

# Only Part of the Story

Media and Organisational Discourse about Health in the United Kingdom

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**A FrameWorks Research Report**

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# Introduction

Health is the foundation of human life. Being healthy is essential for individuals and societies to thrive and flourish. How the United Kingdom, as a society, can be healthy is thus of significant public importance. Yet much remains to be done to ensure the United Kingdom is a healthy society. Most notably, severe health inequalities exist across British society. Experts point out that socially disadvantaged groups in the United Kingdom are far more likely to experience negative health outcomes, such as higher rates of diabetes and cardiovascular disease, and lower life expectancy.<sup>1</sup> These disparities are produced by inequalities in power, resources and wealth. Although the determinants of health are incredibly complex, experts agree that social and environmental factors play a central role in shaping health. Creating a healthy society requires addressing these social determinants that lie at the root of health.<sup>2</sup>

Creating a healthy society also therefore requires fundamental changes to national policy, including changes in the way health is factored into policymaking broadly, reductions in a wide range of social inequalities and increased community empowerment. Each of these requires public will. To effectively strategise about how to build this will and create a climate that is conducive to these changes, experts and advocates working to improve health in the United Kingdom need to understand the current public discourse around health.

The public is bombarded every day with information about health – from information about cutting-edge innovations in medical science to commentary on the state of the National Health Service (NHS) to suggestions about the best consumer products for health. This discourse communicates a vision – or multiple and competing visions – of what health is, what kinds of factors contribute to or detract from it and whether and what can be done to improve it. The visions of health present in public discourse shape how people think about these questions – they help to fill out the ‘pictures in people’s heads’.<sup>3</sup>

News-media coverage plays a particularly important role in determining how the public understands health, and, by extension, the kinds of opportunities and challenges that experts and advocates face in seeking to build greater public will to improve health. The media act as information gatekeepers, amplifying or muting different kinds of messages the public might receive about health.<sup>4</sup> By repeating certain stories and frames, and excluding others, news media can significantly shape people’s beliefs and attitudes – a phenomenon some researchers have called the ‘drip, drip effect’.<sup>5</sup> Over time, this steady drip of information shapes public thinking and action.

The media, however, are not the public’s sole source of information about health. Advocacy, policy and research organisations in the health sector also directly communicate with members of the public. They also serve as important information resources for news media. In these dual capacities, these organisations

play a pivotal role in shaping how the public thinks about what health is, what causes it and whether and how health in the United Kingdom can be improved.

To better understand the kinds of information the British public receives about health, this report identifies dominant patterns and narratives in news media and in health advocacy, policy and research organisations' communications about health. It also analyses how these practices may affect public thinking. Media coverage can be harmful and misleading or informative and productive. Organisations have the ability to push news coverage in a positive direction and to fill in gaps in news stories. In many cases, they are doing so. However, as we will discuss, there are issues on which both news media and the health sector are only telling part of the story about health that experts want to get across. The public is not consistently hearing a fully developed story about health inequalities and health creation, which means the broader discourse is not building the public will needed to support fundamental social change.

This report is designed to provide health experts and advocates in the United Kingdom with a detailed understanding of the existing communications environment, and it offers initial recommendations about how they might shift it. The FrameWorks Institute conducted this research as part of a larger, multimethod project, commissioned by the Health Foundation, to develop an evidence-based communications strategy to broaden understanding of health inequalities and to build support for effective health-creation strategies. The project is part of the Health Foundation's long-term strategy to bring about healthier lives for people in the United Kingdom.

## Methods and Data

We designed this research to answer three questions:

1. How are news media and advocacy, policy and research organisations in the United Kingdom currently communicating about health?
2. What are the similarities and differences between news media and health-sector organisations' communications?
3. How should experts and advocates seek to shift the way that the news media and their own organisations communicate about health to expand public understanding and build support for desired policies and programmes?

The news media sample includes articles taken from newspapers available across the United Kingdom. Sources were selected based on circulation levels and include the *Daily Mail*, *Mail on Sunday*, the *Scottish Daily Mail*, the *Daily Star*, *The Daily Telegraph*, *The Guardian*, the *Metro*, the *Mirror* (including both the *Daily Mirror* and the *Sunday Mirror*) and the *Sun*. Using LexisNexis, FrameWorks' researchers searched and downloaded a random selection of articles available in print or online from these sources using a search strategy designed to capture a broad range of topics related to health.<sup>6</sup> The searches were limited to articles published between 1 January 2016 and 31 December 2016. All articles were first reviewed by researchers to remove pieces that did not deal substantively with human health and duplicate articles (that is, identical articles published more than one time or in multiple news outlets). This process resulted in a final sample of 209 articles, each of which was coded and analysed.

FrameWorks' staff also gathered materials from third-sector organisations that communicate with members of the British public about health.<sup>7</sup> In collaboration with project partners, FrameWorks created a list of advocacy, policy and research organisations explicitly working to improve health in the United Kingdom. We then sampled public-facing communication materials from each of these organisations.<sup>8</sup> As with media materials, organisational materials were only included if they substantively focused on health. In addition, only materials clearly targeted towards public audiences were sampled. To capture the diverse ways that organisations reach the public, different types of materials were sampled, including press releases, reports, 'About Us' web pages, online blog posts and other relevant communications. We selected these materials because they contained content about how each organisation described its mission and specific orientation towards health. In total, the sample consisted of 182 materials drawn from 25 organisations.

# Analysis

Researchers coded each media and sector document for the presence or absence of information related to each of the narrative components shown in Table 1.

**Table 1:** Coding scheme

Narrative Component	Brief Description	Examples of Codes <sup>9</sup>
<b>Topic</b>	<ul style="list-style-type: none"> <li>▪ What and who is the document about?</li> <li>▪ What are the primary health areas or issues being discussed?</li> </ul>	<ul style="list-style-type: none"> <li>– Area of health (e.g., non-communicable disease or illness)</li> <li>– Demographics (e.g., general population, women, men)</li> <li>– Attention to disparities (e.g., mentioned, primary focus, not mentioned)</li> <li>– Type of disparities mentioned (e.g., racial or ethnic)</li> <li>– Primary topic, or issue at stake (e.g., new research and evidence, scientific conflict or uncertainty)</li> </ul>
<b>Causal factors</b>	<ul style="list-style-type: none"> <li>▪ What types of factors determine health outcomes?</li> <li>▪ How do social factors affect health outcomes?</li> </ul>	<ul style="list-style-type: none"> <li>– Biological factors (e.g., genetics)</li> <li>– Behavioural factors (e.g., diet or physical activity)</li> <li>– Social factors (e.g., material resources)</li> <li>– Type of social factors (e.g., material resources, working conditions, discrimination)</li> <li>– Health care (e.g., quality of health-care services)</li> <li>– Valence of social factors (e.g., produces positive/negative health outcome)</li> </ul>
<b>Messengers</b>	<ul style="list-style-type: none"> <li>▪ Who are the people and/or organisations that provide or communicate information about health?</li> </ul>	<ul style="list-style-type: none"> <li>– Politicians and government officials</li> <li>– Members of the public</li> <li>– Health-care providers</li> </ul>
<b>Solutions and responsibility</b>	<ul style="list-style-type: none"> <li>▪ What or who needs to change to improve health outcomes?</li> <li>▪ Who is responsible for improving health outcomes?</li> </ul>	<ul style="list-style-type: none"> <li>– Government</li> <li>– Health-care providers</li> <li>– Individuals and families</li> </ul>

After coding each document, analysis proceeded in three stages:

- **Frequency analysis.** To begin, researchers examined how frequently each code appeared among media and organisational materials, calculating the percentage of materials within each sample that contained each of the individual codes.
- **Latent class analysis.** Next, researchers used the results of the frequency analysis to conduct a latent class analysis. This is a statistical method used to discover whether and how a sample of observations (in this case, media or organisational documents) can be divided into a smaller number of mutually exclusive subgroups, or *classes*, based on several categorical data (in this case, the presence or absence of multiple codes). Here, the term ‘class’ refers to a specific kind of *narrative* being told about health. In keeping with the scholarly literature on narrative and framing, FrameWorks defines a *complete social issue narrative* as one that describes a problem or issue, states why the issue is a matter of concern, explains who or what causes the problem, provides a clear vision of a change or improvement in outcome and delineates actions that can be taken to create change. Narratives influence how people make sense of, remember and transmit information about a given topic.

