

DRAFT

NOTES ON THE CHALLENGES OF TALKING HEALTH EQUITY

Peruse the magazine section of any supermarket or airport in the country and you'll find dozens of cover headlines like this: "Ten Foods to Eat to Live to 100," "Five Ways to Protect Your Heart," "Three Simple Steps to Reduce Stress."

What you're unlikely to spot is a headline like this: "Living Wage Jobs Bring Health Benefits." Or how universal pre-school, or affordable housing, or desegregation, or better transportation can improve our health by improving our lives.

Yet by now the evidence is overwhelming that the economic and social conditions in which we are born, live, and work can actually get under our skin and affect our health as surely as germs and viruses. As Nancy Krieger says in *Unnatural Causes*: "Our history is written into our bodies." Our bodies reflect an accumulation of conditions that start in childhood and, in Jack Shonkoff's words, can lead to "a cascade of advantage for some, a pile-up of risk for others."

Despite the evidence, public debate is still for the most part trapped by the conventional individual, bio-medical paradigm of meds, behaviors and genes.

As many have pointed out, this discourse is built on three legs:

1. Health is conflated with health care
2. Prevention is equated with individuals making the "right choices"—diet, tobacco and exercise
3. And the deus es machina that will save us all lies in medical advances (especially drugs and eventually stem cell and genomic breakthroughs).

This discourse is deeply imprinted in the psyche of the American public. It stands like an elephant squarely in the way of a social determinants approach to health equity since it allows society off the hook. No SDOHE communications strategy will be successful unless it is able to decenter and eventually rupture this discourse and begin to suture together a new one. How can communications strategies help the nation move from the old, individual bio-medical story to the new social determinants of health equity story?

SUMMARY

These notes are meant to prime that discussion, to be the first word, not the last, on what a health equity communications strategy might look like. They are neither exhaustive nor comprehensive. Many will find ideas here that are simplistic, incomplete, or even wrong. That is good. Next time I read this, I will no doubt cringe at parts of it and want to improve it too. Let's look at this then as a living document that will change and evolve over time.

The ideas that inform these notes are drawn from California Newsreel’s experience distributing *Unnatural Causes*, from analysis of the 789 respondents to the *Unnatural Causes* user survey, and from informal discussions among several health equity thought leaders.

These notes are limited to pondering the elements of a communications strategy that can lay the groundwork for a health equity agenda. It is worth stating the obvious: communications is not a substitute for a health equity agenda. I also assume here the not quite so obvious: a communications strategy need not wait until such an agenda is in place. For the objective of a communications strategy is not, at this time, to promote a specific agenda, or win ‘votes.’ It is not a campaign. Rather its challenge is to problematize many of the normative ideas and assumptions that the public and policy makers take for granted about what makes us healthy or sick, and in so doing, enlarge the public space, lay the groundwork, perhaps even feed an eagerness for, a consideration of new ideas grounded in social determinants.

MAKING SENSE OF HEALTH

Health equity is a new idea for most people. It’s not difficult to grasp. But it does require us to change the way we present stories about health differences.

Health equity is **not** about different outcomes per se. *Disparities* or inequalities in health arise from many reasons, including plain darn luck. Health *equity* concerns those differences in population health that are systemic, socially produced, and preventable---and thus inherently unjust and unfair.

In other words, health equity is about those outcomes that can be traced to inequities in other arenas of our lives—the jobs we do, the wages and benefits they pay, neighborhood conditions, the quality of our schools, the power we have to manage the conditions that impinge upon our lives. These are every bit health issues as diet, tobacco and exercise.

But this *story* of how *society* shapes our health has been all but absent from mainstream discussions and policy debate.

We’ve observed among the discussions surrounding *Unnatural Causes* screenings three sets of mutually constitutive assumptions that mask how society can make us healthy – or sick. They reaffirm much of what has already been written by Cultural Logic, Frank Gilliam, Susan Bales and Frameworks, Larry Wallach, Lori Dorfman and others.

1. Personal Responsibility

Research suggests that most Americans – and policy makers – view unequal population outcomes as a result of individuals making the wrong choices, be it from ignorance, lack of self-discipline, cultural practices, or “lifestyle” choices.

