non-specialists should participate in managing health risks or evaluating the procedures, methods, and tools by which a health policy is conducted (Martin 2008; Henderson 2010; Meijer, Boon, Moors 2013).

The theory of social representations is one of the concepts falling within the sphere of lay knowledge but differs from other concepts in this field. Representations are social in nature, not individualistic: that is, they are considered to be the attribute and at the same time the product of whole social groups, not individuals. They are not countered by any type of expert or professional knowledge, because they do not assume the existence of 'proper' knowledge or a 'proper' notion of some subject. Nevertheless, because social representations are the creation of social groups, it is assumed that various groups could have differing representations of some subjects, for instance, the representations of health shared by experts and persons who are not professionals in that area (cf. Flick 2000; Álvarez 2006). Because the aim of the present analysis is to describe society from the viewpoint of its perception of health and to attempt to illustrate the social consequences, the choice of this concept appears apt.

Social Representations of Health[2]

The classic study of social representations of health, which has constituted to this time the departure point for many researchers, is a study conducted among the French middle class by Claudine Herzlich (1973). Herzlich established that a representation of health could be classified according to three dimensions which are at the same time a particular type of health: 'health-in-a-vacuum', 'reserve of health', and health

[2] This section describes also some studies in which other theoretical frameworks than the theory of social representations were used to describe common notions on the subject of health.

as equilibrium. The first type, 'health-in-a-vacuum', simply means the absence of illness—health without any qualifiers. The second, a 'reserve of health', could be described as capital assets with two aspects: physical vigor and strength, as an individual's potential to resist pain and illness. These reserves can change—growing or diminishing over the course of an individual's life—and can also be intentionally increased or depleted. The next type is 'health as equilibrium', which comprises not only the physical state of the individual, but also all the spheres of the individual's functioning. These include physical well-being, the sufficiency of physical reserves, psychological well-being, the absence of fatigue, balanced moods, activeness, effective action, and good relations with other people. 'Equilibrium' is an individual norm to which an individual aspires but which is seldom obtained, and the appraisal of whether an individual has achieved equilibrium depends on his or her individual feeling, without requiring external points of reference. Later, other forms were added to the three identified by the French scholar, for instance, 'functional health' (Faltermeier 1994, after Sęk 2001; Raport 2006) or 'health as lifestyle' (Flick 2000).

An example of a different approach is another French study (d'Houtaud, Field 1984), which distinguishes two aspects of health. The first, which involves the hedonistic use of life, equilibrium, reference to the body, and vitality, is a matter largely of individual norms; the second, which is composed of psychological well-being, hygiene, the value of health, prevention, physical aptitudes, and the absence of sickness, is mainly a matter of social norms. The first aspect is characteristic of the middle and upper classes, the second—of the others.

Three similar aspects of health, as summarized by Blaxter (1990), were found in various studies of lay manners of understanding health conducted in Great Britain among various groups—working-class mothers of young children in southern Wales, working-class Scotswomen, elderly persons living in Scotland, and primary health care patients (Pill and Stott 1982; Blaxter and Paterson 1982; Williams 1983; Blaxter 1985, after Blaxter 1990). Health was defined negatively, as a lack of illness; functionally, as the ability to manage daily living; and positively, as good physical condition and mental well-being. In all these studies the idea of health as a reserve also appeared.

Contrary to the above-mentioned studies, which were conducted on small samples or were qualitative in nature, Blaxter herself studied notions of health among a representative sample of 9003 persons who were inhabitants of England, Wales, or Scotland. Analysis showed that health was most often defined as not being ill and as the absence of diagnosed disease ('never ill, no disease'), 'physical fitness and energy', 'functionally being able to do a lot', and being 'psychologically fit'. At the same time, this last form was more often used by the respondents to describe their own health than when they spoke about the health of other persons. Other ways of defining health also appeared—'health as a reserve', a 'healthy life', or in terms of 'social relationships'—but were mentioned rarely.

Similar dimensions to those obtained by British researchers were obtained from studies of how elderly people in the USA understand health (Damron-Rodriguez, Frank, Enriquez-Haass, Reuben 2005). These dimensions were lack of illness and

the ability to perform ordinary activities, that is, physical health; a positive attitude, intellectual activeness, and religiosity as psychological and spiritual health; and good relations with people—giving and receiving social support as social health. The answers of American teenagers (Buck, Ryan-Wenger 2003) show that they understand health as the absence of illness, the good condition of the organism, the ability to perform various physical activities, the avoidance of risky behaviors, the adoption of pro-health behaviors, and also physical, psychological, and social well-being.