To improve the stability of the model, researchers only included codes that were prevalent in at least 10 percent of materials in the analysis, or collapsed codes present in fewer than 10 percent of materials with other thematically related codes. The final number of classes, or narratives, was selected based on statistical criteria and ease of interpretation.<sup>10</sup>

- **Cognitive analysis.** Finally, researchers examined findings against the backdrop of the public’s cultural models – the deep assumptions and implicit understandings that members of the public hold about health – which were identified through FrameWorks’ other research for this project.<sup>11</sup> This analysis identified how frames embedded within media and organisational materials are likely to affect public understanding. In the concluding chapter of this report, we offer initial communications recommendations based on this cognitive analysis.

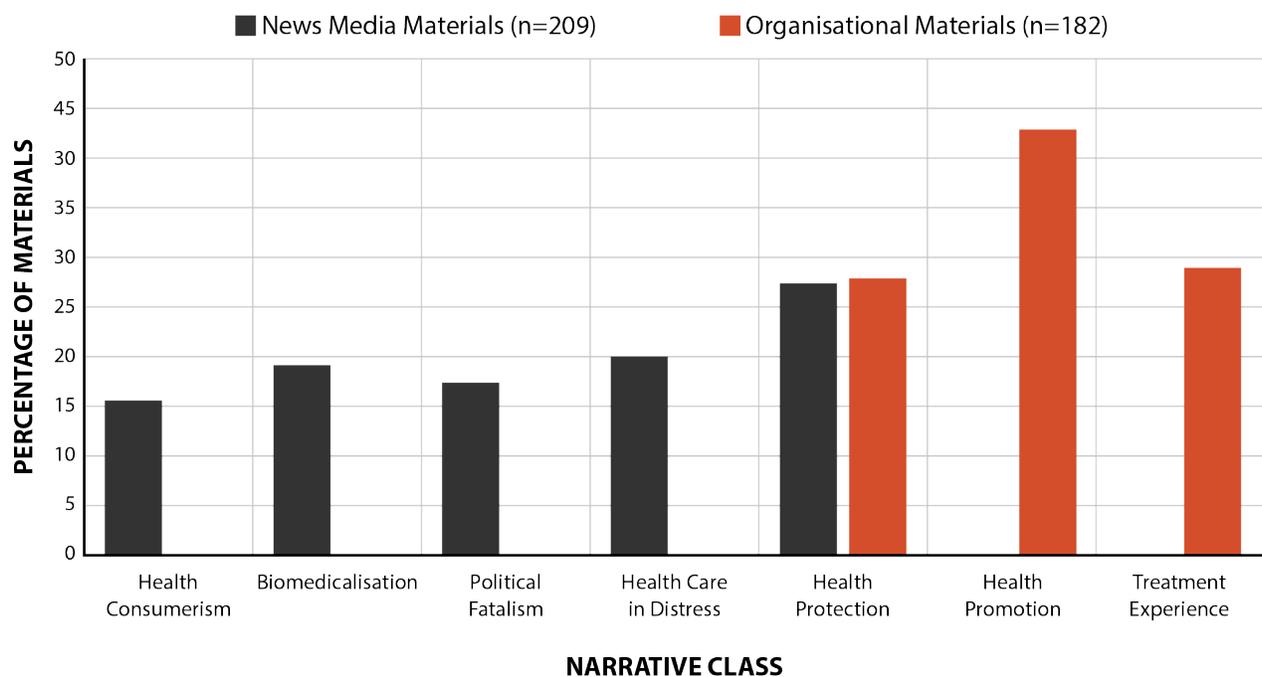
# Findings

In this section, we draw on a combination of evidence from the frequency analysis and latent class analysis to provide a set of key findings about media and organisational communications. These findings, taken together, provide a picture of how news media and key third-sector organisations frame health, and what narratives are currently being told.

Before we report on the specific findings, we provide a brief, quantitative summary of the narratives we identified through the latent class analysis. Figure 1 presents each narrative we identified in media and third-sector materials, along with the percentage of materials that tell each type of narrative. The identified narratives were mutually exclusive, meaning that each material in each sample was categorised into just one of the narrative types displayed in Figure 1.

Overall, we found that media materials told one of five narratives, and sector materials told one of three. In addition, there was only one narrative told in materials of both types: a *Health Protection* narrative. We provide more information about this narrative, and each of the others, in our discussion of the specific findings below.

**Figure 1:** Narrative classes identified in media and organisational materials



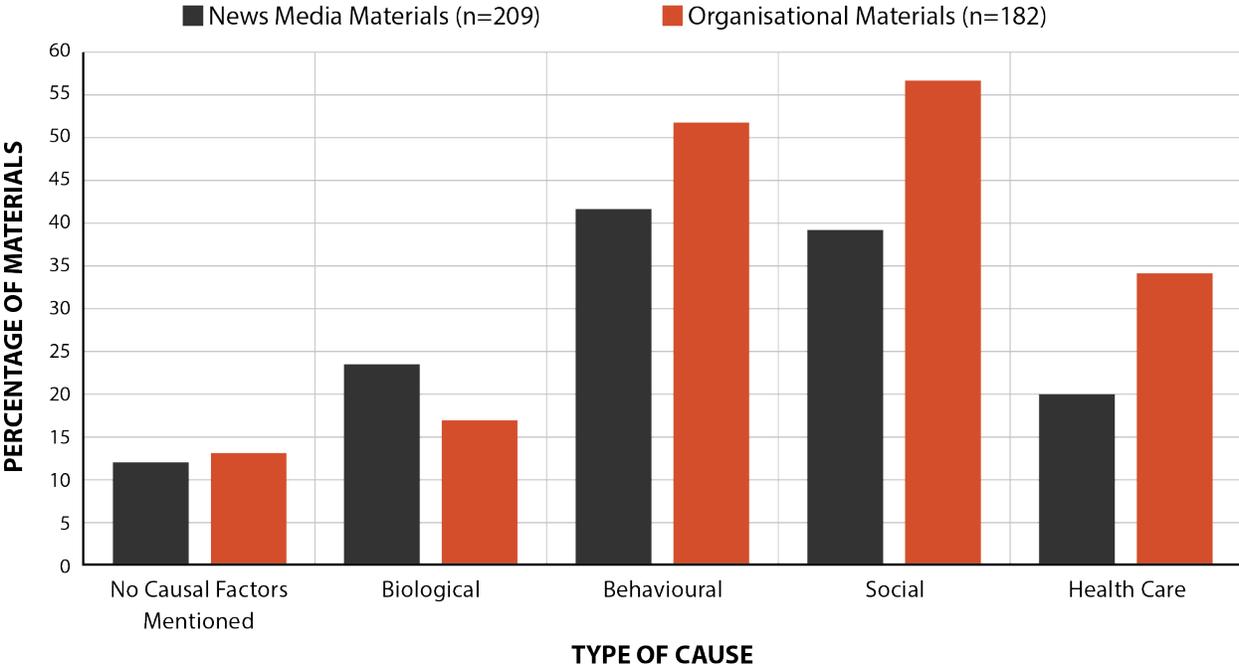
When examining the frequency analysis results below, it is important to keep in mind that, when coding documents, researchers could attach multiple codes of the same type to a single document. For example, a document might mention both behavioural and social causes of health outcomes, in which case researchers would attach both codes to the document. Therefore, in many cases below, the percentages reported from the frequency analysis add up to more than 100 percent.

**FINDING 1**

**News and organisational materials frequently mention social factors as causes of health, but don't offer a coherent story about how they can create health.**

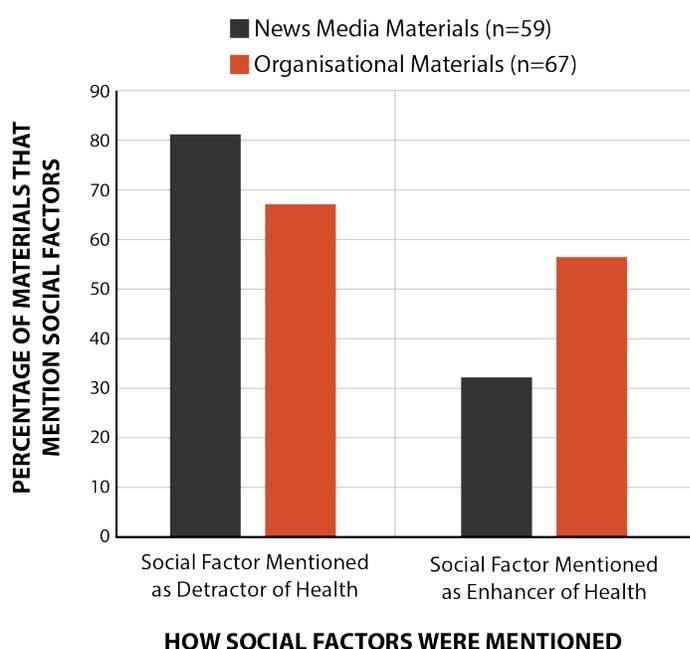
When discussing the determinants of health, both news-media and health-sector materials frequently mentioned social factors, such as access to and quality of material resources like food, water and shelter. They cited social factors more often than health care and biological factors (such as genetics) and about as often as behavioural factors (such as dietary choices). As Figure 2 shows, 39.2 percent of news-media materials mentioned at least one social factor as a cause of health, while 41.6 percent mentioned behavioural factors as causes and just 23.4 percent mentioned biological factors. Social factors were mentioned in organisational materials more often than any other type of factor and more frequently than in media materials, with 56.5 percent of organisational materials touching on these.