As has been pointed out by Grady and Aubrun, this default “right choices” behavioral frame removes individuals from their societal context, reinforces the divide between “them” and “us,” and stops political action dead in its tracks.

2. Health gaps unfortunate but not necessarily unfair or unjust

Whereas progressives view unequal outcomes as ipso facto evidence of unjust social arrangements, for others hierarchy simply reinforces their naturalized view that the world is working as it should, reflecting choices made by self-determining individuals. If some groups fare worse than others, that's simply more evidence they made the wrong choices, have a dysfunctional culture, or even have bad genes. It's certainly not a reason to "redistribute the wealth."

3. Nothing can be done.

Health gaps (when acknowledged) are viewed as deeply entrenched and too big a problem to address. And when those different health outcomes are perceived as the logical result of personal behaviors, government interventions are easily disparaged as the "behavioral police" or the "nanny state." The lack of a specific health equity policy agenda and action steps make it easier for critics to employ this tried and true mode of censure.

These conceptual frames serve as the "common sense" prism through which the public filters, interprets and gives meaning to health news and blinds itself to the social determinants of health inequities. As a result, even when the press does run an occasional story about health "disparities" (i.e. different outcomes), research suggests the public is likely to blame the victim for making the wrong choices.

A FRAMEWORK FOR HEALTH EQUITY COMMUNICATIONS

What implications, then, should we draw for how we talk about health equity? We posit for discussion six key communications challenges, or message frames, that need to be integrated into the new story of how society structures health opportunities. (These complement the message frames in California Newsreel's "10 Things to Know About Health.")

1. Focus on the Social Determinants of Health Equity

As implied above, it's not enough to demonstrate unequal outcomes. Rather we need to re-focus our lens on the inequitable social structures, institutions and social and economic arrangements that generate and drive those outcomes.

There are two parts to helping people see this: First, we should certainly acknowledge that behaviors and individual responsibility are important, but also demonstrate how *the behavioral choices we make are often constrained by the choices we have*: the challenge of getting five to seven fruits and vegetables a day while living in a food desert, or of shopping and cooking after a long commute or working two jobs; the difficulty of exercising if the neighborhood isn't safe and walkable and lacks parks and green space, or perhaps even more commonly, if long working

hours and commutes and lack of child care preclude the time to exercise, shop and cook. Environments also shape norms that in turn influence behaviors.

But it's equally essential to demonstrate how many health outcomes have *nothing* to do with individual choice.

Government and corporate decisions over which individuals have little say can expose us to health threats or health promoters: the location of toxic dumps, the quality of schools, whether factories stay open or shift jobs overseas, where parks and freeways--or public transit--get built, the wages and benefits jobs pay, regulation of the mortgage market and foreclosures, even tax policy. These all profoundly affect our opportunities to live healthy and flourishing lives.

Because these societal resources are distributed unequally by class and by race, so too are our patterns of health and disease. Michael Marmot wrote: "Health inequities arise because of a toxic combination of poor social policies, unfair economic arrangements and bad politics. These, in turn, affect the circumstances in which people are born, grow, live, work and age."

2. Redefine Risky Behaviors.

We know that smoking, drinking, lack of exercise, fast food diets, are all risky behaviors. But what about bankers who made predatory loans and in their wake have left block after block empty and millions of lives destroyed? Or the bond traders whose securitized derivatives and collateralized debt swaps made those predatory loans not only possible but profitable—and brought our economy down while doing so? Or the lobbyists for agribusiness and the food industry and their paid pawns in Congress who subsidize corn—and thus corn syrup and obesity—with our tax dollars, as has been so eloquently described by Michael Pollan and Eric Schlosser? Or General Motors executives who spent millions opposing first seat belts and other safety regulations, and then mileage standards, and whose refusal to invest their profits in new, fuel efficient auto technologies finally led to bankruptcy and the loss of tens of thousands of jobs. Or those corporations which have dumped their pensions entirely, or the many others that cost-shifted pension risk onto the back of employees by selling Americans on the magical virtues of 401(K) plans, and so now retirees find their material assets unexpectedly slashed, and their health at risk?

