External Factors vs. Right Choices

Findings from Cognitive Elicitations and Media Analysis
on Health Disparities and Inequities
in Louisville, Kentucky

A Cultural Logic Research Report
For The Center for Health Equity

Axel Aubrun, Andrew Brown, Joseph Grady

cultural logic LLC

May 2007

INTRODUCTION

The Louisville Metro Department of Public Health and Wellness has been pioneering efforts to improve public health in innovative ways, including tackling health problems and disparities that are rooted in the social conditions in which Louisville residents find themselves. In particular, the Center for Health Equity puts the focus on the ways in which race, geography, economics, immigration and so on create an uneven landscape where not everyone gets the same opportunity to lead a healthy life. The Center is working to create health equity across Louisville's diverse neighborhoods by bringing more attention to the public health impacts of social conditions, social injustice and health disparities; by involving communities themselves in the work of improving the situation; and by grounding its efforts in research-based science and analysis.

Every important policy initiative requires public understanding and support, but especially initiatives that approach problems from new and unfamiliar directions. Success will ultimately require that public health officials and community leaders be able to communicate successfully about what the Department and the Center are trying to do, and why. If members of the public don't understand and engage with these messages, policies and initiatives are unlikely to gain the traction needed to bring about real and lasting change.

For this reason, it is helpful to explore aspects of the public's underlying *thinking* about topics related to health, health disparities and steps that can be taken to improve outcomes. In order to explore the public's understandings around these issues, Cultural Logic conducted twenty in-depth interviews with a cross-section of average people living in the city of Louisville. Cultural Logic also undertook an analysis of news media reports in Louisville, in order to see what patterns of thinking are being reinforced or contradicted by the stories in the news. This review also sheds light on how the messages of public health officials and experts are "translated" in the stories written by journalists.

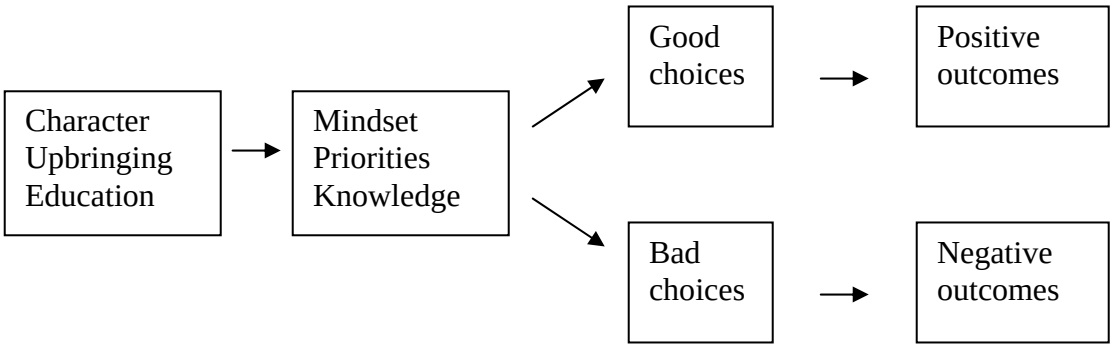
The report discusses the discrepancies between what public health experts want people to understand, and what the public currently believes about health and health disparities. The experience of Cultural Logic and many other researchers, in a variety of issue areas, has established that if patterns of thinking aren't explored and accounted for from the outset, they can derail communications in unexpected ways.

This research brief represents the first step toward ensuring that the Center's new and important approach to public health can be conveyed to the public clearly and compellingly.

SUMMARY

The Right Choices model

When Louisvillians think about health and health inequalities in their community (i.e. differences between the health outcomes of some groups vs. others), their thinking is guided by a powerful, default understanding that we call the "Right Choices" model: *People's health outcomes are determined by their own choices and actions* (which, in turn, are determined by their upbringing, values, their knowledge about health, and so on).



This model is simple and clear, and feels both obvious and complete, in the sense that it seems to "tell you everything you need to know" about why some people end up healthier than others.

It also has *moral significance* for Louisvillians. It relates to people's character and values, and is not only a reflection of how things *do* work, but of how they *should* work, in a fair world.

It will come as no surprise to insiders that Louisvillians tend to think in something like these terms. But the elicitations research helps clarify just how powerful this model is, and just how damaging its effects are for any attempt to engage support for solutions to health inequities.

> *One of the model's most damaging aspects is that it leads Louisvillians to either misinterpret or reject advocates' messages about health inequities.*

Distorting effects of the model

While the model is not *false* – personal choices certainly do play a role in health outcomes – it is an extremely *limited and limiting* perspective. It obscures many factors that have significant effects on health outcomes. Yet the Right Choices model is such a good fit with "common sense" that it is a powerful default even for people who do or should know better on some level.

The Right Choices perspective has a number of important distorting effects on people's thinking:

- It excludes “Material” conditions.

  Because it focuses exclusively on the “Mental” world of knowledge, priorities, beliefs, choices, character, willpower, etc., this model excludes consideration of material circumstances of people’s lives, such as their socio-economic status or their physical access to health facilities, opportunities for exercise, etc. It also excludes other material factors such as the biological effects of stress.

- It excludes broad, systemic conditions.

  Because it is about individuals and how they think, the model excludes consideration of how health is affected by economic conditions or social structuring of a community as a whole.