**Figure 2:** Types of causes mentioned in media and organisational materials



Although the news media and health sector frequently discussed social factors, they focused more heavily on how they *negatively* impacted on health – on how social factors can harm health, rather than promote or create it. As Figure 3 illustrates, among the media materials that mentioned social factors, 81 percent mentioned how they *detract* from health (that is, either increase the chances of a negative health outcome, or decrease the chances of a positive one). In stark contrast, just 32 percent mentioned how social factors promote health (that is, increase the chances of a positive health outcome, or decrease the chances of a negative one). The news media thus overwhelmingly linked social determinants to harm.

**Figure 3:** Types of mentions of social factors in media and organisational materials that mentioned a social factor



The health sector also discussed social factors in negative terms more often than positive terms: 67.2 percent of organisational materials that mentioned social factors as a cause of health discussed how they worsen health (see Figure 3). A majority – 56.7 percent – did, however, also discuss how social factors can enhance health outcomes.

While organisational materials frequently *mentioned* how social factors can enhance health, the sector did not tell a coherent and consistent story about health creation any more than the news media did. As discussed above, the latent class analysis tells us where coherent narratives *do* exist – where there are consistent ways of linking causes and solutions, for example –

and the latent class analysis did not identify a positive narrative that addressed a broad range of social factors and told a consistent story about health creation. As we discuss below, the positive narrative identified in organisational materials focused narrowly on access to health care, rather than telling a positive story about social determinants generally.

The coherent narrative that both the news media and the sector *did* tell about social factors was a negative one – the *Health Protection* narrative. Twenty-seven percent of media and 26.2 percent of organisational materials fell into this narrative class. The *Health Protection* narrative typically documents the rise in a specific negative health outcome and shows how this problem can be attributed to a social factor. The narrative often uses a crisis tone, raising the alarm about how social factors are creating a significant health problem. However, the solutions in this narrative were fairly wide-ranging, including everything from calls to change systems to changes to specific, individual behaviours, and the solutions within this narrative class were generally vague and lacking in concrete detail, as exemplified by the excerpt below.

What you earn, where you live, and your education should not mean that you're more likely to be diagnosed with a killer disease – everyone should have the same opportunities to lead a long and healthy life. We now have a population living longer and healthier lives. However, there is an alarming gap in life expectancy between those at the top and those at the bottom of society. This could not be truer for lung disease [...] Outdoor air pollution, which is generally higher in deprived areas, worsens symptoms of lung disease and can even cause it to develop. Poor housing is another challenge. Mould spores and dust mites, which can lead to asthma and general respiratory irritation, are most common in damp, less well-constructed houses. This obviously affects mainly people who are on the lowest incomes and unable to afford a better home [...] It's vital that we explore solutions that will help us to mitigate these disparities.

-NHS England, 23 November 2016<sup>12</sup>

Materials telling this narrative bring attention to environmental and social factors, such as poor housing and poor air quality, as in the above excerpt. However, they focus much more on how these factors lead to problems, and frame health issues as severe crises (for example, 'killer diseases' and 'alarming gaps', as in the excerpt) without a clear understanding of how they can be remediated. The *Health Protection* narrative, thus, is primarily about defining negative health outcomes as problems (i.e., problem definition) rather than offering clear solutions or explaining how to promote positive health outcomes.

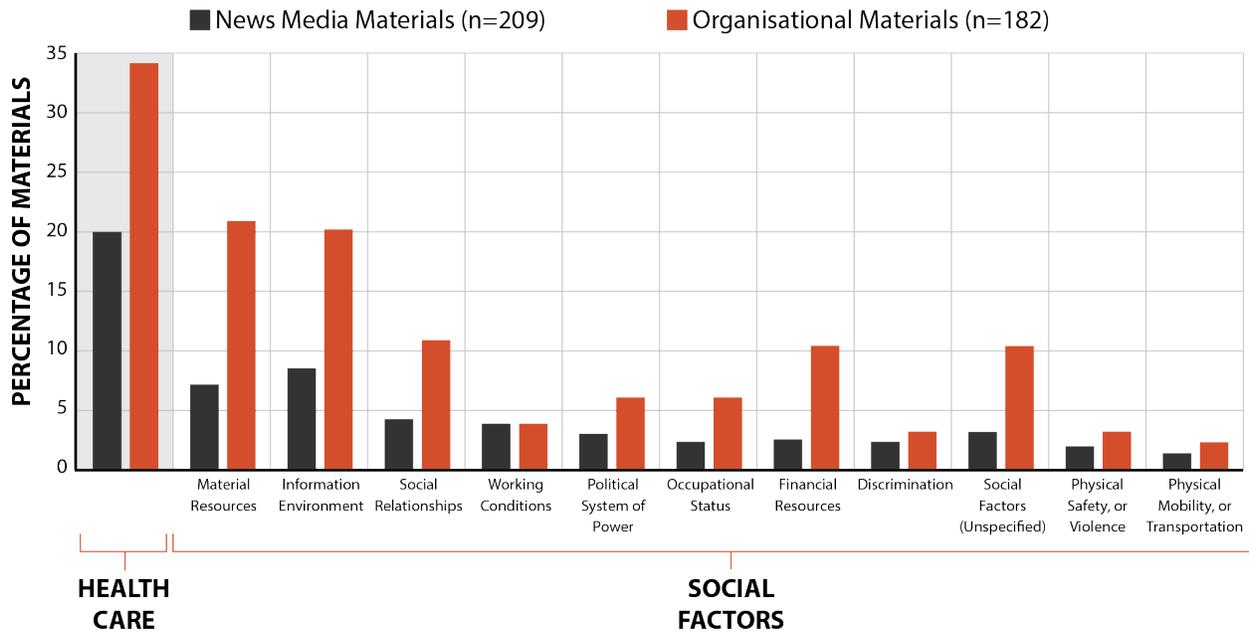
## FINDING 2

### Both media and sector materials focus disproportionate attention on health care.

The frequent mention of social factors in both media and organisational materials seems, on the surface, to be quite promising, as it indicates that both types of sources devote significant attention to social determinants. However, when we look more deeply, a different view comes into focus. It turns out that no particular social factors received a very large amount of attention and, critically, none received nearly as much attention as health care.

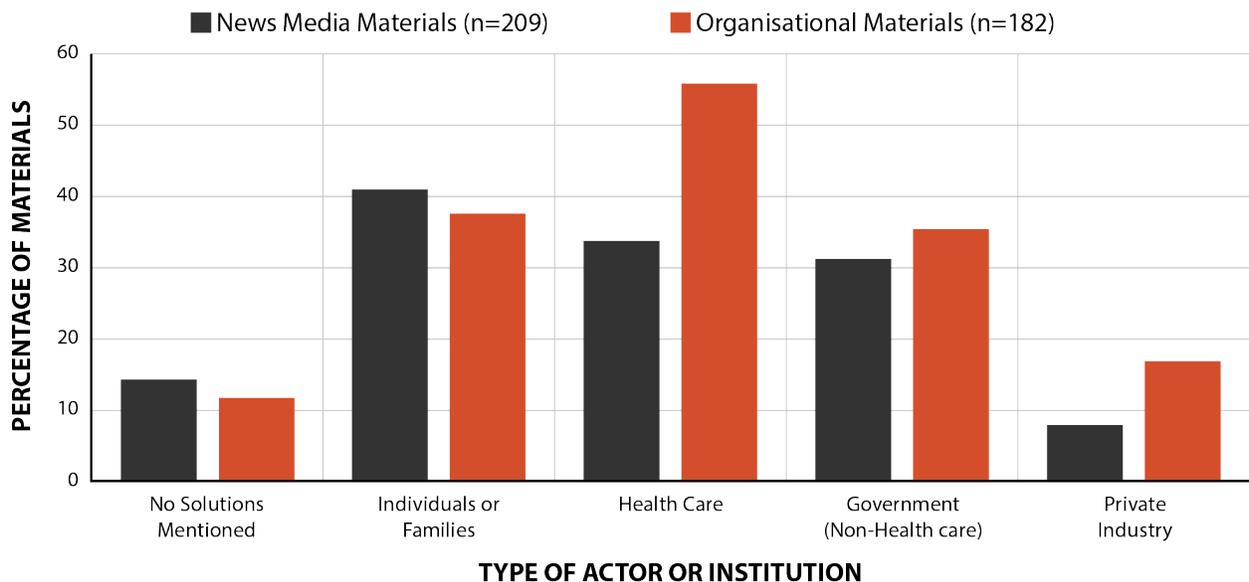
As Figure 4 shows, both media and organisational materials mentioned health care much more frequently than any single social factor. About 20 percent of media materials and over 30 percent of organisational materials mentioned health care as a cause of health. By contrast, just under 10 percent of media materials and roughly 20 percent of organisational materials mentioned material resources as a cause. The figure further shows that other types of social factors were mentioned even less frequently in both types of materials.