Why don't we define these actions as risky behaviors and assess them not only in the currency of profitability but also in the currency of health?

The British medical sociologist Graham Scambler rather infelicitously calls this approach "the greedy bastard" hypothesis of health. He argues that diminished health status and reduced life expectancy of the middle class and the poor are in significant part due to the "risky behaviors" of the globalized corporate elite.

3. Redefine Compliance: Hold Government and Corporations as well as Individuals Accountable

This is a corollary to redefining risky behaviors. Doctors hold patients responsible for taking their medications; if they don't they're labeled non-compliant. But take a poor asthma patient who lives in a damp and moldy apartment overrun with cockroaches and vermin and other asthma triggers. Why don't we hold the landlord to be out of compliance as well? Or the Housing Department or the Mayor charged with enforcing housing laws and regulations? Or the legislators who write the laws? Or most of all the political and legal arrangements that allow large developers, their trade associations, lobbyists, publicists, and media campaigns to exercise such one-sided, disproportionate power over government officials and their decisions that lead to the inequities and oppression faced by our asthma patient?

Since the conditions for health are created by the individual and government and corporations, shouldn't we hold each accountable? Elected officials can make policies that influence the kind of jobs available, whether they are secure or will move overseas, the money and benefits they pay, the supply of affordable housing, the quality of our schools, the power we have over our lives... These are every bit health issues as are diet, tobacco and exercise.

So, as NACCHO senior policy analyst Richard Hofrichter has pointed out, let's ask new questions: Rather than, for example, just asking: "How can we promote healthy behaviors?" Let's also ask: "How can we target those responsible for dangerous conditions and better ensure healthy spaces and places?"

3. Make Health Equity an 'Us' Issue.

Health Equity is a problem for all of us, and an opportunity to build cross-racial and cross-sectoral alliances.

Following the "right choices" frame, much of the public, especially middle class white people, think of health gaps (when they think of them at all) as pertaining to "them," "those people:" the poor, people of color, all of the above.

But the wealth-health gradient suggests that it's not just that the rich are healthy and the poor are sick, but that the health of the great majority of Americans, perhaps 80% of the population, is threatened by the growing inequality between the rich and the rest of us and our degraded economic, social and built environments.

Second, there's a financial cost we all share: Our sick care system has hit the wall. We already spend more than twice per person on health care than the average rich country, more than \$2.5 trillion per year, 1/6 of our GDP. A healthier population can relieve some of the pressure on the system.

And third, unhealthy people are not productive and harm our competitiveness. According to a study by the Santa Monica Institute, business is losing more than a \$1.2 trillion a year and growing in lost productivity due to chronic illness.

Still, many believe that at its core the *us vs. them* issue is about race, or more precisely, racism. Should this be confronted directly? How? How do we render visible the deep-seated structures of racism, not just personal prejudice, that disproportionately channel power, status and wealth to white people? As John Powell says in our earlier documentary series, *Race-The Power of an Illusion*: “The slick thing about whiteness is that you don’t have to personally be racist to reap the benefits of a racist system.” John Powell himself has eloquently argued for a way to talk about racism and class in our ‘post-racial’ world that he calls targeted universalism. (<http://academic.udayton.edu/race/01race/racism12.htm>)

4. Americans’ Health is America’s Choice

Our health inequities are not set in stone. They are not natural, not inevitable. As David Williams puts it in *Unnatural Causes*: “These are not acts of God, and they don’t happen by chance.” On the contrary, population health is a product of decisions we have made -- not just as individual bodies but as a body politic -- and can make differently. We’ve changed them before and we can change them again.

There are several ways to raise this issue:

Use history to demonstrate how population health tracks social changes and policy. Health gaps narrowed in the wake of civil rights and the war on poverty, yet began widening again beginning in the early 1980s, paralleling the growing inequality since the Reagan administration kicked off a three decades-long project of cutting back social programs, tax cuts for the rich, and most of all, deregulating our way into an unbridled free-market and degree of corporate power not seen since the Gilded Age.

One result is that we’ve fallen to 29th in life expectancy and according to the CDC we are now also 29th in infant mortality.

