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## POLITICS & INTERNATIONAL RELATIONS | CRITICAL ESSAY

# Forgetting health disparities: A one size fits all narrative

Lauri Address<sup>1\*</sup>

**Abstract:** This qualitative synthesis explores a public health narrative and events in the US that may have contributed to the prominence of a one-size-fits all communications frame and public health tool that excludes the significance of social status. An analysis of past events is used to carry out a textual analysis of two communications framing studies. One central narrative is found to be more effective than other potential themes on equality, social conditions, and health inequities. The potential impacts of this narrative on disadvantaged, older communities are explored. Consequently, the current claim that the built-environment narrative is “good for everyone” is contested because of the likelihood that it could diminish the quest for health equity by ignoring social status. The findings provide insight to advocates that want to use a social justice narrative to create social change interventions targeting population health and social inequities.

**Subjects:** Introductory Politics; The Body; Political Sociology; Social Class; Built Environment; Health and Safety; Planning; Specialist Community Public Health Nursing

**Keywords:** public health; health equity; built-environment; social determinants of health; social justice; narratives; public policy



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### ABOUT THE AUTHOR

Address has dedicated her career as a social sciences researcher and policy analyst to public service where her expertise lies in linking scholarly work with social issues, the public policy process, and community organizing. Connected to her broader interests in social justice and uneven power relations, Address' research interests have focused on policies affecting the social determinants of health (SDOH), especially social and community development policies that result in health inequalities. This includes, but is not limited to: (1) the SDOH with respect to chronic diseases such as obesity and diabetes and related policy solutions; (2) the role that ideas, framing, narratives, and political ideology versus science, facts, and evidence play in policy discussions; (3) how community civic capacity influences the policy making process and can shape a SDOH policy agenda; and (4) the ways in which the advocacy of different groups (corporations, communities, government, science) can influence policies affecting the SDOH.

### PUBLIC INTEREST STATEMENT

The public health built-environment narrative runs the risk of neutralizing discussions of socially unjust conditions experienced by vulnerable groups resulting from policies that perpetuate social stratification. If society avoids the existence of inequities based on the specific circumstances, history, and treatment of different groups we will lose the battle to achieve equity. The belief in the claim that the built-environment approach is “good for everyone” may ultimately diminish the quest for health equity if it fails to address the differential impacts that may result from failure to recognize our differences based on social status.

## 1. Context

Efforts to address health inequities in the US rarely link the social determinants of health (SDOH) with a social justice narrative. Instead, it is through the narrowed lens of improving the built-environment that the public health profession promotes a one-size-fits-all, healthy community narrative across the United States.

### 1.1. Social determinants of health

The SDOH encompass societal, environmental, and contextual factors (e.g. the economy) controlled by public policy levers (e.g. monetary policies). This growing recognition of the role of the SDOH in addressing population health issues like childhood obesity must take account of many factors including (a) individual behavioral decisions, (b) genetic or biological predispositions, and (c) broader societal factors (e.g. the marketing of low-cost unhealthy foods); and regulatory demands such as agricultural policies and built-environment resources for healthy food and exercise (Larson, Story, & Nelson, 2009; Sallis, Bauman, & Pratt, 1998; Story, Kaphingst, Robinson-O'Brien, & Glanz, 2008). Public policy strategies that target both individuals (internal factors) and external “upstream” factors like physical environments and social and economic barriers are now needed (Kersh, 2009).

### 1.2. Built-environment

Research on the built-environment underscores that the concept is an environmental factor that shapes lifestyles, and can facilitate and impede regular physical activity and healthy eating by citizens. Elements of the built-environment encompass any component in the physical environment that has been built by humans, for example roads, buildings, infrastructure, and parks. The built-environment has three major dimensions: (1) the transportation system, i.e. the physical infrastructure of roads, sidewalks, biking and walking trails, railroad tracks, bridges etc., (2) land use (i.e.) the distribution of activities across space, including the location and density of different activities, where activities are grouped into relatively coarse categories such as residential, commercial, industrial, and other activities; and regional design, i.e. refers to the design of a region - urban or rural - and the physical elements within it including their arrangement and appearance and the function and appeal of the public spaces and landscape (Handy, Boarnet, Ewing, & Killingsworth, 2002).