- It frames Groups as multiple Individuals.

  Because it is focuses on individual thinking, it guides people to reason about Groups (e.g. economic, racial) as though they were just collections of individuals. That is, the health outcomes of Groups are understood as products of the choices made by the individuals in the Group.

Reinforcement in the Media

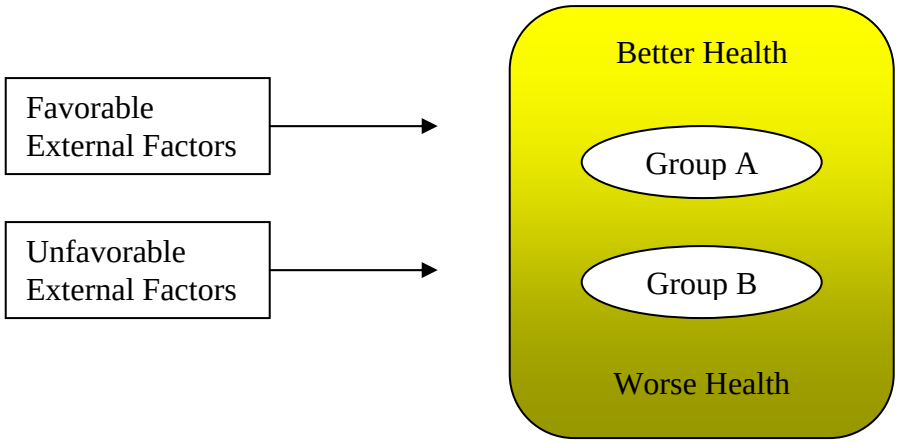
With some exceptions (discussed below), the Right Choices model tends to be strongly reinforced by media coverage. Sometimes this effect is direct, as when an article focuses on the health effects of an individual’s choices (about diet, smoking, etc.). In many cases the effect is indirect and possibly inadvertent, as when a reporter (inadvertently) invites associations between bad health and other factors that are strongly associated with individual choice (e.g. being a convict, having a “bad” job).

Most subtly, the reporting reinforces the Right Choices model whenever it fails to offer a strong and compelling *alternative* to people’s default views of how health outcomes happen. When such alternatives aren’t offered, it is most natural for people to read *any* information as confirmation of their default understandings.

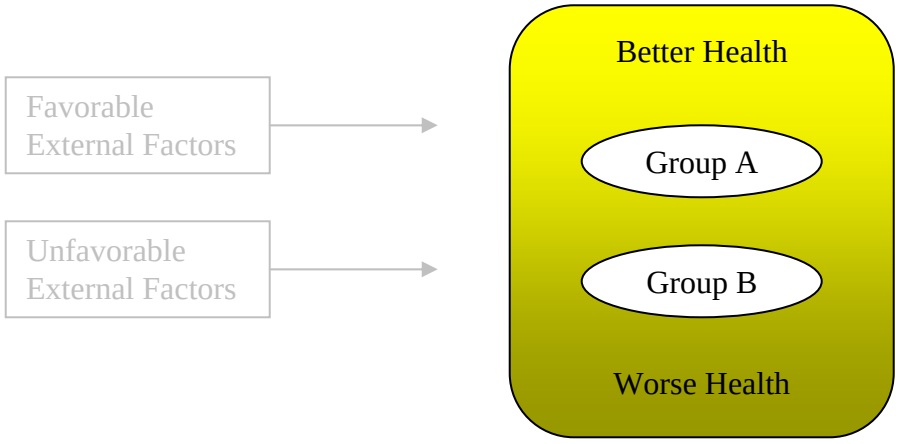
Responses to Disparities/Outcomes messages

One critical question addressed by the research was, *How do average people respond when health advocates talk about health disparities*?

Health advocates would like the public to understand the nature of *health inequities*, i.e. the way in which unfair and avoidable differences in life circumstances lead to disparities in the health outcomes of different groups in Louisville. Because the relevant causal factors lie outside the control of individuals, we will refer to them as External Factors, and can schematize the expert story as follows:



Advocates sometimes focus on publicizing the *disparities in outcomes*, as in the diagram below:



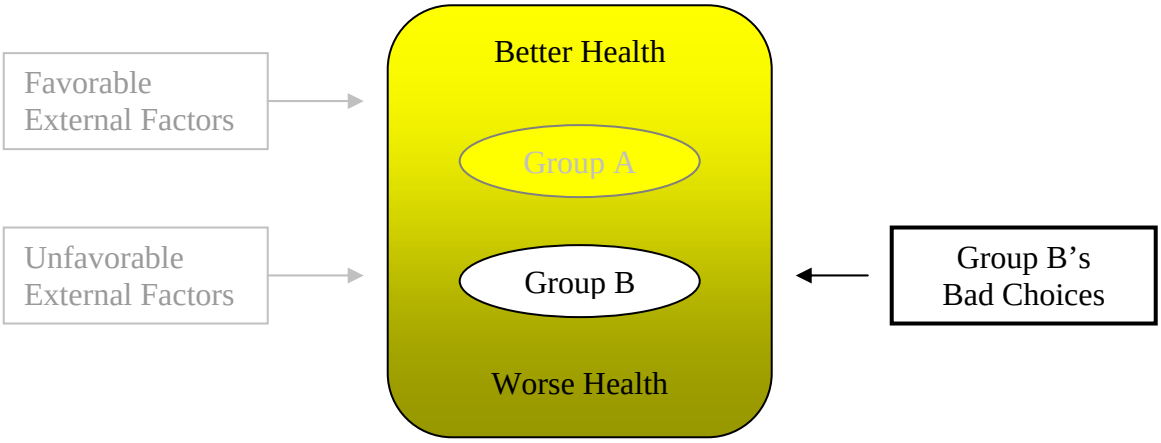
E.g. advocates point out differences in diabetes rates or cancer deaths among Whites and African-Americans. The hope and expectation behind this strategy is that:

