

*Building A Social Movement for Health Equity:
Narratives and Shaping Discourse
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The promotion of greater awareness and interest in health inequities within the public discourse is one factor that will help to make the problem a public issue, move it onto the public agenda, and create a social movement for related public policies needed to address the social determinants of health that contribute to health inequities¹.

While this sounds like a straightforward directive, several hurdles make it difficult to generate a public discussion around health inequities. This article examines one such obstacle in the form of the cultural tool kit and mental frames that societies most commonly associate with health.

The cultural toolkit includes a set of distinctive spiritual, material, intellectual, and emotional features that a society uses to interpret experiences. The toolkit is comprised of the attributes of groups or societies that shape how they classify, evaluate, and assign meaning to understand experiences. These attributes include shared values, codes of manners, dress, language, religion, rituals, norms of behavior, and systems of belief².

Current evidence lends qualified support to several health narratives most prevalent in the United States that act as barriers to public discourse on health inequities : (1) an “individualistic” position where health-related conversations are negotiated around narratives based upon the choices that people make and the degree to which individuals take responsibly for themselves; and (2) a health care narrative where the central focus is on either access to or the quality of care to the exclusion of other contextual determinants of health³.

Research also shows that when health is discussed in a broader context as a sociopolitical phenomenon additional, non-productive narratives often appear forestalling efforts to advance a health equity agenda⁴.

All of these various narratives present a key problem, namely, the contradiction between the basis for health inequities as an observable sociopolitical fact calling into question the

¹ For purposes of this paper health disparities and health inequities are different. Health inequities are health differences which are socially produced, systematic in their distribution across the population, and unfair. Identifying a health difference as inequitable is an appeal to ethical norms. Alternatively, health disparities are any group differences in health, i.e., the fact that women generally live longer than men. The differences in health that are disparities may or may not be unjust.

² Lauri Andress, "The emergence of the social determinants of health on the policy agenda in Britain: A case study, 1980--2003" (January 1, 2006). *ETD collection for Houston Academy of Medicine-Texas Medical Center*. Paper AAI3258575.
<http://digitalcommons.library.tmc.edu/dissertations/AAI3258575>.

³ Aubrun, A. Brown, J. Grady, J. External Factors vs. Right Choices: findings from cognitive elicitations and media analysis on health disparities and inequities in Louisville, Kentucky. A Cultural Logic Research Report. 2007.

⁴ Andress, 2006.

role of public policy versus a common set of beliefs, values, opinions, and attitudes that frame health as simply a determinant of healthcare and individual action.⁵

Values are of utmost importance in any effort whose goal is to shape the preference for and selection of a set of policy recommendations. This is so because enduring values are deeply entrenched within an individual's cognitive system and serve as precursors for other more overt expressions such as opinions, attitudes, beliefs, and behaviors⁶.

To begin to get traction on health as an issue of social justice focused around a broad array of public policies we must engender a broader association with and discussion about health as a sociopolitical phenomenon. A central question then is how to shift the values, systems of belief, and mental frames in the cultural toolkit, alter the discourse, and expand current narratives about health to enlarge it beyond current narratives so tightly linked to health care, self-responsibility, individualism, and private experiences?

How do we begin to understand the reasons for the inability of the public to make an association between health and systemic, structural, and contextual factors that lie outside the body?

Previous research demonstrated that broad media coverage of health and social inequalities via print media failed to alter public perceptions and awareness of the relationship between structural factors and health (Andress, 2006). Analysis indicated that over a twenty-three year period of time sustained media coverage failed to impact public notions regarding health and its connection to lifestyle/behavior (Andress, 2006).

American explanations for this finding of no relationship in the public's mind between health and the structural determinants of health rest upon the difficulty of shifting deeply entrenched public values surrounding notions of personal responsibility. This narrative has been ingrained and reinforced over many years by two commonly reinforced ideals.