Similarly, many historians argue that the 30-year increase in life expectancy during the 20th century was driven mostly not by medical advances but by social changes that enabled productivity increases to be shared by ever-larger segments of the American population: the eight hour work day, sanitation and housing codes, the right to collective bargaining, social security, banking and business regulation, a progressive income tax, the civil rights movement and the environmental movement, the war on poverty, Medicaid and Medicare.

Appeal to National Pride: Why don’t we, the world’s richest and most powerful nation, have the world’s best health outcomes? What do these other countries have that we don’t? Do they have better genes?

There are arenas in which we are #1:

- The greatest wealth inequality
- The highest poverty rate
- The highest child poverty rate
- The smallest middle class

- The least social spending (as a % of GDP)
- The highest incarceration rate (1/4 of the world's prisoners)
- The lowest voter participation rate

It's by now fairly common knowledge that the U.S. is the only rich country not to guarantee universal health care. But it's also the only rich country not to guarantee by law:

1. Universal health care
2. Paid vacations
3. Paid sick leave
4. Universal pre-school
5. Paid parental leave

And if we lose our job, let alone our home, we're on our own. Sink or swim. As Joe Biden's economic advisor, Jared Bernstein, put it, we're a YOYO society - you're on your own. Whereas the social democracies of Europe are more like WITT societies - we're in this together. They make social investments that lessen inequality and also make access to many health promoters more universally available independent of an individual's household resources. Why wouldn't our health outcomes reflect these policies and arrangements?

5. A New Rx for Health: Social Policy *Is* Health Policy

What kind of programs can make a difference? What policies constitute a health equity agenda? It's not enough to talk in the theoretical and abstract. What are three key initiatives or policies, for example, that can improve health equity, gain political traction and energize people? And bring that agenda before the administration? High profile national health equity efforts have been launched in other countries, especially in the wake of the WHO CSDH report. But not here.

There are three overlapping yet distinct arenas for action:

1. Close the gap between the rich and the rest of us. Policies like living wage laws, earned income tax credits, tax reform, regulation of banks and financial institutions, paid vacations and sick leave, union check-off, job training and career ladders, and perhaps most salient, residential desegregation and racial justice can all lessen inequality and improve population health.
2. Protect under-resourced communities and households from health threats through de-commodification – i.e. make social investments in what are now too-often commodities accessible only to those who can pay for them: universal quality pre-school and an enriched education, quality affordable housing, affordable transit options, nutritious food, environmental justice, recreation facilities and parks... These policies provide means of achievement—and health—to those with fewer family resources.
3. Open and democratize decision-making that is too often dominated by concentrated economic and political power, such as land use decisions, political campaign reform,

labor law reform, banking oversight, works councils, etc. For example, the more than 200 municipal redevelopment agencies in California collectively are far and away the largest real estate developer in the state. Yet their actions are so opaque that few of us even know what they do, who chairs the local redevelopment agency and how it financed, let alone hold it accountable.

6. Appeal to Common Sense

The logic and evidence are ample. Investing in health equity makes good moral sense and good fiscal sense. In fact, it's common sense. Let's make the arguments clearly, simply and concisely: Investing in creating the conditions for health today is not an expense; it brings a return on investment and more healthy and prosperous society tomorrow: less money spent on our bodies' repair shops, higher productivity and a healthier old age.

STRATEGIC COMMUNICATIONS: SEVEN MEDIA DOMAINS

Digital media are not just dissolving the boundaries between traditional media platforms (print, TV, radio, theatrical) but the domains in which they operate. Nonetheless, at the risk of oversimplifying, we'll postulate seven media domains (thanks to Amanda Rounsaville for suggesting this typology). An eighth is advertising, but we'll omit that here. Working for health equity in each of these domains increasingly demands operating in multiple media platforms: print, radio, tv, on-line, DVD, etc. And each initiative to be effective, must communicate not just data but good story-telling appropriate to its audience. And not only good story-telling but a *new* story, the "society matters" kind of story that informs *Unnatural Causes* and contests the conventional, oddly intertwined myths of the self-determining individual and the *deus es machina* (literally: god in the machine) of technological fixes that together prop up not only the individual, bio-medical approach to health but structures of power..