An entirely different representation of health was identified among the Chinese minority in Great Britain. The authors of the study, Jovchelovitch and Gervais (1999) claim that the key element of notions of health among this group is the idea of balance and harmony: the healthy functioning of the body depends on a balance between elements and forces inside the body, as well as between them and the external environment, including society.

Since the social representations of various phenomena fill an integrative function and mark the boundaries of social groups, those considered to be different in some respect have often been studied. For instance, the representations of health among nurses and clerks from East and West Germany, and those of women living in Berlin and Lisbon (Flick 2000) were compared. Representations of health in old age were also studied among primary care doctors and nurses in Germany (Flick, Fisher, Neuber, Schwartz, Walter 2003), and representations of health among surgeons and hospital patients in Spain (Álvarez 2006).

Only a few researchers into social representations of health have reflected on the functions of such representations. For instance, the representations of health among the Chinese minority in Great Britain (Jovchelovitch, Gervais 1999) serve, as Howarth (2006) claims, to preserve and protect the cultural identity of that society. On the other hand, the result of research conducted in Spain shows that representations of health could also function to determine activities. As a result it was claimed that representations of health are connected with differences in health behaviors and various strategies for dealing with the first symptoms of disease (Echabe, Guillen, Ozamiz 1992). The studies done in Poland by Puchalski, Korzeniowska, and Piwowarska-Pościk (1999) suggest that social representations of health could condition health practices. The persons studied by the authors were divided into those who were active (that is, those who behaved advantageously in terms of their health) and passive (those who did not take any steps for their health). The persons described as active were more inclined to perceive health as a positive value to be striven toward, that is, as a way of life involving healthy behaviors; they were also convinced of their own potential to influence their state of health. On the other hand, the passive people conceived health rather as a natural state, a reserve that was drawn upon without making efforts to increase or strengthen it.

The above review of studies shows rather a lack of reflection on the significance of how people perceive health, even though health is an important concept in developed societies. Thus the social representations of health identified in the present study in Poland should be considered in these terms.

The Social Representations of Health in Poland

The study was composed of two parts and one of its aims was to reconstruct the social representations of health in Poland. The first, exploratory part of the research involved individual in-depth interviews in the period from June 2007 to April 2008. In-depth interviews were conducted with 30 persons unconnected with medicine. The purposive sample was chosen to include men and women, persons of varying educational level, persons of varying ages, and the inhabitants of Warsaw, smaller towns, and the countryside. Finally, 15 men and 15 women were chosen for qualitative study. Among the respondents there were 8 persons under the age of 31, 12 persons between 31 and 50, and 10 persons over 50 years of age. The respondents differed in terms of education: 12 persons had higher educations, while the remainder had elementary or vocational school educations (10 persons), or secondary or post-secondary educations (8 persons). 10 persons were residing in Warsaw; the remaining 20 were inhabiting other parts of the country, including 10 persons living in the countryside.

The second stage was conducted by means of questionnaires given on 12–19 November 2008 to a representative nationwide sample of 934 persons, as the first part of the Public Opinion Research Center's 'omnibus' study. The sample was chosen randomly, in layers, from the PESEL (population registration) database. The layers were *województwa* (provinces) and the type of residence location (cities, towns, villages). 1500 persons were selected and 934 were surveyed (with a sampling error of 3% and a 95% confidence level). The analysis used weighted data.

The Substance of Social Representations of Health in Poland

Among the issues raised in the individual in-depth interviews were ways of understanding health. The questions concentrated on the idea of health itself and to a lesser degree on the perceived relation between health and other phenomena such as lifestyle, medical institutions, treatment, and so forth. The following questions were asked: What is health? What do people understand by the idea of 'health'? What associations does the word 'health' have? What other words could be used to describe health? Who can consider himself/herself a healthy person? Is one definition of a healthy person (criterion of health) more important than others? Is health something a person either has or doesn't have, or can a person have more or less of it?