> *If people are aware of different outcomes, they will then recognize the (unfair, and avoidable) differences in life circumstances.*

This, after all, is how insiders respond to such differences in outcomes, given their own knowledge and assumptions.

Unfortunately, the elicitations research establishes that a focus on differences in *outcomes* (i.e. health disparities) has little or no constructive effect on people's thinking.

Average Louisvillians account for these differences using the Right Choices model:



From the Right Choices perspective, *the differences in health outcomes confirm that Choices lead to real consequences*.

In fact, the different outcomes may even count as *evidence of the world working as it should (i.e. fairly)*.

In short, the Right Choices model "hijacks" data about outcomes and turns it into a story very different from what advocates intend. *Consequently, there is little or no value in publicizing health disparities per se.*

Responses to External Factors stories

> Another basic question addressed by the research was, *How do average people respond when advocates try to point out social determinants, systemic factors, etc.?*

Advocates sometimes focus on (causal) stories about how particular conditions – related to race, social exclusion, poverty, etc. – *lead to* particular health outcomes.

In principle, these arguments could displace the Right Choices model in favor of more productive and accurate perspectives.

Unfortunately, however, the elicitations suggest these stories too, as they are usually told, are unlikely to move thinking in a productive direction.

The "External Factors" stories tend to fail for several reasons related to the Right Choices model:

- Causal stories relating to the factors are ***cognitively weaker*** (less familiar, harder to understand, more complex, etc.)
- The External Factors are understood as ***excuses*** people use for their own failures(while Right Choices tells the "real" causal story).
- External Factors such as poverty and even race-related social exclusion are often understood as ***outcomes*** (of people's choices), rather than causes.
- When they are acknowledged as things that could affect health outcomes, the External Factors tend to be understood as ***barriers that can and should be overcome***.

In short, the External Factors stories that advocates would like to tell currently ***can't compete with the Right Choices model***, and tend to be rejected or reinterpreted in a variety of unhelpful ways.

Opportunities

In addition to the "bad news" we have focused on so far, the elicitations research suggested a number of areas where there is potential to move the public conversation in more productive directions.

- Stressing Opportunities vs. Outcomes

  Discussions of Outcomes tend to be "hijacked" by the Right Choices model. At least in principle, discussions in terms of *opportunities to be healthy* have a chance to be much more effective. Equal opportunity is a value held by Louisvillians and other Americans.

  In order to be effective, this *values-based* approach would need to be complemented by more effective *explanatory* approaches, to help people understand that opportunities *currently are not equal* – in ways that are not fair and that can be addressed through collective/public action.

- Explaining the role of (particular) external factors

  The Louisville public currently lacks an understanding of how external factors play a role, and ***explanations of this topic need to be very clear and compelling in order to compete with the Right Choices perspective***.

  There are a number of current understandings that might be built on:

  - The health effects of living in Rubbertown (i.e. material conditions beyond individual control)

- The health effects of the Built Environment (sidewalks, parks, recreation centers, etc.) that either does or does not create good opportunities for physical activity
- The health effects of Vibrant Communities (where people walk around and are physically and socially active; where people feel secure and interact with and support one another).

- A Clear and Practical Vision

  One of the most striking gaps in Louisvillians' current thinking is any sense of ***what ought to be done to address the problem of inequities***.

  Since average people currently don't recognize a problem in the way experts do, they also don't have "solutions" in mind.

  And to date, advocates have not put forward a clear or compelling vision of how Louisville could look different.

  Research in numerous issue areas has shown that clear explanations of practical steps, with a high likelihood of success, are very engaging and motivating.

- Health as an Exceptional Case

  The elicitations revealed some "cracks" in the Right Choices model, when it comes to health coverage, in particular. Louisvillians tend to believe that everyone should have access to medicine and doctor visits, and thinking about health in this way, as a fundamental and universal need, helps people stay away from the Right Choices perspective.

  With the right messaging, it may be possible to avoid triggering the Right Choices model by making a clear case that everyone ***should have access to certain health basics***. Broadening this list beyond the obvious and narrow categories (such as life-saving medicines and occasional doctor visits) would be one important challenge inherent in this strategy.

- Explaining the "Health Gradient"

  One of the most challenging, but potentially most important steps, that communicators in this issue area could take, would be to find user-friendly ways of explaining the basic and powerful connection between socio-economic status and health outcomes.

  To advocates, the idea of the Health Gradient – e.g. the powerful correlation between SES status on the one hand, and health status on the other – is simple and powerful.

  Yet Louisvillians currently have little awareness of this concept, beyond a simple "dollars and cents" understanding that not everyone can afford the best health care.