1. **The News Media** - Both mainstream and ethnic

The news media should be seen not just as a target, but a partner. Journalists should be cultivated, press and video news releases and backgrounders sent out regularly, if not daily, that frame causes and solutions to health inequities beyond individual-level factors. Similarly, health equity seminars and presentations can be made at all apposite journalist conventions and fellows programs. News media, today more than ever, are looking for new content opportunities that cost them little. Provide B-roll video, develop reader polls and quizzes, provide story ideas, serve as sources. Make connections to community-based organizations. As far as politicians are concerned, the news media are a proxy for public opinion. They define problems, finger causes, make moral judgments, and legitimize remedies. The challenge is to provide stories that invert the way the news media conventionally organizes and presents its coverage. As Todd Gitlin has argued, we need to draw attention to the underlying condition, not the event; the group, not the individual; organizing for change, not just the conflict; and the facts that explain the story rather than the ones that simply advance it. Lori Dorfman and Larry Wallack call this, "describing the landscape surrounding individuals and events."

2. **Community Media**—Characterized by hyper-local orientation
The challenge here is to re-purpose health equity stories for local use as well as tap the collective “wisdom of the crowd” to generate their own content, their own “backyard” investigations and priorities (e.g. neighborhood health indicator maps, calls for action, house meetings) as steps towards further engagement. By tapping into local, front-line activism, by submerging the text in its local context -- neighborhood, clinic, church, workplace or classroom -- community media offers opportunities to better ensure that content will be encountered in a structured setting where action is not only possible but expected.
3. **Social Media**—Peer-to-peer networks and virtual communities.
Build capacity and reach of health equity advocates through learning communities and social networks, messaging and talking points, and the sharing of local success stories (and failures) such as spotlighting and sharing cost-neutral county initiatives that have cut infant mortality rates. Build through RSS feeds, Facebook, YouTube, Twitter, story share and photo-voice, on-line workshops, and perhaps most of all, the generation and mining of data bases. Connect individuals and organizations to each other as well as trigger rapid responses to action opportunities: legislative, media, public events, etc. Some of these virtual communities will be “loose and fluid,” others “strong and fixed.”
4. **Educational Media**—for both formal (i.e. classroom) and non-formal education.
Includes documentary and trigger films, webinars, discussion and facilitator guides and companion curricular materials. This is an arena that California Newsreel can justifiably claim some expertise. But even its contours are changing with the advent of digital delivery, and the ability to repurpose and aggregate content from discrete programs and media sources. (Note that educational media, while lacking the sex appeal of entertainment media, reach large and diverse audiences. More than two million people screened *Unnatural Causes* within the first 18 months of its release in educational settings alone. These audiences are both more diverse than the self-selected audience for television broadcasts and theatrical release, while the quality of the viewing is more engaged, more purposeful and more critical since most screenings include a discussion, follow up activities, or even a writing assignment or test.).

(California Newsreel has identified several multi-media documentary projects that can build on the success of *Unnatural Causes* and further promote an SDOHE framework. The first, called *American Birthright*, will address the “social ecology” of early childhood, specifically the role of class and racism and society’s responsibility to facilitate the stable, secure and stimulating environments all children need to thrive. The issue appeals to what Gunnar Myrdal called our “civic creed,” the American belief that each individual deserves an equal opportunity to realize his or her full potential. Investments in early childhood can payoff in improved chances for life-long cognitive, psychological and physical health, and reduced costs to society. America’s economic and social future depends on nurturing all our children, the smartest investment any country can make.)

