

**THE STORIES WE TELL**  
**Some Health Equity Communications Lessons Learned from**  
***Unnatural Causes: Is Inequality Making Us Sick?***

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I feel not a little uncomfortable speaking here. Not only do I know nothing about aging (other than being in denial about my own), I have no background in health. Documentary film producers rarely do original work; we simply try to make popular and compelling the work done by others. And receive all sorts of generous help doing so. That's certainly true of *Unnatural Causes*. Never have I been involved in a project where so many gave so much so freely, including some of you here at this conference.

Take Len Syme for example. As we initiated this project, I called upon Dr. Syme. And rather than tossing me out of his office for my impertinence, he helped walk me through all the fallacies in my thinking and then joined our Advisory Team. In fact, far and away the best thing about being a documentary film producer is the privilege of receiving private seminars—and for free!--from some of the top thinkers of the field.

So I won't be so presumptuous to talk to you about aging this evening. But I will try to share some of the lessons we've learned from producing and distributing *Unnatural Causes* about how we might more effectively communicate the imperative of taking what one of Len Syme's many formidable former students, Harvard's Nancy Krieger, calls an "ecological approach" to health. Some of this, I hope, is applicable to building public support and the political will for the frameworks and policies advocated so eloquently here at this conference.

I take as our starting point words from the background paper accompanying the establishment of Michael Marmot's WHO Commission on the Social Determinants of Health: "Evidence is rarely if ever sufficient by itself to catalyze political action. In political terms, what might be at least as crucial as the evidence itself is the 'story' in which it is embedded."

But in thinking about effective stories, let's also keep in mind this acute observation from Upton Sinclair: "It is difficult to get a man to understand something when his salary depends upon his not understanding it."

Like many of you, I stopped at the magazine stand at the airport on the way here. And once I got past the headlines of the latest celebrity screw-up and redemption story, what stories did I notice?

"10 Foods That Will Let You Live to Be 100" "Five Ways to Protect Your Heart."  
"Three Simple Steps to Reduce Stress."

What I didn't see-and I bet you didn't either-- were any headlines like: "Living Wage Jobs Bring Health Benefits." Or "Affordable Housing Linked to Healthy Hearts & Arteries" or how universal pre-school, desegregation, better transit and other *social policies* can improve our health by improving our lives.

Yet what blew our minds at California Newsreel when we started work on *Unnatural Causes* is that the evidence was overwhelming, documented in hundreds of journal articles, that the economic and social conditions in which we are born, live, work, play and age can actually get under our skin and affect our health as surely as germs and viruses. As Nancy Krieger says in the beginning of the series, "Our history is written into our bodies." Our bodies reflect an accumulation of conditions that start in childhood and, in the words of Dr. Jack Shonkoff, director of the National Center for the Developing child, can lead to "a cascade of advantage for some, a pile-up of risk for others."

Yet, despite the evidence the *story* of how economic and social forces shape our health has been all but absent from mainstream media. Public policy, popular opinion and journalism remain stuck in the conventional story that focuses almost exclusively on what individuals can do to be healthy. This individual, bio-medical paradigm features what we came to call The Big Three: our meds, our behaviors and genes. In other words:

1. Health is conflated with health care (and here, allow me to pause a moment and plug our latest release, Money-Driven Medicine, which dispels the myths about what's really driving the costs and quality of medical care: [www.moneydrivenmedicine.org](http://www.moneydrivenmedicine.org))
2. Prevention is equated with individuals making the "right choices": eat right, don't smoke, exercise (more on this later).
3. And the deus es machina that will save us all lies in medical advances: "breakthrough" drugs, new diagnostic techniques and technologies, and eventually the holy grail itself, stem cells and genomics.

Now, there is obviously truth to all of these: health care, individual behaviors and medical technologies are important. But not only are they only partial truths, in presenting an apparently coherent "story" of what drives the public's health, the individual, bio-medical model eclipses and renders invisible even more powerful health-promoting and health-threatening factors, factors rooted in how we organize society itself. The conventional story ignores how forces outside the body – the jobs people do, the money we make, the neighborhoods we inhabit, the power and resources people can access—can get under our skin and shape risk factors for all the chronic diseases, but also pattern health outcomes along class and racial lines. In short, this conventional story removes individuals from their social context and lets society off the hook.

And because the individual, bio-medical model is so deeply imprinted in the psyche of the American public and policy makers, it stands like an elephant squarely in the path of social change.