**Figure 4:** Mentions of health care and social factors in media and organisational materials



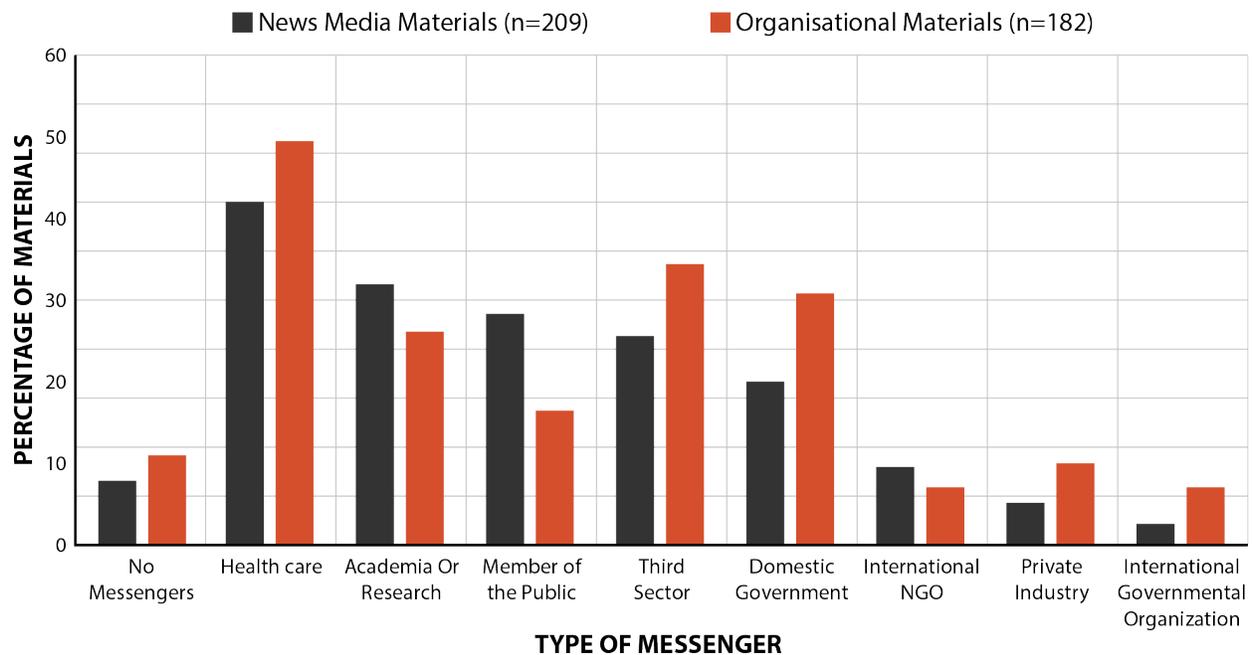
As Figure 5 illustrates, health care also figured prominently in media and organisational materials' discussion of solutions. Over 33 percent of media materials mentioned solutions targeted at improving access to, or quality of, health-care services, such as reforming practices in the delivery of care. Changes to health care were the most commonly discussed solution in organisational materials. Fifty-five percent of organisational materials mentioned solutions targeted at improving health-care services.

**Figure 5:** Types of actors and institutions targeted by solutions mentioned in media and organisational materials



Health-care professionals were also the primary messengers of information about health in media and sector communications (see Figure 6). Health-care organisations or providers, such as doctors, nurses and the NHS, were quoted or paraphrased in more than 40 percent of news-media materials and nearly 50 percent of organisational materials. By contrast, messengers from domestic government, meaning government officials or agencies whose work is not exclusively in health-care provision, were quoted or paraphrased in just 20.1 percent of media materials and 30.8 percent of organisational materials.

**Figure 6:** Types of messengers in media and organisational materials



These results demonstrate a consistent and disproportionate focus on health care in both media and sector communications about health. It is hard to overstate the significance of this finding. As we explain at greater length below, in discussing the implications of our findings, this heavy emphasis on health care reinforces a narrow view of health centred on illness and medical treatment, which undermines the goal of deepening the public’s understanding of the broad range of social determinants of health, and of the kinds of measures needed to actively maintain and create health.

Although media and organisational materials share a disproportionate focus on health care, it is important to stress that the narratives of health care they are telling are quite different. The media focus narrowly on crisis in the NHS or on biomedical innovations, while the sector treats health care as a positive social factor that can promote health.

In the media, 20.3 percent tell a *Health Care in Distress* narrative, which centres on the increase or prevalence of some negative outcome. In contrast to the *Health Protection* narrative, which also focuses on negative impacts but discusses a range of social factors, the *Health Care in Distress* narrative links

negative health outcomes solely to internal dysfunction or external challenges confronting the NHS. Thus, the only solutions offered in this narrative involve improving health-care access and services. Like the *Health Protection* narrative, the *Health Care in Distress* narrative adopts a crisis tone, as in the excerpt below.

Improving the UK's mental health system is among the greatest challenges facing the NHS. Rising suicide rates, long waiting times for inpatient and community health team appointments, and people in crisis unable to find a hospital bed anywhere near home are just some of these challenges. [...] In a time of austerity and unprecedented funding constraints, there is a huge mountain still to climb.

-*The Guardian*, 19 May 2016<sup>13</sup>

A second narrative about health care – the *Biomedicalisation* narrative – was present in 19 percent of media materials. This narrative is more positive, focusing on how health outcomes can be improved, but almost exclusively discusses biological factors and how health can be improved or transformed through medical study, diagnosis or treatment, as illustrated by the below example.

A breakthrough cholesterol drug with phenomenal power has the power to switch off heart disease, cardiologists said last night. A major trial revealed that heart patients treated with the injectable drug Repatha saw the plaques clogging their main arteries 'melt away'. These plaques are the cause of heart attacks – when a clot forms in a major artery it blocks the blood supply, leaving the heart starved of oxygen. Any treatment that reverses the build-up of plaques, known as altheromas, significantly reduces the risk of a heart attack [...] British experts last night welcomed the results as heralding a new era in medicine.

-*Daily Mail*, 16 November 2016<sup>14</sup>

While the *Health Care in Distress* and *Biomedicalisation* narratives have different focuses, both cast the health-care system as the primary – if not exclusive – setting in which health issues must be addressed, and health-care professionals as the primary agents who can affect change on health outcomes.

In contrast, sector communications included a positive narrative about access to and quality of health care that was not narrowly focused on biological causes and biomedical innovations – a *Health Promotion* narrative. This was both the primary narrative that organisational materials told about health care and the most frequently told narrative in general (told by over 40 percent of organisational materials). The narrative is positive and future-orientated, focusing on how increasing access to and improving the quality of the health-care system will have positive impacts on health outcomes. As the following example illustrates, this narrative – in contrast to the media's *Biomedicalisation* narrative – was not exclusively focused on biological causes, leaving space for occasional reflections on how health care is linked to other social factors.

Social prescribing, sometimes referred to as community referral, is a means of enabling GPs, nurses and other primary care professionals to refer people to a range of local, non-clinical services. Recognising that people's health is determined primarily by a range of social, economic and environmental factors, social prescribing seeks to address people's needs in a holistic way. It also aims to support individuals to take greater control of their own health.