A narrowed focus on the built-environment represents a sharp departure from the viewpoint expressed by the World Health Organization’s (WHO) Commission on Social Determinants of Health in its final report *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (Commission on the Social Determinants of Health, 2008). The Commission’s conceptual framework for addressing the SDOH calls for interventions to address broad, non-clinical determinants of health that reflect unfair and inequitable societal structures and processes.

Analysis of how economic and political systems inequitably distribute economic and social resources is an essential component of the WHO approach (Solar & Irwin, 2007). The report recommends that sectors of government work in cooperation to:

- (1) Improve the conditions of daily life—the circumstances in which people are born, grow, live, work, and age.
- (2) Tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life—globally, nationally, and locally.

The disjuncture between the Commission’s recommendations and the expression of US public health practices is evident in how public health interventions focus on a narrow range of SDOH that emphasize the built-environment to the exclusion of numerous issues related to social disadvantage including lack of material and social resources (Chaufan, Yeh, Ross, & Fox, 2014; Zavestoski & Agyeman, 2014).

Many involved in long-term, comprehensive community redevelopment programs recognize that low wealth communities are multifaceted entities composed of physical, social, economic, and political components (Green & Haines, 2008). As just one example, community development experts acknowledge that a built-environment approach fails to address the existing issues of gentrification that displace low-income residents as property values become unaffordable (Anderson & Sternberg, 2013; Madden, 2013; Slater, Curran, & Lees, 2004).

The purpose of this article is to explore how public health has framed and limited its narrative on healthy communities to exclude health disparities and social and economic conditions. The potential impact of these actions on disadvantaged communities is the perpetuation and deepening of inequities between residents in older, low wealth communities and middle income residents in newer, planned communities.

## 2. Methodology

### 2.1. Methods and procedure

A qualitative synthesis of an analysis of past events was integrated with a textual analysis of two communications framing studies. Textual analysis is a data gathering method used to make sense of how others interpret the world around them (McKee, 2003). Textual analysis is employed when trying to describe the content, structure, and meaning of messages contained in visual or recorded texts (Frey, Botan, & Kreps, 2000).

Meanings in texts can be determined by analyzing the producer, consumer, and the interpreter of the text (Lindkvist, 1981). Further, textual analysis can be used to answer larger questions about social movements, social practices and social structures (McKee, 2003).

## 3. Textual literature review

### 3.1. Evolution of the social justice narrative and the social determinants of health

Explanations for disease and death, reflecting shifts in society's values or belief systems, have shifted over time carving out positions over which health-influencing features in society are taken as immutable versus alterable (Tesh, 1988). For example, US explanations for health in the mid-19th century assigned responsibility for health to the economic and social conditions and physical infrastructures that shaped the lives of community residents.

In the mid-1800's professionals and civic leaders recognized that congestion, cesspools, and other physical features caused diseases endemic to the tenements of urban environments. Block-to-block surveys demonstrated that health was linked to environments, although the causal nature of that relationship was unclear at the time (Levy, 2009; Peterson, 1979). It was recommended that cities be arranged so as to lessen excessive crowding and physical congestion and provide parks with trees abundant enough to refresh the air (Peterson, 1979). The subsequent steps taken by civic leaders, engineering professionals, and social organizations included designing the built-environment through the systematic arrangement of city buildings, sidewalks, and streets, and policies prohibiting environmental conditions that threatened the health of the community at large.

It was not until the mid-20th century that ascendance of the individual as the locus of health occurred. Much of this paradigm shift resulted from the rise of medical science and breakthroughs in areas of vaccination and medical treatments (Tesh, 1988). Public health practice abandoned the earlier focus on poverty, unsanitary living conditions, lack of open space and clean air, and unsafe, poorly constructed, overcrowded housing (Fairchild, Rosner, Colgrove, Bayer, & Fried, 2010). The 20th-century conversion to understanding disease as a biological and medical phenomenon rather than as an indicator of social conditions and relations legitimized a depoliticized, scientific basis for attacking disease and the existing social order and its inequities (Foner, 1998). Disease was now

thought to result from risky behavior, a failure of individual responsibility (Chin, Monroe, & Fiscella, 1999). Accordingly, starting in the mid twentieth century public health interventions were now directed at the body and changing the risky, immoral behaviors of individuals (Lupton, 1995).