Our experiences suggests that *no* health equity communications strategy can appreciably advance Americans' health unless it is able to help de-center and eventually rupture this discourse and begin to suture together a new discourse, a new story, one grounded in the principles of the social determinants of health equity..

Our documentary series *Unnatural Causes* attempted to open up such a space for a broader way of thinking about health, for a different story that connects population health not just to behaviors, meds and genes but to the socio-economic structures and policies that generate unequal access to the resources people need to gain control over the conditions of their lives.

To stretch Len Syme's road metaphor another meter or two: The old-fashioned model of health focuses on our bad driving habits: our fast-food diet, smoking, lack of exercise. All are important, of course.

But the new model suggests there's also something even more basic at work. And that's not just the condition of our roads, but also the traffic lights that disproportionately direct populations down different paths.

Currently the affluent drive the best roads: their jobs pay well and give them lots of power and control; they live in leafy neighborhoods with parks and green spaces and supermarkets filled with healthy foods, they send their kids to well-resourced schools and take regular vacations. In sum, there's less wear and tear placed on their engines.

Down the class pyramid, the roads we travel get bumpier, more twisted, pitted with potholes: The anxiety of living from paycheck to paycheck, fear of job loss, home foreclosures and downward mobility, speed-up at work, overcrowded and poor schools, worry about the kids' safety, neighborhoods with few supermarkets or farmers' markets offering fresh fruits and vegetables, only fast-food joints or mom-and-pops, and there may be little time to shop and cook anyway after long commutes, or working two jobs.

And the roads traveled by African Americans, Native Americans, Latinos, Pacific Islanders and some Southeast Asian populations tend to be bumpier still.

Traveling these unequal roads of life hastens the stress and strain on the engines of the less affluent, especially poor people of color, increasing the risk of engine breakdowns at earlier ages. Off to the repair shops we go—if we have auto insurance.

The new model of health would have us tackle the unequal road conditions. Not only would that improve population health, it could relieve some of the demand on our repair shops and thus lower medical spending. A win-win.

As Harvard's David Williams put it in our film: "Housing Policy is health policy, jobs policy is health policy, education policy is health policy. Everything we do to improve people's lives is health policy."

(There was a question this morning that asked about different kinds of environments—or roads—that shape opportunities for health. There are several typologies. But many researchers and community-based organizations talk about four kinds of local environments: the built environment, the economic environment, the social environment, and the service environment.)

Let's pause for a moment now and take a look at 10 minutes from *Unnatural Causes* [screen film clip and provide context]

[after clip]

But a film series does not transform consciousness or shift paradigms by itself. In that spirit, *Unnatural Causes* was conceived in association with leading health equity scholars, advocacy groups and policy makers as part of a broad-based, multi-tiered communications and public engagement campaign that would use the series' PBS broadcast and DVD release to inject these ideas about health equity into a broader public dialogue. The campaign was intended to help those trying to reframe the national discourse about health and what society can and should do to tackle health inequities. More than 15,000 events involving *Unnatural Causes* have taken place since the series' release in spring, 2008--community dialogues, policy forums, trainings, classes, even town-hall meetings—organized by more than 412 official Outreach Partners and countless others.

### **So, what have we learned?**

To begin, our experience reaffirmed much of what has been written by Cultural Logic, Frank Gilliam and Frameworks, Larry Wallach, Lori Dorfman and others: We noticed three underlying sets of interlocking and mutually reinforcing values and beliefs, or frames, that Americans use to interpret and make sense of health findings. These frames buttress and support the bio-medical model and mask how society can make us healthy – or sick.

#### **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” (those making bad choices) and “us,” and stops political action dead in its tracks. It holds such traction because it itself is built upon a deeper ideology, the myth of the self-determining individual.

But let's be honest. This belief is also fueled by racism. Many white folks don't recognize or acknowledge how opportunities they take for granted are not only disproportionately denied to populations of color but have been advanced by a web of public policies. The personal responsibility frame allows the poorer outcomes of people of color to be cast as individual failure, not social injustice.

#### **2. Health gaps unfortunate but not necessarily unfair or unjust**

Whereas progressives view unequal outcomes as ipso facto evidence of unjust social arrangements, for most others hierarchy simply reinforces their normatized view that the world is working as it should, reflecting choices made by self-determining individuals. If some groups fare worse than others, well, that's simply more evidence they made the wrong choices, have a dysfunctional culture, or even have bad genes. As a result, even when the press does run an

occasional story about health “disparities” (i.e. different outcomes), our experience with *Unnatural Causes* discussions suggests much of the public is likely to blame the victim for making the wrong choices.