  In principle, the Health Gradient idea (expressed in more user-friendly terms, see below) has several important communications advantages:

- It is about *everyone*, at all points on the scale – not just "the poor."
- It is a very new concept, that could provoke an "aha!" effect.
- At bottom, it is a *simple and concrete idea* that might help organize lots of more particular information.

For it to be effective, this new story would need to be felt as a *simple and intuitive new account of how health works*, and would have to stress causality rather than correlation. In other words, it would have to become an idea that could *compete with Right Choices as an explanation of why some groups are healthier than others*.

RESEARCH METHOD

The analysis presented here is based on interviews conducted by Cultural Logic in 2007 with a diverse group of 20 individuals in the Louisville metropolitan area. A review of several dozen newspaper articles from Louisville's *Courier-Journal* also informed and added additional dimensions to the analysis.

Subjects

Subjects were recruited by various means, including postings on Web sites, random phone contacts, on-site recruiting by researchers, and through a process of ethnographic networking – researchers began with "seed contacts" and developed a pool of subjects from which a diverse range was selected for interviewing.[1] The sample included 13 women and 7 men. Subjects' ages ranged widely – 6 subjects were in their teens or 20s, 3 in their 30s, 3 in their 40s, 2 in their 50's and 6 were 60 or older. 12 of the subjects were European-American, 6 were African-American, 1 was Hispanic-American and one was Native American. The sample also included a mix of political orientations (9 conservatives, 1 moderate, and 10 liberals). Educational backgrounds also ranged widely (high-school only to graduate degree) as did occupations. Subjects represented people who had spent their entire lives in Louisville as well as more recent transplants.[2]

Elicitations

Subjects participated in one-on-one, semi-structured, recorded interviews ("cognitive elicitations"), conducted according to methods adapted from psychological anthropology. The goal of this methodology is to approximate a natural conversation while also encouraging the subject to reason about a topic from a wide variety of perspectives, including some that are unexpected and deliberately challenging. One of the key goals of the conversations is to encourage subjects to think aloud about the issue, rather than reproducing opinions they have stated or heard before.

Cognitive Analysis

The analysis of elicitations data, based on principles of cognitive anthropology and linguistics – yields insights not available from standard interview, polling, or focus group techniques. It does not look for statements of opinion, but for patterns of thought that may even be unconscious. It does not look for familiarity with issues in the news, but for more default reasoning patterns, that are likely to be stable and durable. Some of the clues to these important patterns come from topics that are *omitted*, moments of *inconsistency* where one understanding clashes with another, and the *metaphors* people use to talk about a subject. Furthermore, the method is designed to explore the differences between *rhetorical mode* – in which people define themselves in opposition to other groups and perspectives, and repeat

---

[1] See discussion of "snowball sampling" as a key technique of ethnographic research in H. Russell Bernard's *Research Methods in Anthropology: Qualitative and Quantitative Approaches, 2nd Edition.* 1995. (pp.97ff).

[2] Note that, rather than emphasizing differences between groups as some research methods do, cognitive elicitations focus primarily on common patterns of thinking across groups of Americans.

ideas and phrases familiar from public discourse – and *reasonable mode* – in which they reflect their own experiences, think for themselves, and are more open to new information. Put briefly, this analysis focuses on *how* people think rather than *what* they think.

Cognitive research works on the premise that unconscious, default understandings of the world (cognitive and cultural *models*) can guide people's understanding of an issue in ways they do not even recognize. One of the most important aspects of these default models is that they often lead people to understandings that they might reject at other moments of more careful reflection. For example, average Americans may recognize on an intellectual level that advertising can influence patterns of eating, yet easily default to the idea that fitness is entirely a matter of personal choice. Habitual ways of thinking about food and eating create cognitive "blind spots," and people who *know better on some level*, still tend to "forget" about external factors that shape our diet. The hidden, underlying understandings can be very difficult to challenge and displace, and, if they are not accounted for, they can derail communications.

Cognitive Media Analysis

Cultural Logic reviewed over 50 newspaper articles appearing from September 2004 to April 2007 in the Louisville *Courier-Journal*. The sample focused on local Louisville content and reporting rather than pieces with a national context such as AP Newswire articles. Articles were located by searching archives using such terms as "public health," "disparity," "inequality," "poverty," "working poor," "AIDS," "uninsured," "minimum wage," and "healthcare." The collection of articles featured both pieces that focused on diseases traditionally associated with inequality (cancer, diabetes, AIDS) as well as articles that generally surveyed the state of public health disparity in the Louisville metro area.

Although the research included a broad sampling, this analysis is not a quantitative look at the *number* of various types of articles published, but a qualitative examination of how topics related to health disparities are treated in the materials, and the likely implications for readers' thinking. The analysis looks at such factors as the types of topics that are and aren't mentioned in a given article, the ways in which topics within a story are treated as either related or unrelated, the causal stories conveyed or implied by the articles, and so forth. The analysis is less about cataloguing what is explicitly said than it is about identifying the implicit understandings that are conveyed by the materials.

The analysis also touches on the relationship between the stories told in newspapers and the stories people already have in their heads, as established by elicitations research undertaken at the same time.