-The King's Fund, 2 February 2017<sup>15</sup>

An additional narrative revolving around health care was also told in organisational materials – a *Treatment Experience* narrative. Just under 30 percent of organisational materials told this narrative, which almost entirely focuses on treating health issues after the fact.<sup>16</sup> While this narrative often asserts the kinds of values that should guide the health-care system, it mostly lacks anything about whether and how prevention fits into health, at either the systemic level (that is, through the actions of health-care or non-health-care institutions) or the individual level, and typically suggests increasing public awareness about health issues and health-care services as the way to improve health. As the following example demonstrates, this narrative often relies on or is told through personal accounts and experiences of health and health-care providers.

I was diagnosed with Type 1 diabetes 13 years ago in my first week of secondary school. As well as having to deal with an oversized & lucid purple blazer, I was also taken to hospital and told I would now have to inject insulin every day [...] Everyone has their own relationship with the condition and no two diabetics are the same (more to be said on this later), so this by no means is intended to be the gospel on diabetes management. But my hope is that by sharing some of my experiences it will help others to engage with their condition.

-NHS England, 12 December 2016<sup>17</sup>

Media and organisational materials offered different narratives about health care, but what these narratives have in common is more important than their differences. All of these narratives foreground health care as the key to health, which means the public consistently hears a story about health focused on health care rather than other social factors.

### **FINDING 3**

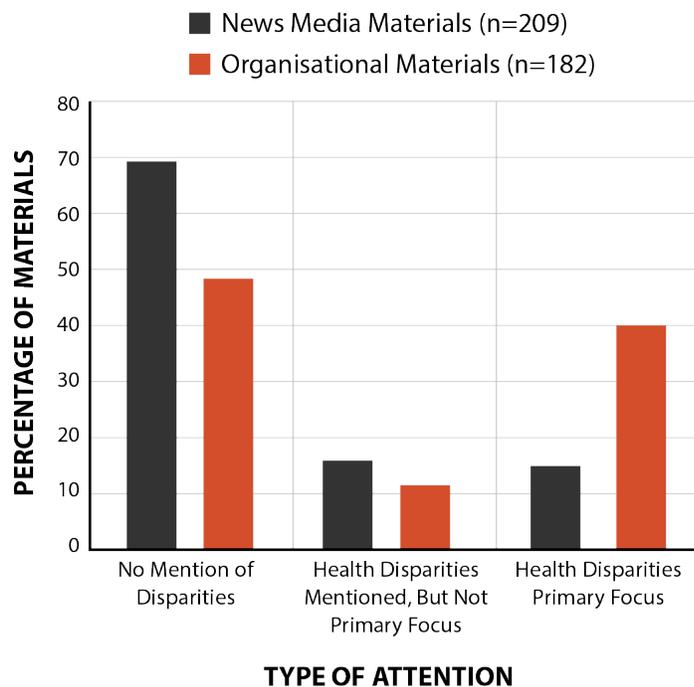
**Health disparities receive little attention in media materials, and important types of disparities are relatively absent from sector materials.**

In our earlier research on expert and public thinking about health in the United Kingdom, experts explained that health outcomes reflect structural inequalities in power, money and other resources.<sup>18</sup> The more socially disadvantaged a group is in society, the more likely its members are to experience poorer health outcomes compared to the rest of the population. Experts note that health disparities exist along

various dimensions, including social class, gender, race and ethnicity, education, income, disability status, geographic location and sexual orientation.

Despite the existence of significant health inequalities in the United Kingdom, health disparities receive very little attention from news media. As Figure 7 shows, almost 70 percent of news-media materials made no mention of disparities at all. In addition, when media materials devoted attention to disparities, they were about as likely to merely mention them as to make them a primary focus. Disparities were merely mentioned in about 16 percent of media materials, and were a primary focus in 15 percent.<sup>19</sup>

**Figure 7:** Types of attention devoted to health disparities in news-media and organisational materials

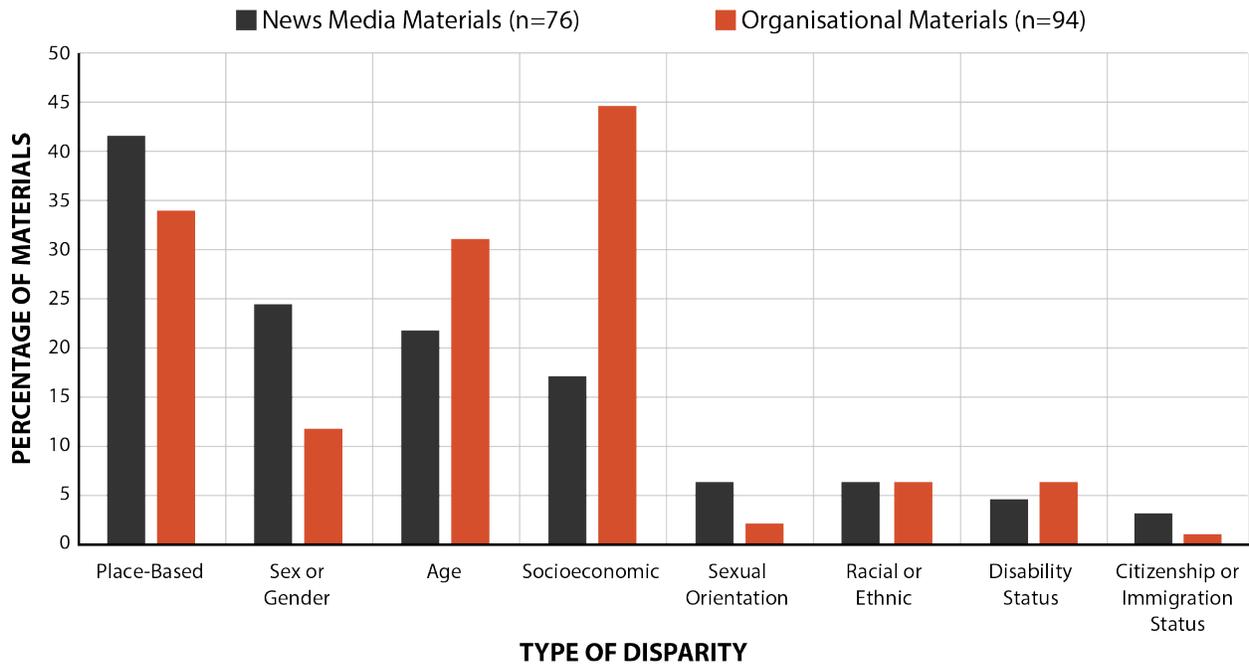


Disparities received much more attention from the health sector. A slight majority of organisational materials – 51.6 percent – either mentioned or centrally focused on health disparities of some kind. In addition, when organisational materials devoted attention to disparities, they were more likely to make them a primary focus than simply mention them. 40.1 percent of organisational materials focused primarily on disparities, while 11.5 percent only mentioned them.

Although the health sector discusses disparities frequently, both the sector and the media discuss some types of disparities much more often than other types. Figure 8 shows that both organisational and media discussions of disparities were heavily tilted towards certain types of

disparities, while other types were rarely brought up. Scant attention is devoted to disparities tied to race and ethnicity, sexual orientation, disability status and citizenship or immigration status. Of news-media and organisational materials that mentioned or had a primary focus on disparities, race and ethnicity, sexual orientation, disability status and citizenship or immigration status were each discussed in less than 6 percent of materials. In contrast, disparities tied to place, sex and gender, age and socioeconomic status were each discussed with much greater frequency. For example, while just 6 percent of organisational materials devoted attention to racial and ethnic disparities, nearly 35 percent mentioned or focused on place-based disparities.