### **3. Cynicism. Nothing can be done.**

Population health gaps (when acknowledged) are viewed as deeply entrenched and too big a problem to address. This resignation feeds on a distrust of government. And if those different health outcomes are perceived as the logical result of personal behaviors, then government interventions are easily disparaged by those who oppose them as the “behavioral police” or the “nanny state.”

These conceptual frames—personal responsibility, unfortunate but not unfair, too big a problem—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.

## **A FRAMEWORK FOR HEALTH EQUITY COMMUNICATIONS**

What implications, then, should we draw for how we talk about health equity? This is where we need more investigation. Nonetheless, indulge me as I posit for discussion several key communications challenges, or message frames, that need to be integrated into the new story of social connectedness, how or economic and social structures shape health opportunities. (These complement the message frames in California Newsreel’s “10 Things to Know about Health” on your conference registration CD)

### **1. As Len Syme said this morning: let’s refocus attention on the different conditions of the roads of life different populations travel.**

What’s pushing different groups down different paths? What precludes the less affluent, especially poor people of color, from driving on the smooth roads traveled by the wealthy? As I implied earlier, 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, what Michael Marmot calls, “the causes of the causes.” In other words, let’s study and scrutinize not so much poverty, but the *relations* between power, classes, racism and the state that generate and reproduce poverty for many even as they create riches for others. We’ve discovered that two observations begins to render the impact of social and economic structures visible.

First, while we should certainly acknowledge that behaviors and individual responsibility are important, we should 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 because supermarkets have redlined certain neighborhoods but fast food joints are common; the difficulty of exercising if the neighborhood isn’t walkable and

safe 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.

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 control or say can expose us to health threats or health promoters: the location of toxic dumps, corporate dumping of your pension, the quality of schools, where parks and freeways--or public transit--get built, the wages and benefits jobs pay, whether factories stay open or shift jobs overseas, predatory lending and foreclosures and the regulation of mortgage and financial markets, even tax policy. These all profoundly affect our opportunities to live healthy and flourishing lives.

And—and to Len Syme again--what about the uncertainty if you don't know whether you'll have a home, or whether you're retirement savings have just disappeared or not, or whether your kid is safe. You don't think that doesn't get those corticosteroids flowing through the body, wearing down our engines?

And as you know, even after controlling for behaviors glaring class and racial health inequities remain. Poor smokers, for example, are more likely to get sick than rich smokers.

Because power and 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."

Let's be clear: this is not a question of "lifestyles." In fact, can we banish that word from our health vocabularies? Going Goth or Hip Hop or being a Skater-dude may be lifestyles. But eating healthy or eating fast food, being active or sedentary is not a "lifestyle."

## 2. Let's 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 have left block after empty block and millions of destroyed lives in their wake? Or the bond traders whose securitized derivatives and collateralized debt swap produced 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 puppets 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 has now 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 us on the magical virtues of 401(K) plans, and so now retirees find their materials 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 in the currency of health?

The British medical sociologist Graham Scambler, rather infelicitously calls this "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.

Vicente Navarro takes this a step further. He argues that contra the subtitle of *Unnatural Causes*, that it is not inequalities that kill but those who benefit from inequalities who kill.

### **3. A Corollary of Redefining Risky Behavior is to Redefine Compliance**

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 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 results in 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.

Consider this: city and county public health directors have emergency police powers. They can, for example, shut a restaurant down for code violations that threaten public safety. What would be the response if those officials used their powers to declare a public health emergency in a neighborhood wracked by subprime mortgage defaults and declare a moratorium on foreclosures?

### **4. 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.

First, as Len Syme pointed out earlier, the continuous 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 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, one-sixth of our GDP. A healthier population would relieve some of the financial pressure on that 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 folks who, well, look like me? As John Powell says in our earlier 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."

## **5. Americans' Health is America's Choice**

Let's remember: Our health inequities are not set in stone. They are not natural, not inevitable. As David Williams says in the series, "These are not acts of God, and they don't happen by chance." Our health is a product of decisions we have made -- not just as individual bodies but as a body politic -- and can make differently. Other countries have. And we in the United States have changed them before and we can change them again.

Both class and racial health gaps narrowed between 1966 and 1980 in the wake of civil rights and the war on poverty, yet they began widening again beginning in the early 1980s as 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 and inequality not seen since the Gilded Age.