5. **Entertainment Media**—This is where Americans (sadly) spend much of their diurnal existence. Entertainment media normalize the values of our consumer society, i.e. turn them into “common sense.” Yet there may be opportunities to serve as an info / story resource for TV/film/game producers, and also work with them and the Writers Guild proactively (such as through the Lear Center for Hollywood, Health and Society and other vehicles) to develop “landscape” stories that address how racism and class operate on health rather than the standard fare of individual triumph and tragedy. New media also open up the possibility of producing our own viral video “info-snacks” and then hyper-syndicating them through iTunes, YouTube and multiple other platforms not dependent on conventional entertainment media channels.
6. **Consumer Media**—These are the ‘lifestyle’ and personal health and improvement communications products of corporate America. They range from WebMD to Men’s Health to Readers Digest. WebMD gets 10 million web hits a month. Not surprisingly, social determinants and health equity have made little headway here since these vehicles make their money by constructing consumers not citizens, atomized individuals not members of a society. But there are some possibilities. One component of California Newsreel’s *American Birthright* initiative plans to provide tips to parents for targeting “toxic” social and economic environments.
7. **Trade Media** - The publications and communications pathways of associations and organizations (business, labor, housing, racial justice, environmental, etc.) are known as trade media. These are already-existing networks with active stakeholders and well-defined interests and policy positions of their own. How do we interact with them so that they see our issue, health equity, as their issue? This is another arena where California Newsreel has long experience and some success.

FORM AND GOVERNANCE: BUILD INTERNAL CAPACITY OR NEW ENTITY?

So, how might this work? Should communications training and capacity building be provided to health equity organizations? Or should communications professionals be trained in health equity and then brought together in a distinct communications entity that is somehow held accountable to the field? Both, of course. Health equity groups must improve their communications capacity considerably and they need the funds and training to do so. Communications should not be seen as an add-on but as a core organizational function.

Still, I suspect it’s probably too much to expect already over-worked and hard-pressed health equity organizations to take on yet another function (communications) and to do so with the expertise, élan, timeliness and creativity needed to make a significant impact. Let’s remember: corporations view communications as vital and strategic. For decades they have poured tens, even hundreds of millions of dollars into building their communications capacities as individual companies, through their trade associations, lobbyists and their “think tanks.”

But I don’t think this work can just be farmed out to a PR company either. An effective health equity communications operation will require a broad combination of skill-sets and knowledge:

storytelling (on multiple media platforms), information science, publicity experience, data base management, web design, visualization of data, framing and discourse theory and, of course, a thorough understanding and grounding in the social determinants of health equity and how structural racism and class operate.

It especially needs people who have already built and managed a successful national communications campaign. The Obama election campaign people, obviously, set the standard here (though the mismanagement of health care reform shows that any communications campaign is only as effective as the program and leadership it is promoting).

Most of all, such a health equity communications operation will require courageous and visionary leadership, leadership willing to make tactical compromises of course, but leadership committed to long-term, transformative change in the racial formations and class arrangements that structure the opportunities for people to lead healthy and flourishing lives.

In a way, this is all a cart before the horse problem. Communications for what? Communications need to serve ends and agendas, and there is as yet no common health equity program or agenda. Yet the basic principles of health equity are, I think, enumerated well enough that a communications operation that embraces them can help set the groundwork for such a campaign. Especially since the critical task at this point remains rupturing the conventional, individual, bio-medical health discourse and the grip it holds over our collective imaginations.

To reiterate some points made at the top of this paper, we need to shift the locus of attention away from unequal health outcomes to the class and racialized structures (often hidden) that generate those outcomes. At the same time, we need to communicate a sense of possibility, that those unequal outcomes are not “natural,” nor culturally determined, but rather arise from political decisions that we as a nation have made - and can make differently, as history teaches us. Not only does one not need a specific health equity agenda or program to advance these ideas, one might even argue that until we rupture the conventional bio-medical discourse there will be little room for a health equity agenda to take root.

A cautionary note: Once an agenda is in play (presumably not fixed but ever-evolving), there's the temptation to fall prey to the conventional tension between the “Do we want to change their hearts and minds?” or “Do we want their vote?” that marks so many communications campaigns.

But there's also another way to look at movement building, and that's not as a contest for votes nor for hearts and minds, but rather as a deepening of democracy and critical thinking through reflection and debate, civic engagement, unleashing a sense of possibility, and building new coalitions that can contest structures of power and oppression. Communications must serve community organizing, bring in new voices and construct new publics. Communications is not just about speaking to but speaking with, a form of empowerment and entwinement. The word “communication” shares its Latin roots with community and communion. The real goal here is not to preach or convert but to begin new conversations.

By Larry Adelman, Executive Producer, *Unnatural Causes*; Co-director, California Newsreel
(www.newsreel.org)