**Figure 8:** Types of disparities discussed in media and organisational materials that mentioned health disparities



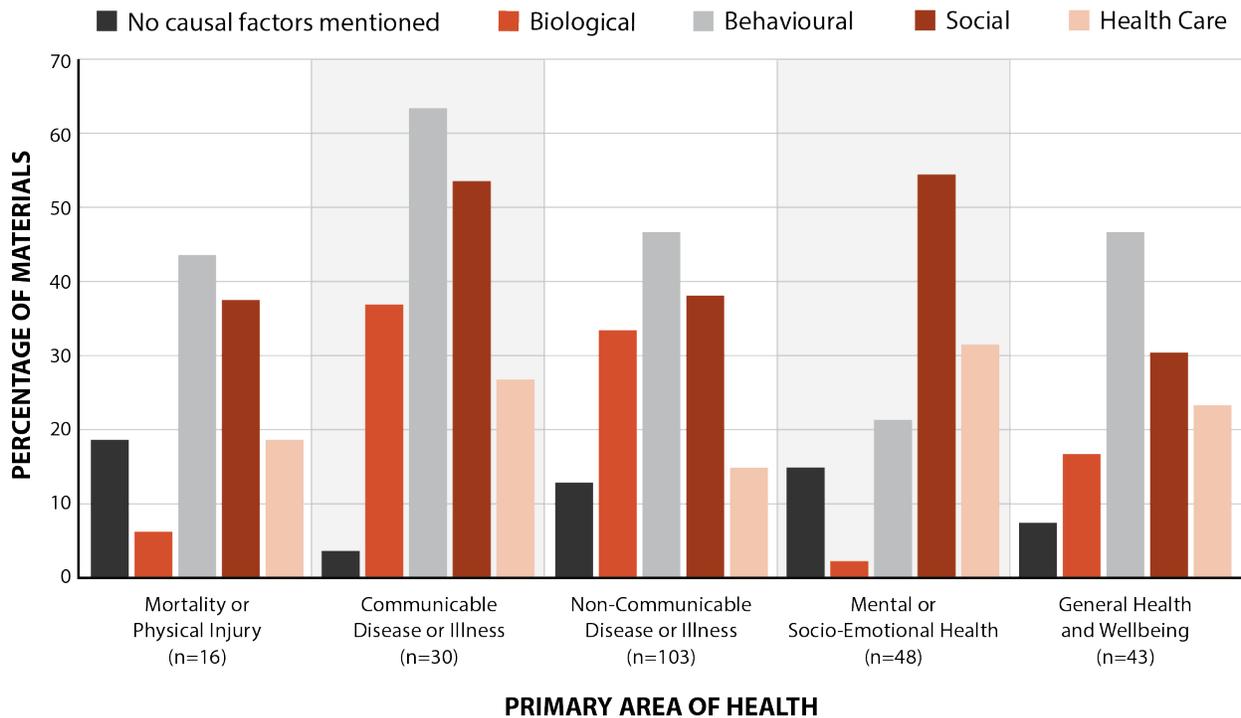
**FINDING 4**

The media focus to a significant degree on individuals’ responsibility for health outcomes, while organisational materials do this but to a lesser extent.

Despite mentioning social factors relatively frequently, the media often focus on individual behaviour as a primary factor in improving or worsening health outcomes. As discussed above, media mentioned behavioural factors about as much as social factors (see Figure 2 above). Media discussions of solutions also frequently highlighted individuals and families; 41.1 percent of media materials mentioned solutions targeted at individuals or families, such as raising public awareness or encouraging different dietary choices (see Figure 5 above).

Moreover, looking at media materials that primarily focused on different areas of health showed that whether they mentioned social or behavioural factors as causes of health depended on the area of health on which they were focused. Media materials were more likely to mention behavioural factors (and less likely to mention social factors) as causes when they focused on areas of health other than mental or socioemotional health. For example, 46.6 percent of media materials focused on non-communicable disease or illness mentioned a behavioural factor, while only 37.9 percent of these materials mentioned a social factor (see Figure 9). By way of contrast, only 20.8 percent of media materials focused on mental or socioemotional health mentioned a behavioural factor as a cause, while 54.2 percent mentioned a social factor – a striking difference of 33.4 percentage points. In other words, with the exception of mental and socioemotional health, media coverage offers a mostly individualistic perspective on the sources of health.

**Figure 9:** Types of factors mentioned as causes of health in *media* materials focused on different areas of health



The presence of individualism within media coverage is further supported by the latent class analysis, which identified a *Health Consumerism* narrative in media materials. Approximately 15 percent of news media materials fell into this narrative class. The *Health Consumerism* narrative locates the causes of and solutions to health issues entirely in people’s choices and behaviours; social and environmental factors are wholly absent from this narrative. Often told in the second person, materials that are a part of this class often approach readers as consumers, highlighting the importance of decisions about purchasing various products. The narrative, thus, centres on choices people make outside of health-care settings. In the below excerpt, for example, the key to being healthy is framed as a matter of buying the right and most-expensive bed.

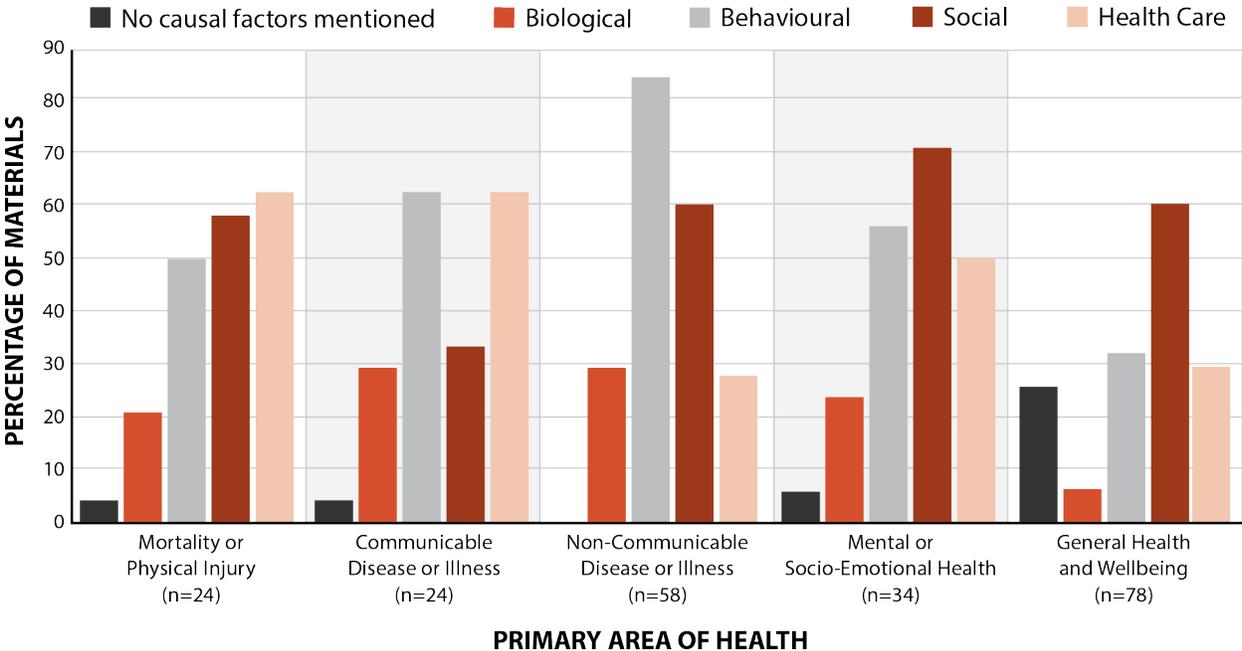
We will spend almost a third of our lives sleeping, so it makes sense to spend time, thought and money on which mattresses we buy. The right one, says Deane Halfpenny – a consultant in musculoskeletal pain medicine – and osteopath Rehana Kapadia, can ensure you are not only more comfortable, but healthier, too. Kapadia recommends investing time trying them out. ‘Some people just go into the shop and press them to see how they feel,’ she says, ‘but I would say you should lie down for 20 minutes on each one. If you just hop on and hop off, it’s hard to imagine how you will feel after an eight-hour sleep.’ Halfpenny agrees and says spending as much as you can afford on a bed is a good long-term investment in your health – especially when they typically last between seven and 10 years.

-*The Guardian*, 1 February 2016<sup>20</sup>

While a fully individualistic narrative was not identified among organisational materials, these materials still often suggested that health outcomes are the responsibility of individuals in a variety of ways. Though organisational materials mentioned behavioural factors less frequently than social factors as causes of health outcomes, over 50 percent of the organisational materials sampled did mention a behavioural factor as a cause (see Figure 2 above). Furthermore, organisations mentioned solutions that target individuals and families about as often as they mentioned solutions related to government services and social systems other than health care, such as housing (37.4 percent v. 35.2 percent; see Figure 5 above).

Like media materials, organisational materials also tended to bring up behavioural factors more or less often depending on the area of health on which they were primarily focused. They were especially likely to mention behavioural factors when discussing non-communicable disease or illness: 84.4 percent of materials about non-communicable disease or illness mentioned a behavioural factor as a cause of health (see Figure 10). By contrast, just 32.1 percent of organisational materials about general health and wellbeing mentioned a behavioural cause. In addition, as with media materials, organisational materials about communicable and non-communicable diseases or illnesses were slightly more likely to mention behavioural factors as causes than they were to mention social factors (62.5 percent v. 33.3 percent and 84.4 percent v. 60.3 percent respectively).