One result is that we've fallen to 29<sup>th</sup> in life expectancy and according to the CDC last November, we are now also 29<sup>TH</sup> in infant mortality.

Similarly, many medical historians argue that the 30-year U.S. increase in life expectancy during the 20<sup>th</sup> century was not driven mostly 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 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.

We might also 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 do that we don't do? Do they have better genes?

There are arenas in which we are #1. We have:

- 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 (don't know if last year's presidential election changed that).

By now we all are cognizant 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. Paid vacations
2. Paid maternity (and in some cases, paternity) leave
3. Paid sick leave (the CDC has urged those with swine flu symptoms to stay home from work and keep their kids home from school if they present with swine flu symptoms. Yet 47% of the U.S. private sector workforce have no paid sick leave; they face the choice of going to work sick, or staying home and missing a day's pay. Let alone do they have paid parental leave to take care of sick children).

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? Tony Iton says: "Politics is the battle over the distribution of scarce resources." Which is why medicine is, as Virchow famously said 150 years ago, simply politics by another name.

But this is a doom and gloom scenario. Others have said we'd have more success focusing on success stories, America's promise and sense of possibility. Which is why we've started collecting "inspiring stories" of communities battling together to improve their health and are posting them on the [www.unnaturalcauses.org](http://www.unnaturalcauses.org) web site.

## **6. 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 two or three key policies, for example, that can gain political traction and energize people around a health equity agenda? And bring that agenda before the new administration?

There are three distinct but overlapping arenas for action:

1. **Close the gap between the rich and the rest of us:** policies that guarantee pensions, 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 thus the gaps between the rich and the rest of us.
2. **Protect under-resourced communities and households from health threats**– i.e. make social investments in what are now too-often health-promoting commodities usually accessible only to households which can purchase 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 to those with fewer family resources.
3. **Open and democratize decision-making** that is too often dominated by concentrated economic and political power, e.g. land use decisions (especially redevelopment), political campaign reform, labor law reform, regulation of banking, works councils, etc. For example, the more than 200 municipal redevelopment agencies in my state of 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 agency or how they are financed, let alone do we hold them accountable.

## 6. Appeal to Common Sense

Finally, let's 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 and concisely: Investing in creating the conditions for health today is not an expense. It brings a return on investment tomorrow: Less money spent on our bodies' repair shops. Better productivity. And a healthier old age.

How might we bring these issues up? One way is to ask new questions. Steve Bezruscka reminded me that Thomas Pynchon once wrote: If they can get you to ask the wrong questions, they don't have to worry about the answers.

Richard Hofrichter, senior policy analyst at the National Association of County and City Health Officials (NACCHO) has posed a few questions:

- Rather than, for example, just asking: “How can we promote healthy behaviors?” let's also ask: “How can we target dangerous conditions and reorganize land use and transit policies to ensure healthy spaces and places?”

- Or rather than just: “How can individuals protect themselves against health threats,” let’s also ask: “How can community organizing and alliance building drive policies that protect health and well-being?”
- And rather than just asking “What populations are vulnerable?” let’s also ask, “What causes the unequal patterning of health promoting and health harming exposures in the first place?”

A quick word about language: I mentioned earlier that I thought we should banish the word “lifestyle” from our discussions of health.

But many think we should also distinguish between health *disparities* and health *inequities*. Disparity means difference. Health disparities are different or unequal outcomes between groups. They may be caused by any reason, including plain bad luck.

But health inequities are population differences that are systemic, socially produced and avoidable and preventable—and hence inherently unfair and unjust.

The stories we tell can help people understand that improving population health and tackling health inequities is not just about healthy behaviors but unavoidably a public matter of politics, of people working with their neighbors and co-workers and engaging in struggles over how government allocates resources, regulates corporate power and implements the principles of democracy.

And the key word here is politics and struggle. Pluralism holds that if we can only convince policy makers of the rightness of our ideas we would prevail. But remember Upton Sinclair’s observation: “It’s hard to make a man understand something if his paycheck depends on his not understanding it.”

Here, we can harken back to a story about Obama. It is said that when he was an Illinois state legislator two people came into his office one day to lobby him to support a state regulation they proposed. Obama replied, “You’ve persuaded me of the rightness of your cause and that I should back you.. Now go back to your community and make me back you.”

Frederick Douglass got it right 150 years ago: “Power” he said, “concedes nothing without a demand. It never has and it never will.”