Based on the SDOH, three events from roughly 2005 to 2008 might be characterized as US public health's effort to reintegrate external environmental and social conditions into a model of health production. First, in 2005, the public health community responded to the WHO Commission on Social Determinants of Health definition of health equity as "the absence of unfair and avoidable or remediable differences in health among social groups" (Solar & Irwin, 2007). Around that time, the US health community began to consider the use of the value-laden words *inequalities* and *inequities* to describe health differences rather than the simple, descriptive term *disparities*. In most cases the term health disparities is used in the US in contrast to the term health inequities which is found in the British, Canadian, and wider European public health literature (Braveman, 2006).

Use of the term disparities is simply a way to convey variations in health between groups based upon statistical analysis of data (Sherriff, Gugglberger, & Davies, 2013). In contrast, British, Canadian, and European public health communities use the words *inequity* or *inequality* to convey that these differences are usually unfair and unjust (Andress, 2006; Raphael, 2006). Further, in other countries the terms *inequity* or *inequality* suggest that something needs to be done about these differences in health that are unjust and preventable (Sherriff et al., 2013).

Second, the National Association of County & City Health Officials published *Tackling Health Inequities Through Public Health Practice: A Handbook for Action* (Hofrichter, National Association of County Health Officials, & Ingham County Health Department, 2006). The volume utilized public health's 19th century interest in social justice as a reason to address adverse economic and social conditions. The text instructs public health practitioners to reorient public health practice to address the adverse social conditions that are shaped by economic and political systems and implemented through public policy.

Finally, in 2008 a groundbreaking series titled "Unnatural Causes: Is Inequality Making us Sick?" was released (California Newsreel, 2008). The documentary portrayed the root causes of socio-economic and racial inequities in health. Following the airing of the production nationwide on the Public Broadcasting System, the US public health community participated in hundreds of local screenings of the documentary, which highlighted how the SDOH, shaped by American public policies and attitudes, were the greater contributory factors in the production of health inequities (California Newsreel, 2008).

Accordingly, a 21st century opportunity arose for a revived model of public health closer to the 19th-century agenda that addressed social conditions as part of public health practice. It became possible for the US public health practice to take responsibility for addressing not just individual behaviors but the social and economic conditions and public policies that shaped the behaviors.

### **3.2. Narrowing the public health narrative to a built-environment frame**

How did these opportunities to reconstruct the public health narrative around a social justice model of health addressing social conditions come to exclude these very conditions. To illustrate how this may have happened, two reports, referred to as the Louisville study (parts A and B) and the Robert Wood Johnson Foundation (RWJF, 2008) report, are analyzed to demonstrate the evolution from a broad SDOH narrative to a focused emphasis on place based initiatives or the built-environment.

The opening of the Center for Health Equity by the Louisville, Kentucky, regional health department provided opportunities for a new and invigorated SDOH agenda (LouisvilleKy.gov, 2006). The new Center was to focus on the social conditions and public policies associated with health inequities. However, meeting this goal presented several challenges. First was the problem of building community-wide support for the Center's nontraditional focus on equity. The second was gaining

support for policies focused on economic and social conditions. Finally, the Center had to explain how its equity focus was an improvement over traditional programming targeting minority health issues of access to care and risky behaviors.

A series of studies were commissioned to examine how the Louisville community conceptualized issues of health and equity. The purpose was to identify how to frame inequities not as problems of health behaviors, or the unhealthy behavior of racial and ethnic groups, but rather as the result of systemic structures that discriminated against groups of people based on social status while privileging others. The Louisville study (part A) found that ideas about health held by all demographic groups consisted of simple and powerful frames dominated by the notion of individual responsibility for health (Aubrun, Brown, & Grady, 2007). Individual responsibility was a core belief where health outcomes are determined by one's own choices and actions that are the result of upbringing, personal values, and health knowledge (Aubrun et al., 2007; Louisville Center for Health Equity, 2008).