**Figure 10:** Types of factors mentioned as causes of health in *organisational* materials focused on different areas of health



While the media presented a consistent and coherent narrative about how individuals are ultimately and solely responsible for causing health issues and for taking steps to address health problems, organisational materials did not. However, organisations *did* still frequently mention individual-level causes and solutions, especially when discussing communicable or non-communicable diseases and illnesses. Thus, individualism is fairly present among both media and organisational discourses.

## FINDING 5

### Media materials are fatalistic about government efforts to improve health.

The latent class analysis revealed that the media, at times, tell a *Political Fatalism* narrative (17 percent), which was not identified in the organisational materials. Like the *Health Protection* narrative, the *Political Fatalism* narrative typically highlights a negative health outcome and uses crisis language to communicate the severity of the issue. The example below, which focuses on suicide, is illustrative of articles in this class.

Suicide prevention campaigners will take to the steps of Stormont to beg for help for those struggling with mental health issues. Community groups from across Belfast will urge MLAs [Members of Legislative Assembly] to do more [...] Earlier this month, it was reported a ministerial co-ordination group on suicide prevention has failed to meet since last April. It was set up more than 10 years ago [...] More people have now died from suicide in Northern Ireland in the years since the Good Friday Agreement – in excess of 3,700 – than the 3,600 killed due to the Troubles.

-*Daily Mirror*, 26 January 2016<sup>21</sup>

This example also reveals a key feature of the *Political Fatalism* narrative, and one that distinguishes it from the *Health Protection* narrative: scepticism about government efforts and interventions to improve health. As demonstrated in the below example, while this narrative generally supports government intervention to improve health, articles in this class typically argued that political leaders do not actually have the necessary will or capacity to create meaningful change or are wrongheaded in their efforts. In other words, this narrative calls for political and governmental intervention, but usually by casting doubt on the likelihood that necessary interventions will ever come to fruition.

It's that time of year again, around the Christmas period, when we all notice that there's an obesity crisis. The causes of the crisis depend entirely on the political persuasion of the speaker, of course. And here come the politicians to demand that we make sure that people aren't doing things that aren't healthy (by 'people' we of course mean poor people). The thing is, paternalism generally backfires [...] But before we go assuming the citizenry (and again, at this level of tax we are talking about mainly the poor here) are a bunch of blithering idiots who don't know that sugar rots your teeth, has anyone done a study to see whether children have better weight outcomes if both parents aren't working unstable zero-hour contracts?

-*The Guardian*, 11 April 2016<sup>22</sup>

## Implications

Based on FrameWorks' prior analysis of the cultural models that the public uses to reason about health, we can further identify how the patterns and narratives present in media and organisational discourse described above may affect public thinking:

- **Current discourse supports recognition of how social determinants *harm* health, but not how they *create* health.** Health creation is a blind spot for the British public.<sup>23</sup> Members of the public recognise that social determinants can harm health, either directly (for example, toxic exposures) or by constraining behaviour (for example, limiting opportunities to exercise or eat well); yet because people often think of good health in negative terms – as the absence of illness – they do not always see the ways in which health can be actively created.<sup>24</sup> Media and organisational discourses offer little help in this regard. The media consistently emphasise links between social determinants and negative health outcomes, reinforcing the public's focus on how environments can harm health. While organisational discourse is more positive, the sector is also not currently telling a consistent, coherent narrative about how environments can create health. To shift public thinking and cultivate a better understanding of health creation, the sector needs to repeat a consistent story about what health is, the influences on health, the nature of the problems to be solved in the United Kingdom today, and how shifts in policy and practice could create a healthy society.
- **The disproportionate focus on health care in media and sector communications encourages a medicalised understanding of health and obscures the importance of other social factors.** Experts emphasise that social factors other than health care are primarily responsible for outcomes and, in turn, that creating a healthy society requires focusing outside the health-care sector and intervening in other social domains. While the public already recognises that social factors other than health care matter, people tend to associate health with medicine and, as described, are less able to explain how health can be actively created. The focus on health care in media and organisational communications reinforces this medicalised understanding of health and limits understanding of how health can best be created. Building this understanding will require a profound shift in focus away from health care and towards other social domains.
- **The lack of discussion about disparities in media materials and uneven coverage of disparities in sector materials keeps the reality of health inequalities out of public view.** Earlier stages of this research show that the public does not generally recognise or fully appreciate how discrimination and power imbalances between different groups determine health.<sup>25</sup> Little media coverage is devoted to health disparities, which means the public is not even hearing about health inequalities in the United Kingdom, much less the power inequalities responsible for them. Organisational discourse devotes considerably more attention to disparities, yet even the sector

says little about disparities around race and ethnicity, sexual orientation, disability status and citizenship or immigration status. The public thus doesn't hear about these disparities from these sources, leaving them especially out of public view. Cultivating public understanding of health inequalities will require moving disparities to the centre of public conversation. And if the sector is not itself telling a full story of disparities, there is little hope that the media will.

- **The individualistic strain in media coverage reinforces individualistic thinking among the public.** As previous research has found, the public's dominant way of thinking about health is individualistic. People assume that health is ultimately driven by and up to each of us to engage in the right daily behaviours and choices. The media's tendency to focus on individual behaviours reinforces this way of thinking. Strengthening the ecological strain in public thinking, which recognises the ways in which money, community, commercial and physical environments, or other contextual factors shape health outcomes, requires shifting the balance of media coverage away from a focus on individual behaviours and towards a discussion of these social factors and health creation.
- **Fatalism in media coverage discourages support for government efforts and interventions to improve health.** In the media, the public primarily hears two stories involving public health policy and programmes, both of them negative. One is focused entirely on the challenges faced by the NHS. This narrative often uses crisis-laden language about the extent of the problem, coupled with vague solutions about how to address these challenges. The other narrative focuses on how the government has not effectively addressed – or, in some cases, *should* not address – health issues. While members of the public commonly attribute responsibility for health to the government, each of these narratives casts doubt on whether and how the public sector can affect meaningful change, and is likely to trigger fatalism about the efficacy of large-scale government interventions in health.

## Recommendations

This analysis reveals that, in some critical ways, health-sector organisations are communicating about the social determinants of health in ways that align with the expert perspective detailed in earlier phases of our research. The sector already more consistently talks about social and environmental factors than individual behaviours. Health-sector organisations are bringing attention to disparities in health outcomes along some axes of inequality as well. Unfortunately, these promising patterns are not yet present in the news media. Media coverage contains a large dose of individualism and devotes little attention to disparities. The first part of the sector's communications strategy must consist of efforts to push media coverage to be more like the sector's communications.

There are, however, important ways in which sector communications are missing key parts of the expert story and failing to challenge certain misunderstandings in public thinking. In other words, the sector is not *itself* telling a full and complete story about social determinants, health inequalities and health creation. The second part of the sector's communications strategy must therefore involve shifting its own communications to fill in these gaps.

The following recommendations provide guidance about how experts and advocates can begin to fill in these gaps by deepening and broadening their existing narratives. Subsequent phases of research will expand these recommendations and explore the most effective ways of executing them.

1. **Tell more complete stories that clearly identify the societal causes, consequences and solutions for health issues.** In the absence of a robust, full account of social determinants and health creation, the public is liable to 'fill in the blanks' with default, and potentially unproductive, ways of thinking. Communicators and advocates need to tell complete stories that clearly align causes, consequences and solutions. For example, without an understanding of the structural causes that shape health, public support for policies that address these underlying systemic conditions will remain low. Similarly, if communicators do not provide examples of tangible, actionable ways that we can shift environments to improve health outcomes, the public will likely be left with a deep sense of fatalism. Complete stories are therefore necessary to build public understanding of how problems arise *and* how they can be addressed.
2. **Shift focus away from the health-care system and towards other social determinants.** The analysis shows that both media and health-sector communications focus heavily on health care, and much less on other social determinants. This is likely to reinforce the public's tendency to think about health in medicalised terms and to associate health with illness and treatment, and to prevent people from recognising that other social factors are the primary determinants of health. For the public to understand the various social and environmental factors that shape health outcomes, communicators need to shift their focus to these other determinants and spend more

time talking about the range of ways in which social, material and commercial environments shape health. Doing so will open space for arguing that the best way of improving health in the United Kingdom is to address these environments.