* * * * *

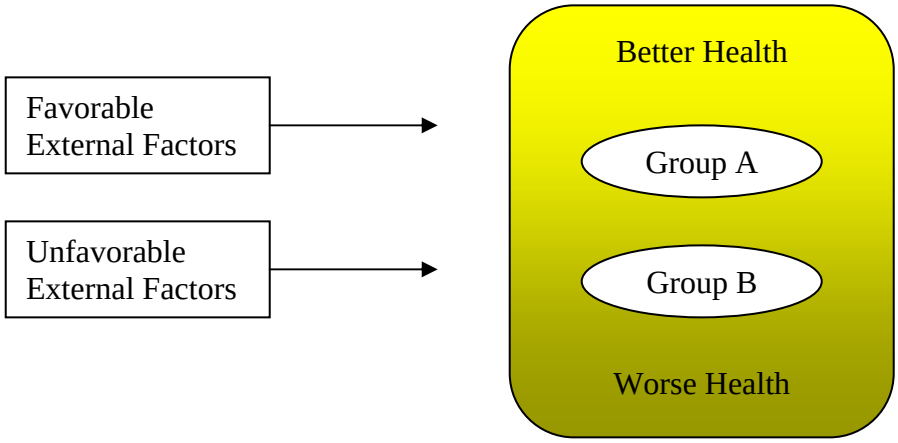
We now turn to a discussion of the major findings from the elicitations.

"External Factors": The Expert Story

Health advocates, including staff of the Center, have an important story to tell about the systemic conditions that lead to disparities in the health outcomes of different groups in Louisville.

We begin with a brief review of this story that advocates would like to be telling.

This story involves Causal Factors related to race, socio-economic status and social inclusion; and Outcomes related to health – different rates of diabetes in different populations, different rates of death from cancer, etc. Because the causal factors lie outside the control of individuals, we will refer to them as External Factors, and can schematize the expert story as follows:

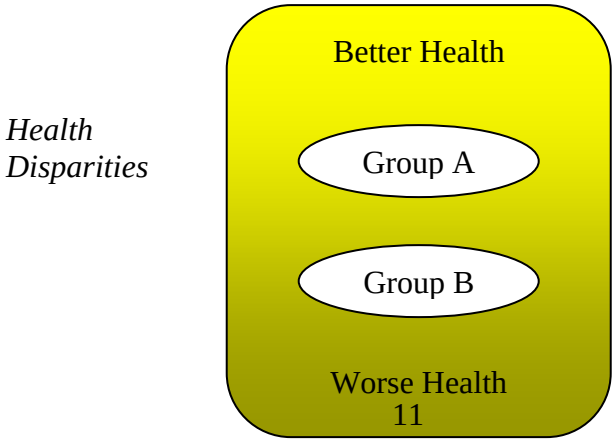


The "Expert Perspective"

The differences between the *outcomes* of different groups – i.e. the differences within the box on the right side of the diagram – constitute "health disparities."

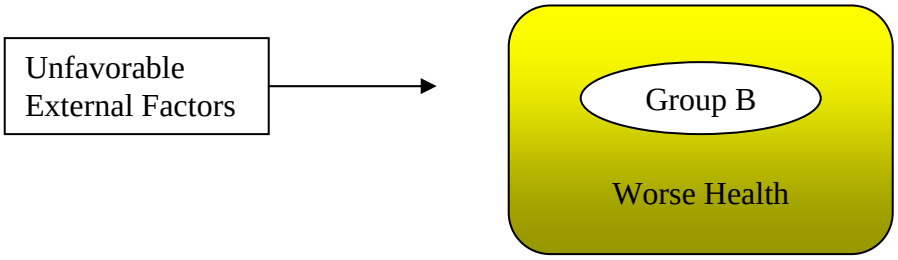
The differences between the trajectories as a whole, including the (unfair and potentially correctable) differences in causal conditions affecting Groups A and B, constitute "health inequities."

Advocates sometimes focus on publicizing the *just the disparities in outcomes*, as in the diagram below:



At other times, they focus on describing *the ways in which particular conditions negatively impact the health of certain groups*:

Particular causal stories



Unfortunately, whichever of these 3 routes they take – a focus on the disparties in outcomes, the health effects of particular life circumstances, or the broader picture of inequities – advocates face a daunting challenge in getting through to the Louisville public.

This difficulty is primarily due to the power of a default understanding we will call the Right Choices model. This model is the focus of the next section of the report.

Findings 1: How the "Right Choices" Model Guides Thinking

Overall, the Louisville public's thinking about health disparities, and health outcomes more generally, is guided by a particular *causal story*, which we will call the "Right Choices" model. In this section we outline the basic shape of this pattern of reasoning, as well as some of its key (mostly negative) implications.

While it will not come as a surprise to advocates that the public tends to think in something like these terms, the elicitations research can help them more fully appreciate how the model works in people's minds, how strong and pervasive the pattern is, and what kinds of challenges it creates for communication.

Description of the Right Choices model

The Right Choices model is a powerful and coherent understanding that seems to tell you "all you need to know" about why some people end up healthy and other people end up unhealthy.

Emphasis on Individual Behaviors

In this model the most profound determinants of health – maybe the only ones that matter – are an individual's choices and behaviors. Does the person eat right, exercise, visit the doctor, avoid risky behaviors, and so on?