Based on the respondents' answers, a concept of health can be formulated that has the nature of a Weberian ideal type. Its specific elements appear to a greater or lesser degree in individual persons' notions of health. In this concept, health is composed of factors linked with three aspects—physical, psychological, and social—of an individual's functioning. The physical aspect of health contains two elements. The first is physical fitness, that is, the proper, effective functioning of the body: the ability to move, to use one's senses (for instance, eyesight), and so forth. Such a manner of understanding health is illustrated by the answer: '*…I look at it this way: if I can walk, if I can do something, I can see and so forth, for me, that's health*' (W11). The second element is the possession of a strong, properly functioning organism,

which is capable of self-regulation, effective adaptation to the requirements of the environment, and resistance to disease. Health is understood as: '*a strong organism, which, shall we say, is able to fight off an infection or, well, in general, not to suffer from any negative environmental impact*' (W18). The accent is placed on the good functioning of the organism as a mechanism. The most picturesque comparison was used by a respondent who compared a well-functioning organism to a car:

'*…like in a car—if all the components are functioning properly, the car runs and doesn't break down. Everything's fine; it uses less fuel then and so on. Similarly, in an organism, when all the organs, including the limbs, the internal organs, and the head are in order, the organism functions well and is then at its most productive*' (W25).

Health in this sense is the basis for health understood as physical fitness.

The psychological aspect of health involves psychological well-being and life energy: the desire to be active. Psychological well-being appears as good spirits, when health is '*associated with energy, with serenity, with a sunny day…with a smile. With pleasant, well, just, with very pleasant* [things]' (W23), with satisfaction with life and '*life without stress*', where '*you've got everything you want*'. Health is also identified with positive energy, vitality, vigor, the desire to act. It is described as a state where '*a person is active, full of energy*' (W2), as '*the strength and desire to live, to live, to want to live!*' (W17), as '*such vitality that a person feels such positive inner energy that it's…let's say, such "power" to act*' (W18). Then, says a respondent, a person wants '*to get out of bed*', has an appetite, and '*wants to meet friends, meet with people, to do something. If I feel like doing all that, I consider that I'm healthy*' (W6).

The remaining elements composing the concept of health—the absence of (a diagnosis) of illness and lack of contact with medical institutions, health as the ability to fill social roles, and health as a lifestyle—are largely social in nature. The conception of health as the absence of (a diagnosis) of illness and lack of contact with medical institutions are negative in nature; health then has no designatum. The result of an absence of illness is the lack of necessity of submitting to medical care and predominantly, in the answers of the respondents, these two things were strongly connected. Formulations reflecting such a manner of perceiving health describe a healthy person as one '*who doesn't go to doctors, doesn't complain of anything, of any infirmities. Nothing hurts, he doesn't have a problem with anything*' (W3); '*he isn't suffering from anything; he doesn't need to go to the hospital, to take some sort of pills*' (W15). 'Health as the absence of illness and lack of contact with medicine' was treated as an element with a social nature, because diseases, as items in the classification of diseases, the process of diagnosing a disease, and the whole process of treatment, are social in nature. On the other hand, health was identified with 'lack of suffering' or lack of 'infirmity', that is, descriptions referring directly to the physical sphere of a person's functioning.

Another aspect of health is the ability to perform social roles. This concerns both the independent performance of daily living tasks, the fulfillment of work obligations, and achieving various aims and life plans. Such a manner of understanding health assumes that there is not one norm proper for every person in a given situation, because it depends on the specific situation of the person and his or her social position

and roles. It could simply mean that a given person does not need care or the help of other persons in order to function in daily life and perform basic activities: that he or she is in a condition '*…to function without anyone's care or any kind of help*' (W15). For another person, health means the ability to undertake professional duties, that is, he or she will describe them differently depending on what those duties entail. One respondent expressed this thought in the following manner: '*But if I were to think that tomorrow I would have to go to work at a construction site, I would feel like a sick person* (…). *Thus I could say today that yes, I am ill* (…). *But that health infirmity* [from which the respondent suffers] *allows me to live normally and function*' (W19). Health of this kind is understood not only as the ability to perform daily tasks, but also the ability to achieve far-reaching aims and life plans, that is, '*a physical and mental state permitting the attainment of certain main goals*' (W24).

It is worth adding that understandings of health as a lifestyle appear sporadically in the answers, for instance: '*a way of life centering on responsibilities and pleasures'; 'health is also how we eat, how we sleep* (…). *But health is also our work conditions*' (W19).