3. **Tell an ecological story more consistently.** While the health sector generally focuses on social causes, there are points at which organisations stress behavioural factors, such as in communications about non-communicable diseases. Because the public tends to see health issues as the effect of individual decisions and behaviours, communicators must be careful not to reinforce this perception by overemphasising the role of individuals. By consistently telling an ecological story that focuses on how commercial and physical environments, financial and social resources, and other various contextual factors shape health outcomes, health-sector organisations can push the broader public discourse and thinking away from individualism and towards a more holistic, structural understanding of health.
4. **Talk about a broader set of health disparities and connect them more clearly to underlying inequalities.** To build public understanding of the full range of health inequalities in the United Kingdom, and to deepen understanding of how these health disparities stem from power imbalances, the health sector must talk about the full range of health disparities that exist – and explain *why* they exist. The public currently lacks a deep understanding of health inequalities and shifting public thinking will require steady exposure to information and explanation. This must start with ensuring the sector’s own communications tell the whole story.
5. **Use concrete examples of health creation to help the public understand what health creation looks like and how it works.** Members of the public struggle to understand what health creation involves, and to think about how health might be proactively built. Health-sector organisations should therefore not only increase communications about health creation but also explain what it involves and provide concrete examples of what it looks like. Communicators must explain *why* and *how* current conditions are not creating health for many people, and explicitly spell out how interventions and policies can address these underlying issues and create a healthy society.

## Conclusion

Improving health in the United Kingdom requires a strong public understanding of health inequalities and what health creation involves. As advocates and experts work to increase public understanding of the social determinants of health and build support for health creation, they must take into account the current public discourse around health.

The analysis presented in this report shows how current discourse around health in the United Kingdom reinforces unproductive assumptions about health, while also identifying promising trends in that discourse and openings for shifting that discourse. Most importantly, advocates must find ways of shifting media and sector communications away from a heavy focus on health care and towards other social factors, and must deepen and broaden the discourse around health disparities. Identifying the gaps in current public discourse – including in the sector’s own communications – clarifies where advocates must focus their efforts.

By shifting the types of stories they tell and working to influence media coverage, advocates and experts can not only help build public understanding of the social determinants of health and sources of health inequalities but also galvanise public support for health creation. Understanding the stories that are currently being told is the first step to telling new ones.



## About the Health Foundation

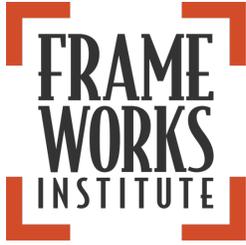
The Health Foundation is an independent charity committed to bringing about better health and health care for people in the United Kingdom. Its aim is a healthier population, supported by high quality health care that can be equitably accessed.

The Health Foundation learns what works to make people's lives healthier and improve the health-care system. From giving grants to those working at the front line to carrying out research and policy analysis, it shines a light on how to make successful change happen.

The Health Foundation connects the knowledge gained from working with those delivering health and health care, and its own research and analysis. Its aspiration is to create a virtuous circle, using what works on the ground to inform effective policymaking, and vice versa.

The Health Foundation believes good health and health care are key to a flourishing society. Through sharing knowledge, collaborating with others and building people's skills, it aims to make a difference and contribute to a healthier population.

Learn more at [www.health.org.uk](http://www.health.org.uk).



## About the FrameWorks Institute

The FrameWorks Institute is a think tank that advances the nonprofit sector's communications capacity by framing the public discourse about social problems. Its work is based on Strategic Frame Analysis®, a multimethod, multidisciplinary approach to empirical research. FrameWorks designs, conducts, publishes, explains and applies communications research to prepare nonprofit organisations to expand their constituency base, build public will and further public understanding of specific social issues – the environment, government, race, children's issues and health care, among others. Its work is unique in its breadth, ranging from qualitative, quantitative and experimental research to applied communications toolkits, eWorkshops, advertising campaigns, FrameChecks® and in-depth study engagements. In 2015, it was named one of nine organisations worldwide to receive the MacArthur Foundation's Award for Creative & Effective Institutions. Learn more at [www.frameworksinstitute.org](http://www.frameworksinstitute.org).

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## Endnotes

- <sup>1</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>2</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>3</sup> See Lippmann, W. (1922). *Public Opinion* (pp. 3–34). New York, NY: Harcourt, Brace and Company.
- <sup>4</sup> Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1994). Growing up with television: The cultivation perspective. In J. Bryant & D. Zillmann (Eds.). *Media Effects: Advances in Theory and Research*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- <sup>5</sup> Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1994). Growing up with television: The cultivation perspective. In J. Bryant & D. Zillmann (Eds.). *Media Effects: Advances in Theory and Research*. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.
- <sup>6</sup> Under LexisNexis, the headline and lead paragraph of articles longer than 500 words were searched for the presence of at least one term from each of the two following sets of search terms (including inflection for plural versions, etc.): cause, determin\*, affect, risk, effect, impact, consequence, implication, factor, outcome, prognos\*, diagnos\*, treat, cur\*, protect, prevent, facilitate, support, promot\*, contrib\*; and health, wellbeing, well-being, wellness, disease, infect, ill, sick, morbidity and comorbid. A random sample of these articles was then coded for relevancy and, when relevant, included in the final sample to be coded and analysed.
- <sup>7</sup> In this report, we use the terms 'materials' and (occasionally) 'communications' to refer to articles, blog posts, web pages or any variety of text included in the analysis.
- <sup>8</sup> We sampled materials from the following organisations: British Medical Association, C3 Collaborating for Health, Cambridge Institute of Public Health, Department of Health, Faculty of Public Health, HSE Ireland, Institute for Health Equity, Institute of Public Health in Ireland, Lankelly Chase, London School of Hygiene and Tropical Medicine, National Institute for Health and Care Excellence, New NHS Alliance, NHS Choices, NHS England, NHS Scotland, NHS Wales, People's Health Trust, Public Health Collaboration, Public Health England, Public Health Wales, Royal Society for Public Health, Scottish Public Health Observatory, Society of Social Medicine, The King's Fund and UK Health Forum.
- <sup>9</sup> Please note the examples listed here reflect only a small subset of the full codebook.
- <sup>10</sup> To select the appropriate number of classes, a two-class model was fit first and then compared to successive classes to determine the best model fit (up to five latent classes), separately for media and organisational articles. Bayesian Information Criterion and Akaike's Information Criterion, as well as the interpretability of each solution, were used to guide the final selection of classes. Using posterior probabilities, each article was assigned to a class based on the highest probability of class membership.
- <sup>11</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>12</sup> NHS England. (2016, Nov. 23) Health Should Not Be a Postcode Lottery. [Blog post]. Retrieved from: <https://www.england.nhs.uk/blog/penny-woods-2/>.

- <sup>13</sup> O'Hara, M. (2016, May 19). Mental Health Services Kept Waiting for Promised 'Revolution'. *The Guardian*. Retrieved from: <https://www.theguardian.com/healthcare-network/2016/may/19/mental-health-nhs-revolution>.
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- <sup>15</sup> The King's Fund (2017, Feb. 2). What is Social Prescribing? [Blog post]. Retrieved from: <https://www.kingsfund.org.uk/publications/social-prescribing>.
- <sup>16</sup> It is important to note that the types of materials telling this narrative vary widely. Thus, the extent to which materials identified as telling this narrative fully conform to the description provided varies somewhat.
- <sup>17</sup> NHS England (2016, Dec. 12). Living with Diabetes. [Blog post]. Retrieved from: <https://www.england.nhs.uk/blog/matt-tull/>.
- <sup>18</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>19</sup> 'Primary focus' means that disparities were discussed in both the headline and lead paragraph, or throughout the majority of the text of a document.
- <sup>20</sup> Khaleeli, H. (2016, Feb. 1). Softly Does It: How to Choose the Perfect Mattress. *The Guardian*. Retrieved from: <https://www.theguardian.com/lifeandstyle/2016/feb/01/softly-does-it-how-to-choose-the-perfect-mattress>.
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- <sup>22</sup> Tirado, L. (2016, Apr. 11). A Sugar Tax? Let's Stop Nannying Poor People and Find a Proper Solution. *The Guardian*. Retrieved from: <https://www.theguardian.com/commentisfree/2015/dec/01/sugar-tax-poor-people-obesity-crisis>.
- <sup>23</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>24</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.
- <sup>25</sup> L'Hôte, E., Fond, M., & Volmert, A. (2018). *Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom*. Washington, DC: FrameWorks Institute.