> *Q: Some people say the city of Louisville should do more to close the gap between those who are in good health and those in ill health. What do you think?*
>
> *A: I think people need to eat better, exercise more, I think that's a big issue here in Kentucky. The way we live. The way we eat. The way we don't exercise, a lot of it is [contributing] to being overweight.*
>
> Conservative African-American woman, age 64

Moral significance of the model

While health advocates and public health experts may not tend to focus on the *moral* dimensions of people's individual health-related behaviors, this aspect of the issue is clearly central to the thinking of average people in Louisville.

> *It's your own personal responsibility to do what you can to improve your health and keep yourself healthy ... If I'm going out, [if] I smoke a lot, if I'm carrying on excess weight or if I have four or five alcoholic drinks every day – I'm making that decision. That's my choice, so I'm hurting myself. I think there's too much of people not taking responsibility for their actions and just letting it go and thinking, well, you know, let somebody else take care of me.*
>
> Moderate White woman, age 75

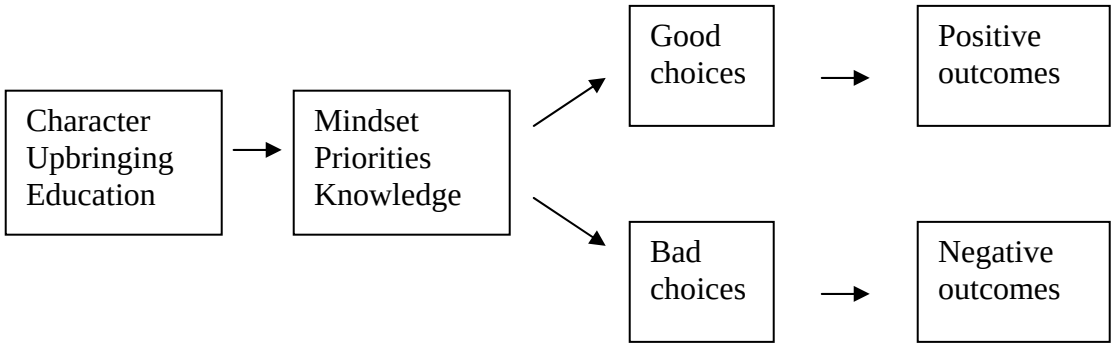
Q: Do you think we as a society owe every person some kind of help for being healthy? Is something like that a right to have?

A: No. Not as a society, because see a lot of times people cause their health problems by the way they live.

Conservative African-American man, age 60

A "complete" picture

As quotes like the ones above illustrate, the Right Choices model – which tends overwhelmingly to guide people's thinking – turns lots of questions into "no-brainers." The story it offers is intuitive, simple and clear. It "feels" true. People are "obviously" creating their own problems when it comes to health, so there's no need to think further about the question.



This is one of the most damaging aspects of the Right Choices perspective – it seems to offer a complete and satisfying explanation of health outcomes, in a way that cuts off further discussion. We explore this point further in the next sections.

Problems and Distortions

As Louisville residents think about why some people and groups are healthier than others, the Right Choices model guides their reasoning in several counterproductive ways, obscuring some important factors and exaggerating others, for instance.

A "Mentalist" model that excludes "Material" considerations

From the Right Choices perspective, the causal factors that matter all exist within people's internal, mental world. It is about choices, character, knowledge, learning, priorities, and other such factors – rather than about more concrete, "material" factors such as physical settings, the availability of particular kinds of stores or facilities, etc.

[You] need to choose a different outlook and then from that different outlook that will perhaps guide you towards a healthier life ... If people understood they actually do have some amount of power – some amount of control in their lives, then that would be a healthier place to start – a healthier viewpoint.

Liberal white man, age 31

It follows from the Mentalist perspective that solutions, if there are any, will focus on getting people to *think* differently, if this is even possible. (Important note: We are not implying that individual choice is not a factor in health outcomes – only that its significance tends to be exaggerated to the point where no other factors are even *visible*.)

An Internal model that excludes External factors

The mental world that the Right Choices model focuses on is also an individual, internal world that excludes "External" factors such as conditions in the community.

It ultimately comes down to the individual. With myself, I know I'm overweight, which puts me at risk for diabetes and heart disease ... I think the knowledge is out there, but it comes down to ultimate choice and, you know, what we choose to do.

Conservative White man, age 29

I think everyone has an option – if they want to be educated. Getting a great job and being able to have healthcare at the tip of your finger because your job offers that. I don't think the deck is stacked against people. Everyone has a fair chance. You just have to work at it ... and some people just don't want to take that way.

Liberal Hispanic man, age 24

In this sense the model is clearly in tune with powerful American cultural models of Individualism.

Even when interview questions had to do with the conditions that people live in, Louisville subjects quickly brought the focus back to the individualistic Right Choices model.

Q: What are some of the things you can think of in the environment around a person that can affect their health?

A: The way they eat. People don't eat right. Probably the way they live. You know, people need to probably exercise a little more and everything, but it's mostly what people eat. And I vouch for that. I don't eat the right things. So, I don't think anybody does eat the right stuff.

Conservative African-American woman, age 44

This type of response reflects the powerful *distorting* effect of the model. It is hard for people to even hear points that don't fit the default understanding.