When study respondents were presented with actual data displaying health disparities among racial and ethnic groups and asked to explain it, the data only served to strengthen these limited narratives of behavioral (and moral) mistakes made by individuals and/or racial/ethnic groups (Aubrun et al., 2007). Bringing race and poverty into discussions was found to be unhelpful and led to even more moral judgments about individuals, and did nothing to eliminate the individual-responsibility narrative. In discussions, inclusion of poverty and race were viewed as: (1) excuses people used for their own failures; (2) outcomes (of people's choices), rather than causes; and (3) barriers that successful people could overcome (Aubrun et al., 2007).

Suggesting the use of education policy as an approach to address health inequities further stimulated traditional narratives that blamed individual health problems on ignorance. Education policy was misconstrued as "health education" and thus seen only as a means to help the individual make better choices (Aubrun et al., 2007).

Part B of the Louisville study had the key aim of creating a message that forcefully presented external factors (housing, employment, educational systems) as causes of group differences in health outcomes (Louisville Center for Health Equity, 2008). Nine themes were tested, but all failed to steer people's thinking away from individual behavior and towards the importance of exposure to a set of adverse living circumstances. Two message components, however, tested well.

The first was a probability narrative that self-will alone may not overcome societal hardships (Louisville Center for Health Equity, 2008). The second theme was the idea of place and its role in health outcomes. The study found that the use of place as an explanatory model for health inequities helped the respondents to focus on how living in a particular locality affects people's lives and their health (Louisville Center for Health Equity, 2008). When respondents were presented with the ideas of probability and place in combination, it allowed people to see how being or living in a particular location can increase or decrease the likelihood of certain prospects, occurrences, or ways of being, including health.

In 2010, the RWJF study on how to talk about the SDOH was issued by the RWJF Commission to Build a Healthier America. The Commission to Build a Healthier America was funded in 2008 as a nonpartisan group of academics, government officials, and nonprofit organizations for the purpose of increasing public understanding of social factors that affect health and health disparities.

The intent of the RWJF study was to develop messages and language that policymakers could use to convey the SDOH to opinion leaders and their elected constituencies (Carger & Westen, 2010). The final recommendations from this research echoed the Louisville findings.

- Americans tend to view their health as something largely under their control and for which they have to take personal responsibility.
- Americans do not “naturally” think about health in terms of social factors.
- Terms often used to describe health disparities, i.e. equal, equality, leveling the playing field) can get in the way of people’s acceptance of the concept of social determinants of health.
- To be effective, the message had to focus on how social determinants affect all Americans (versus a specific ethnic group or socioeconomic class).
- The most responsive messages focused on place, i.e. homes, schools, and jobs.

Ultimately, both the RWJF and Louisville studies demonstrated the deeply held conviction by the public and decision makers in the US that health is the product of individual responsibility and behavior. Further, the research and recommendations on framing the SDOH and health disparities found resistance to all explanatory messages that focus on structural barriers to equality such as poverty, racism, social class, or social exclusion. These concepts did not persuade the study respondents to accept social conditions or structural and systemic barriers to health, and they failed to undercut the idea of health outcomes as predicated on individual choices and responsibility.

It is interesting to compare findings from this public health research on framing the SDOH to other research on public attitudes towards policies to aid the poor. These other studies demonstrate that public conceptions of the underclass or low-income populations are commonly defined using three characteristics: race (nonwhite), a lack of adherence to mainstream norms, and an internal designation of the responsibility for the cause of poverty (Applebaum, 2001).

Moreover, studies have established that support for liberal-leaning policies to aid the poor is supported only when the target is white, exhibits mainstream norms, and when society (not the individual) is viewed as responsible for the target’s poverty (Applebaum, 2001). Accordingly, the Louisville and RWJF findings are consistent with this research in several ways. First, both sets of research indicate that public attitudes regarding causal agents for the problems that marginalized groups suffer tend to implicate the victim as the responsible agent unless some narrative, data, or symbol shifts the picture from the group to a systemic causal agent. Further, to gain support for the solutions and policies, the group must not fall into a racial/ethnic category or exhibit norms that deviate from conventional rules.

The RWJF and Louisville studies left public health workers with a dilemma. For a message to *work*, i.e. gain public support for structural and institutional changes to social conditions and socioeconomic policies, the message had to be void of references to differences based on social status, racial/ethnic differences, poverty, or the goal of greater equity in resources. The narrative of choice that won out muted the issue of inequities among groups; instead, it emphasized place and how communities experience the built-environment. References to more complicated ideas about how systems, institutions, rules, and policies impact groups differently based upon social status were deemed disadvantageous and antagonistic to efforts to construct a public conversation about health inequities.