First is the American vision of the bootstrap principle and the narrative around "rugged individualism". The second reinforcing ideals come from the U.S. version of health promotion messages and the deeply rooted beliefs instilled in public health practice from the behavioral sciences. Historically, public health values rest on the position that the marginalized and unhealthy suffer from lack of self or social control resulting in the inability to restrain destructive urges.

⁵ A value is an "enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence" (p. 5 Rokeach, M. *The nature of human values*. New York: The Free Press: A division of Macmillan Publishing Co., Inc.; 1973). In contrast a belief is the "mental acceptance of and conviction in the truth, actuality or validity of something" (p. 121 Yankelovich, D. *Coming to public judgment: making democracy work in a complex world*. Syracuse, New York: Syracuse University Press; 1991). An attitude is an "organization of beliefs focused on specific objects or situations" (p.18 Rokeach, 1973). An opinion is the "verbal expression of some belief, attitude or value" (p. 2 Kenny, N. Dickinson. R. Dion Stout M, Lessard R. Lougheed G. Radcliffe, S., et al. *National forum on health: values working group synthesis report*. Ottawa: Health Canada; 2003).

⁶ Collins, P. Abelson J. Eyles J. Knowledge into action? Understanding ideological barriers to addressing health inequities at the local level. *Health Policy* 80 (2007) pgs. 158-171.

In this case, unhealthy people are thought to be the product of a condition of personal maladjustment characterized by the incorrectness of the person's private volitions, lack of strength of personal responsibility, and the inability to function as a normalized citizen (Lupton, 1995, Polsky, 1991).

The American notion of self-reliance and the traditional approach from the behavioral sciences centered on "fixing" the person act as barriers to efforts demonstrate a connection between health outcomes and structural determinants of health.

Research from England by Bolam (2004) (p. 1355) explained the lack of association between health and class on "two competing argumentative positions" around which individuals work to negotiate class, identity, and health. The first position denies the significance of class for identity and individual health substituting mythical stereotypical narratives of "heroic and stoic" working class identities (Bolam, 2004) (p. 1355). In the second position associations between the realities of class relations and their implications for health and identity are made only within the context of a broader discussion on health as a social or political phenomenon.

Blaxter (1997) offers several possible explanations to explain why lay people fail to associate health with inequalities. First, the widespread, long-term effects of health promotion education have influenced the way in which individuals conceptualize health.

This conceptualization is a narrow version of health determinants excluding socioeconomic factors and dependent upon lifestyle, behavior, and/or the effects of health care. Second, Blaxter (1997) says that acknowledgement of inequality would be to admit an inferior moral status for oneself or one's peers.

Macintyre (2005) in a quantitative study using data from a community-wide postal survey in Scotland, asked the respondents: "Who do you think is more likely to have the following experiences (health, disease, being fit, cancer, mental illness, accidents/injuries, living longer): rich people, poor people or both about the same?" Across all health categories, the outcomes indicated that those in lower social classes or from poorer neighborhoods were equally or less likely than more socially advantaged counterparts to say the poor had worse health.

On the other hand, after controlling for sex, age, class, and locality, those in lower social classes and in the poorer areas were significantly less likely to say that richer people live longer. Macintyre (2005) concluded that those most at risk for poor health were less likely to acknowledge the health gap or the social gradient in health, which demonstrates the existence of health outcomes based on social class or relative income.

The clearest findings in several studies are that individuals tend not to consider structural causes of health and rarely talk about inequalities in health unless there is an intentional effort to provoke the conversation (Andress, 2006).

A study by Davidson et al., (2006) (p. 2173) found that individuals will discuss the effects of socio-economic deprivation on well-being but only after being “explicitly prompted to talk about inequalities in health with the introduction of images and headlines from the reporting of government consultative and policy documents”...[including] newspaper pictures and headlines on deprivation and health inequalities between the rich and poor. The challenge now is to continue to explore the kinds of images, narratives, and messages that may help to broaden the discussion about health so that it includes systemic and structural factors including public policy decisions.

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