"Groups" as multiple Individuals

Although Louisville residents tend strongly to think in individual terms about health outcomes, they obviously can consider the possibility of health disparities between different groups. When they do, the results often seem simply to be versions of the Right Choices story, as the groups are defined by their own (individual) choices:

> *Q: If you had to take a guess on <u>what groups of people</u> in Louisville would be healthier and what groups would be less healthy, what do you think?*
>
> *A: The couch potatoes would be less healthy.*
>
> Conservative white woman, age 71

And when people extend the default Right Choices causal model to explain different outcomes among demographically defined groups (e.g. differences by race or economic status), the understandings tend to be just as counterproductive.

The Right Choices model says that differences among social groups must be caused by the different priorities, mindsets and knowledge that different groups have, NOT by external or structural factors that shape the conditions of those groups.

Because advocates (and journalists) nearly always discuss disparities in terms of negative health outcomes, the Right Choices model leads people to think that, for whatever reason, entire classes of people are making bad choices.

This pattern is most clearly illustrated by Louisvillians' thinking about race-based disparities – where there is already a rich repertoire of "explanations" about why Whites and Blacks have different priorities and make different choices. The dominant Right Choices model suggests a particular category of reasons as to why African-Americans tend to be less healthy, all based on the kinds of choices they make. For some, these ideas confirm and reinforce various negative (racist) stereotypes. For others, including many liberals who should be most likely to embrace progressive policies, the Right Choices thinking creates a problem: They conclude, but don't want to believe (or say), that African-Americans' choices are the real problem. This conclusion creates an uncomfortable "cognitive dissonance" that can cause them to reject the point entirely.

Negative racial stereotypes

The woman below begins talking about genetics as a reason for disparities, but quickly shifts into thinly veiled bigotry about how Blacks may be to blame for their plight:

> *Q: When it comes to things like race, Whites have lower rates of diabetes, heart disease, lung cancer and so on than Blacks.*

A: Genetic. Our basic chemistry may not be the same. Our races sure aren't, so how can you lay it onto society because this race or that race has more of something than the other one does? ... I don't see that Louisville is that racist anymore.

Q: Do you think that as a group that Blacks in Louisville are worse off than Whites or do you think it's pretty equitable now?

A: Well, I don't know them personally. I've got a neighbor that's one, but there are a lot of nice Black families living out wherever they want to live if they're willing to work for it and I don't know what we do about kids that decide they're not going to school and would rather join a gang and get their selves shot up and all of that.

Conservative white woman, age 71

Racism offers a whole set of long-standing "explanations" for why Blacks don't make good choices, and African-Americans are just as likely to voice these kinds of reasons as Whites:

Blacks don't take care of themselves right. That's why there's more health problems with Blacks than Whites, because they just don't take care of themselves right. They don't eat right. They don't exercise. They don't go to the doctor like they should. That's the problem with Blacks.

Conservative African-American woman, age 44

"Black culture"

A "softer" form of racial stereotyping among Louisville residents emphasizes flaws in Black culture (as opposed to individuals). When presented with the information that Whites have lower rates of diabetes and heart disease than African-Americans, the men below speculated that the difference was the result of a Black culture characterized by ignorance, too much smoking and drinking, etc.

Eating habits is one of the biggest things that's causing most of the diabetes and stuff like that, because unfortunately the Black race has a rich diet. It's got a bunch of grease in it and that's causing cholesterol and all those stuff. Once we get educated on it we will be able to do better.

Conservative African-American man, age 60

Diet, for one thing and a lack of exercise. If I'm not mistaken we have – Blacks have a higher rate of smoking and alcohol consumption. I think that has an effect.

Conservative African-American man, age 48

(Even if there are real differences among demographic groups in terms of behavior, diet, etc. our point is that average people tend to focus on differences at this level *to the exclusion of any "upstream" causal factors*.)

Liberal discomfort with "stereotyping"

Louisvillians thinking aloud about the "bad news" of race-based discrepancies sometimes grow uncomfortable as the Right Choices model puts them in the position of considering what's wrong with the African-American community and its choices.

The young man below, theorizing about what experts would consider an aspect of social exclusion, grows uncomfortable that he is "stereotyping" African-Americans.

> *Historically in this city African-Americans have not been treated equally until really in the last 50 years ... I think there's a historical part where, "Since I'm not important and these are things I didn't have before, I don't need them now. I didn't go to the doctor when I was a kid, I don't go to the doctor now. I didn't trust them then and don't trust them now. My parents didn't trust them and I'm not going to trust them." <u>There's probably some terrible stereotypes in there</u>, but I think what roots back to them is just that's the way it was and that's the way it is now.*
>
> Liberal white man, age 27

The young woman below tries to find more acceptable explanations than ignorance or bad judgment on the part of Blacks, and refers instead to different body-image rules and the idea that African-Americans are under less pressure to conform than Whites:

> *Q: Whites have lower rates of diabetes, heart disease and lung cancer than Blacks in Louisville. If you had to guess why, what would you say?*
>
> *A: I think it has a lot to do with their culture. <u>I'm being stereotypical</u>, but based on what I know, they are okay with the bodies that they have. Some Black people they just have great bodies. Other Black people are bigger than other Black people, but they're okay with themselves, and I think White people have a harder image of what they need to live up to. There's more of a pressure on White people, because we're the dominant race.*
>
> Liberal woman, age 22

Ironically, the fact that the Right Choices model seems to lead to negative judgments about African-Americans *makes it hard for some liberals to engage with the idea of race-based disparities at all* – while in theory they should be a natural audience for messages on the topic.