All the above-mentioned elements were parts of the definition of health formulated earlier by persons studied in the British study (Blaxter 1990) and also in certain other studies. One of these elements, the 'proper functioning of the organism', corresponds to what many scholars have called 'reserves of health', as it concerns that aspect of health that allows disease to be resisted. A similar dimension was identified not only by British researchers, but also constitutes one of the three forms of health described by Herzlich. A similar element such as health as the 'absence of illness and lack of contact with medicine', which was identified as a result of the research presented here, was also found in the French study, in British studies (Blaxter 1990), in American studies (Damron-Rodriguez, Frank, Enriquez-Haass, Reuben 2005; Buck, Ryan-Wenger 2003) and in a study conducted in Poland (Puchalski 1997). Another aspect of health to which the respondents in our study called attention, that is, 'the ability to perform social roles' has been described most often as 'functional health' or 'health as a function' (Blaxter 1990; Faltermeier 1994, after Sęk 2001; Raport 2006). The next manner of perceiving health (as 'a healthy lifestyle') is also not entirely new in relation to what has been observed in studies to date, although in Herzlich's classic study this aspect of health did not appear. On the other hand, the persons studied by Blaxter (1990) described health as pro-health behaviour (such as abstaining from smoking or alcohol, or doing gymnastics), although the majority of these answers concerned the health of other people, and not of those responding. The appearance of the category 'a healthy lifestyle' as a synonym for health has also been observed by other researchers (Flick 2000; Buck, Ryan-Wenger 2003).

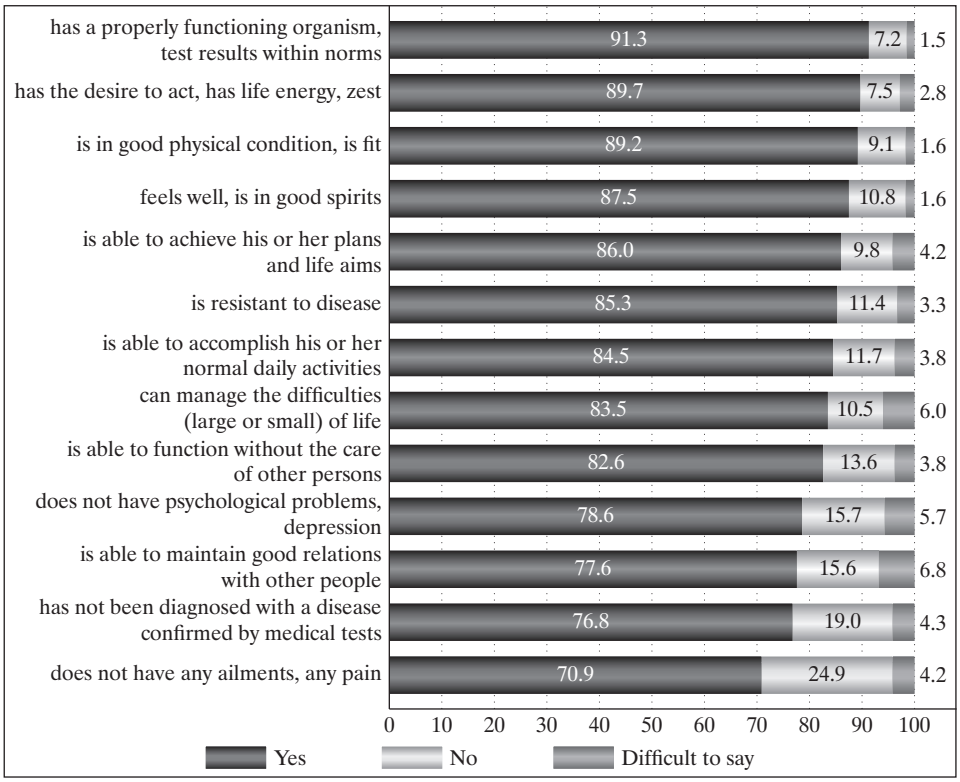
The Spread of Individual Elements of the Substance of Representation

Thanks to the individual interviews it was possible to learn the substance of social representations of health. The answers showed the multi-dimensionality and richness of the representations shared by people. However, the interviews did not make it possible to describe how often people define health in a given manner, to uncover

the internal structure of representations, or to identify particular aspects of the representations (forms of health). This was made possible by the survey research. The results of the qualitative research were used to construct survey questions on shared representations of health. The results are presented in Graph 1.