On the surface, the provision of healthy built-environment initiatives for all communities appears just and fair. This idea is challenged by exploring the potential impact of built-environment strategies on groups of different social status.

#### **4. Discussion and conclusion**

##### **4.1. Implications for health inequities**

The public health built-environment narrative from the RWJF and Louisville studies essentially neutralizes and sidesteps the existence of inequities based on the specific circumstances, history, and treatment of different groups in relation to determinants of health such as wages, housing,

employment, educational opportunities, and the justice system. Policies that perpetuate social stratification are not addressed within the built-environment narrative.

The assertion by public health advocates that equity is achieved when low-income groups are able to live in communities that have been transformed into safe and healthy zones with access to healthy food, physical activity, and mobility has several caveats (Waters, Viera, Phan, Cantor, & Aboelata, 2013). First, some groups have more acute needs than others. For low-income groups this means that simply improving their built-environment is not enough. Second, the creation of safe, habitable neighborhoods in low-income communities is not easily achieved. Last, when the transformation of the low-income community is accomplished the intended recipients of the healthy, transformed community may be displaced by higher property values thus no longer present to enjoy those benefits.

In the first case, middle- to upper-income populations most likely have better levels of health and well-being in comparison to those groups that typically populate older, moderate- to low-income communities. A built-environment strategy will move the needle more easily for wealthier groups because they start at a higher level of health than residents of low-income communities.

Next, the challenges in designing, financing, building, or updating middle-income communities with healthy built-environment amenities are also fewer than those that must be addressed when revitalizing low-income neighborhoods. The planning profession is a witness to centuries of struggle to redevelop and revitalize low income communities (Day, 2003; Goldsmith & Blakely, 2010; Popkin, 2004). Efforts to improve older communities through redevelopment and built-environment strategies are evidence that approaches used in wealthier areas, when used in low-income areas, often require greater political will, resources, and funding (Pacione, 2001). Gentrification of the community and subsequent displacement of the residents remains of paramount concern in any community redevelopment effort (Day, 2003).

Lastly, visible improvement of the built-environment in marginalized communities may attract additional private investment and higher-income groups. This gentrification, which increases property values, potentially prices out or displaces those low-income groups with poorer population health who were the intended recipients of the original built-environment interventions (Anderson & Sternberg, 2013). Consequently, the price of redevelopment to achieve healthy amenities can lead to a cycle of gentrification, displacement, and unhealthy consequences for those displaced (Madden, 2013).

- (1) First, the residents that have lived in the community must secure the political will and financial resources to stimulate the redevelopment of the community.
- (2) Second, the residents must ensure that their voices and ideas can be part of the systems and institutions that will make decisions about their community.
- (3) Next, the residents must be able to withstand the changes in the community as it becomes more desirable thus stimulating an influx of groups, services and businesses that target the needs, tastes, and interests of groups other than the original community. To withstand the transition, original residents most likely need to be equipped with other resources that enable resilience through the transition, including job training, affordable housing options, or employment.
- (4) Last, the lower income residents must be able to afford the increasing property values or rental rates that result as community improvements cause escalating property values.

The price of redevelopment to achieve healthy amenities can lead to a cycle of gentrification, displacement, and unhealthy consequences for those displaced (Madden, 2013).

## 5. Conclusion

The purpose of this article was to explore how the built-environment assumed a place of prominence in public health narratives over other SDOH in the early 21st century. The paper examined the development and dismissal of the social justice narrative and events that may have contributed to the prominence of the built-environment narrative by exploring two efforts to develop language and stories about the SDOH.

This analysis found that studies by the public health community lead them to conclude that a built-environment frame worked better than other frames on equity, social conditions, and group differences in health to explain the SDOH. The paper asserts that while the healthy built-environment narrative appears useful, it may not work for all groups if the narrative fails to account for differences in groups and across communities in terms of class, status, historical experiences, education, occupation, income/assets, gender, ethnicity, race, caste, tribe, religion, national origin, age, and residence.

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