Graph 1

Health Criteria. Distribution of Answers to the Question: 'When Would You Describe a Person as Healthy? When He/She Fulfills Such Criteria As…'



As can be seen in Graph 1, specific definitions as criteria of health were indicated by 71% to 91% of the respondents. Most often indicated were the proper functioning of the organism (91%), the desire to be active, zest (90%), and good condition and physical fitness (89%). To a lesser degree the respondents defined a healthy person as one who is not suffering, who is without pain (71%), who does not have a disease confirmed by medical tests (77%), and who is able to maintain good relations with other people (78%). The fact that only a small percentage of persons disagreed with individual statements suggests the existence of a single complex representation of health in Polish society, where specific elements of that representation appear to a greater or lesser degree in the notions of individual persons. It is a little surprising that negative criteria (lack of suffering, lack of pain, absence of a medical diagnosis) were least often voiced, while the conclusion to be had from various other studies is

that such manner of understanding health is fairly widespread (Herzlich 1973; Blaxter 1990; Puchalski 1997; Domaradzki 2013b). Nevertheless, in the present study positive statements concerning the good functioning of the organism, good physical condition, and zest were most frequent.

Dimensions of the Social Representation of Health

A factor analysis, for the purpose of distinguishing forms/aspects of representation of health (see table 1) was made of the data acquired through the quantitative research into health criteria. As a result of the analysis three dimensions of the representation of health were distinguished. The first dimension comprises, on the one hand, a lack of psychological problems and good mental well-being, and on the other, functioning well in society, that is, the ability to function without the help of other persons, to perform daily activities, to carry out professional activities, to realize life plans. This aspect could be described as 'the ability to function independently'. A second dimension, which could be called 'absence of disease', is composed of such elements as lack of suffering or pain, lack of a diagnosis of illness, and life energy. The third dimension, called 'biological reserves of health', comprises the proper functioning of the organism and resistance to disease. It should be noted that the three aspects of health (the physical, psychological, and social) distinguished as a result of the individual interviews of the present study are in reality strongly intertwined with one another. This is shown by the fact that the dimensions that emerged from the factor analysis intersect but do not overlap with these aspects of health.

As was visible at the stage of the qualitative analysis, the above-mentioned dimensions correspond with the forms of health described by Herzlich and the concepts identified in British studies. The form 'health-in-a-vacuum' identified by the French researcher, the understanding of health as 'never ill, no disease' indicated by Blaxter, and the negative concept of health described by other British researchers, are similar to the dimension 'absence of disease'. However, in so far as the understanding of health revealed in those studies leads to a negative definition—health is simply the absence of disease—the statistical analysis of the present study makes it possible to claim that it also comprises life energy. The dimension 'biological reserves of health', like the 'reserves of health' identified in the French study, includes factors connected to the potential to resist and overcome disease: the proper functioning of the organism and resistance to illness. In Blaxter's study, this dimension was little stressed.

In so far as the dimensions 'absence of disease' and 'biological reserves of health' are very similar to the forms of health identified by Herzlich, the dimension 'ability to function independently' only partially overlaps with what Herzlich called 'equilibrium', but is closer to the 'functional health' described in British studies. Two of the dimensions, 'ability to function independently' and 'absence of disease', are similar to two of the three dimensions distinguished as a result of statistical analyses conducted by Bishop and Yardley (2010) for the purpose of constructing a scale to measure people's convictions about the importance of various signs of well-being. These are the functional and biomedical dimensions, with the biomedical dimension comprising

only the biological and medical aspects (absence of disease and suffering) and not life energy as in the present study. The remaining dimensions are completely different in the two studies, perhaps as a result of a slightly different approach. Bishop and Yardley assumed the existence of certain dimensions on the basis of the literature and constructed corresponding tools. In the present study, however, questions were composed on the basis of answers in the qualitative study and factor analysis was used to find dimensions of the representation of health.

Table 1

Dimensions of the Social Representation of Health in Poland. Results of the Factor Analysis (factor loadings)

When would you describe a person as healthy? When he/she…	Dimension I Ability to function independently	Dimension II Absence of disease	Dimension III Biological reserves of health
is able to function without the care of other persons	.844		
is able to achieve his or her plans and life aims	.765		
is able to accomplish his or her normal daily activities	.744		
is able to maintain good relations with other people	.736		
does not have psychological problems, depression	.578		
can manage the difficulties (large or small) of life	.539		
feels well, is in good spirits	.536		
is in good physical condition, is fit	.519		
does not have any ailments, any pain		.716	
has not been diagnosed with a disease confirmed by medical tests		.537	
has the desire to act, has life energy, zest		.422	
has a properly functioning organism, test results within norms			−.626
is resistant to disease			−.561
Percentage of explained variation	46%	6.1%	3.3%

The Kaiser-Meyer-Olkin (KMO) measure is .936. This is a test to verify the adequacy of data for factor analysis. It gives a value of 0 to 1. A value near 1 signifies a sufficiently high level of correlation between variables to make their factor analysis reasonable. The analysis was conducted by the principal axis factoring method with direct Oblimin rotation with Kaiser Normalization. The number of factors was determined on the basis of a scree plot. The resultant dimensions explain 55.5% variation of the analyzed variables. Factor loadings greater than .4 are presented.

However abstract and difficult to conceptualize and operationalize the object of the study, and however the differences of research method may limit comparison of the results of various studies, certain conclusions can yet be drawn, as a kind of hypothesis. The representations of health identified in our research correspond with Herzlich's findings and those of the British researchers, even though their studies were conducted over a dozen years earlier. This suggests that the social representations of health shared within our European cultural circle are similar and do not show much change over time. It is also possible that the findings reflect to a certain degree the cultural influences of the middle class (studied by Herzlich about 40 years ago) on other social classes, and the influence of the Western cultural sphere, represented

by France and Great Britain, on Polish society. Comparison of the results of these studies with, for instance, studies of representations of health among Great Britain's Chinese minority (see Jovchelovitch and Gervais 1999), shows that it is possible to speak of representations of health proper to the European cultural circle.

Even though the social representation of health appears to be fairly stable in the European cultural sphere, the subtle changes that seem to be occurring—such as greater emphasis on positive aspects of health and the appearance of a new element such as identifying health with a healthy lifestyle—are worthy of attention. They can be partially attributed to the activities of health promoters, who propagate this kind of positive vision of health and promote healthy behavior. In the context of the discussion on the efficacy of implementing health promotion in Poland it is worth adding that the impact of these activities on the image of health does not need to be direct in nature (cf. Słońska 2005, 2012; Puchalski 2005). It is rather the result of certain information being brought into the general discourse by means of the mass media and so forth. This process contributes to spreading the ideology of 'healthism', which consists in concentrating on health as an essential value encompassing nearly all positive spheres of life, and the conviction that an individual must make efforts—in terms of 'healthy behavior'—on its behalf (Crawford 1980; Słońska, Misiuna 1994; Borowiec, Lignowska 2012).

What Functions Could Social Representations of Health fill in Polish Society?

The dimensions of the social representation of health identified in our study can be viewed in terms of their significance for the social order. The role that could be filled by a perception of health as 'absence of disease' seems obvious in the context of modern societies, where a large part is played by the medical social control: this involves its medicalization—the process of extending medical jurisdiction to areas previously under other institutions of control such as religion or law (Foucault 1999; Zola 1972). In other words, medicalization is '…defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to "treat" it' (Conrad 1992: 211). As Davis (2006) writes, in the majority of definitions medicalization stresses a process whereby an originally non-medical problem is transformed, through redefinition and treatment, into a problem within the jurisdiction of medicine. The literature describes the medicalization of many phenomena that were once considered normal problems of daily life, natural life processes, or sins, crimes, or immorality (Davis after Kłos 2014; Conrad 2005; Clarke 2003). These processes lead to the subordination of increasingly large areas of life to medical social control. It would seem that this is still happening in spite of the erosion of medical authority signaled in the last decades of the 20th century (Conrad 1992). The role of other persons, institutions, and phenomena in driving the process of medicalization appears to be growing. These include pharmaceutical firms, which desire a larger market for their products; lay groups, which demand that certain conditions and behaviors be recognized as diseases; patients, who are

increasingly like clients or consumers in requiring certain medical interventions; and also biotechnology and 'managed care' (see Clarke 2003; Conrad 2004; Conrad 2005; Wieczorkowska 2013).

Nevertheless, medicine still provides the conceptual frame for defining issues in medical categories (determining the criteria of health and disease) and then, within that sphere, performing medical tests, interpreting the results, making diagnoses, and undertaking activities to resolve the problem (cf. Conrad 2005; Davis 2006). In such conditions, understanding health in medical categories—as an 'absence of disease' contributes to maintaining the domination of medical institutions and medical social control. Defining a specific problem as a disease justifies medical intervention and at the same time medicine's control over the ill person. This is accompanied by an increasing commercialization of health care and the creation of greater demand for pharmaceuticals and surgical interventions, thus serving the material interests of certain groups connected with medicine—not only doctors, but also persons connected with the pharmaceutical or medical industry (cf. Clarke 2003; Conrad 2004; Conrad 2005). In other words, this dimension of the representation of health serves to maintain a set social order, in which not only the medical social control plays a large role, but specific advantages are also obtained by entities that are 'agents' of medicalization.

The next dimension, 'biological reserves of the organism', is also a notion in which health is identified with the proper functioning of the organism and resistance to disease. The assumption here, which was not strongly stressed in the answers of the respondents in the Polish study, is that these reserves constitute a potential that can be increased or diminished. Such a manner of understanding health could play a large role in the modern society, where not only being ill is the object of medical interest, but also being at risk of illness. And as Clarke and others (2003) write, a person can be ill or at risk of illness without symptoms of this state, and furthermore no one is free from the risk of illness but is only at risk to a lesser, medium or greater degree. Therefore, people are required to undertake special activities to reduce this risk (see Clarke 2003; Crawford 1980). Not only specialists of public health refer more or less explicitly to health in terms of a renewable resource (cf. Słońska 2005: 97, 2012: 111) but also journalists covering health issues, pharmaceutical firms, and the sellers of other goods and services connected with health, for instance, sports clothing, health food, and even phone apps supporting physical fitness.

Clarke et al. (2003: 172) write that '…we inhabit tenuous and liminal spaces between illness and health (…) rendering us ready subjects for health-related discourses, commodities, services, procedures, and technologies'. Without the vision of health as a renewable resource there would be no sense in the activities of those groups aiming to persuade people to healthy behaviors (to reduce the risk of illness) and to purchase goods and services furthering this aim. It can thus be concluded that this dimension of the social representation of health protects the interests of those social groups. On the other hand, this dimension could also function to motivate health practices whose goal is to maintain, or even improve, the condition of the organism. The total effect of these activities in the form of improving the health condition of society can be evaluated by objective indicators.

The dimension 'ability to function independently' concerns an entirely different aspect of the individual's functioning, namely the possibility of that individual's filling social roles. This notion assumes that a person is healthy for as long as he or she is capable of fulfilling his or her vocational and family responsibilities and of pursuing long-term plans. This understanding of health as the ability to fulfill social roles allows individuals who, having a medical diagnosis of disease, are not healthy in the biomedical understanding of health, to function normally in society. In particular, this concerns the chronic diseases that are increasingly widespread in developed societies. It can be hypothesized that the understanding of health as 'the ability to function independently' enables persons facing long-term illness and the related social, interactive, and existential problems to maintain their identity; it protects them from stigmatization while integrating them with society (Charmaz 1983). The perception of health as 'the ability to function independently' could, to a certain degree, guard persons from the stigmatization resulting from 'victim blaming', that is, the conviction that the disease is the fault of the sufferer (Słońska, Misiuna 1994; Crawford 1980).

Because the limitations resulting from a disease are largely limitations of physical fitness, a disease may be less visible and stigmatizing in the case of a person performing intellectual work. Such persons can remain professionally active in spite of illness. It would seem thus that this dimension permits primarily, if not solely, persons having such work to maintain their identity and avoid stigmatization. At the same time, persons who do physical work could be condemned, on falling ill, to change vocations or become unemployed. On the other hand, such a manner of perceiving health protects society to a certain degree against the costs resulting from the necessity of maintaining persons who are ill.

The conclusion from the above considerations is that not only concentration on health, its care, its control, and health practices may be ideological in nature, but also the manner of understanding health itself. How people understand health could contribute to maintaining a social order in which medicine and medical social control still play a large role. In addition, it could protect the interests of other groups who receive benefits from the process of medicalization. Nevertheless, certain manners of understanding health seem to function to motivate health practices, protect the identity of chronically ill persons, and even to protect the financial interests of the state.

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