Rejection of race-based disparities

Some people rejected race-based explanations altogether. The man below sees such an idea as divisive and wrong:

> *I just don't think race has anything to do with health. We're all human beings.*
>
> Liberal Hispanic man, age 24

If the Right Choices model leads to an unacceptable conclusion, and if it is the only causal understanding available, then for many people the entire topic must be rejected.

The Right Choices model in the media

Unfortunately, the Right Choices model is strongly reinforced in newspaper reporting about health. Even many of the "sympathetic" portrayals are likely to be read in terms of the Right Choices model, leading to a "blame the victim" interpretation.

The following newspaper article, "Louisville checkup sees a sick city," begins by laying out the negative health outcomes that affect many in Louisville, but some groups more than others:

> Louisville has been given its second annual health checkup, and the diagnosis by the metro health department is not good. Death from several diseases is far more common in the city than nationwide, with the heart disease death rate 19 percent higher than the national average and the lung cancer death rate 36 percent higher. Racial health disparities continue, with infant mortality more than twice as high for African Americans as it is for white residents.
>
> *Courier-Journal*, 12/24/05

The article then explains these problems in terms of the Right Choices model, emphasizing the idea that individuals are making poor choices, such as smoking, over-eating, and not exercising. These individuals then suffer the unfortunate, but predictable, consequences:

> Adult smoking and overall infant mortality are up ... [Both] the city and the state lag far behind the nation, as reflected in a year long *Courier-Journal* series that found that poverty, lack of education, unhealthy habits and health-care access problems are key factors making Kentucky one of the nation's sickest states ... Diana Talbott is one of many Louisvillians struggling with health. Talbott, 47, has high blood pressure, kidney disease and is trying to cut down on fat and sugar to deal with her obesity. Talbott said she has never had health insurance and did not get regular checkups until she started going to the Family Health Center-Portland clinic about a decade ago. Before she began seeking regular medical care, Talbott said, "I was really in bad shape." She said she still sometimes finds it difficult to exercise and stay fit.

In this typical journalistic presentation, the writer "illustrates" the poor state of public health in Kentucky using an individual character sketch, in this case an ailing and obese woman who eats too much fat and sugar, finds it difficult to exercise and stay fit, and who, until recently, didn't go to the doctor. Although "poverty," "racial health disparities" and "health-care access problems" are mentioned in the article, the journalist offers nothing in the way of a *causal story* that could compete with the Right Choices model.

Stereotypes reinforced

Negative stereotyping of minorities is often (if inadvertently) reinforced in newspaper reporting that addresses race-based health disparities**.** For example, in her article, "KY may require inmate Aids test", Laura Unger writes about the public health benefits of testing prisoners for HIV-AIDS. To the extent that the article brings in the matter of race-based disparities, it (inadvertently) reinforces negative stereotypes of Black men as threats not only to their own women and children, but also to society at large. In its discussion of a pending Senate bill, the article makes it clear that Black men are the problem – both as victims of the disease and carriers of infection.

> For the larger community, experts say, the high levels of HIV in prisons translate to a greater risk when infected inmates eventually are released. Supporters say Senate Bill 201 would particularly help the African-American population, which constitutes almost a third of state inmates in Kentucky. Black men are five times more likely to have AIDS than white men in Kentucky, and black women are 19 times more likely to have the disease than white women.
>
> *Courier-Journal,* 3/7/07

Because the article does not offer any underlying, structural reasons for the disparities mentioned, readers are left with the default causal model, Right Choices, as they think about why Blacks are more affected. In fact, the article explicitly associates high HIV rates with bad choices and risky behaviors on the part of the men, as well as those women who choose to have sex with ex-convicts:

> The vast majority of HIV-positive inmates enter prison already infected because they are more likely than the general public to use intravenous drugs or participate in risky sex ... Black women – who represent the nation's fastest-growing group with HIV – remain particularly vulnerable, partly because their partners are more likely to have spent time in prison.
>
> *Courier-Journal,* 3/7/07

Because this article about health disparities offers no causal model to compete with the Right Choices model, it ends up reinforcing negative racial stereotypes about Black criminality, drug use, destructive sexuality, and inadequate fatherhood.

In an article about a conference on race-based disparities, the writer selects the following quote that emphasizes poor eating choices and deficient parenting in the African-American community:

> Rodgers-Rose [founder of the International Black Women's Congress] said African-Americans need to do more to protect their health. "We can't continue to eat and raise our children on McDonald's food," she said.

This quote is immediately followed by a contrasting statement from Louisville Metro public health director, Dr. Adewale Troutman, which closes the article:

> But Troutman said black families also face other obstacles to good health, including poverty, lack of education and lack of access to medical care. He said dealing with those inequities is key. "It is the most basic issue that I can think of," he said. "It's the very life and death of millions of people."
>
> "Conference at U. Of L. spotlights African Americans' health," *Courier-Journal*, 3/17/06

This quote rightly stresses causal factors other than individual choices. Unfortunately, however, a late, brief reference of this kind has little chance of challenging a powerful default understanding like the Right Choices model.

Even articles that explicitly lay out the case for race-based disparities, can ultimately imply that Blacks' health problems are their own fault – e.g. because they aren't as effective at taking advantage of existing systems.

> This is the fifth year Louisville has taken part in the national day devoted to raising awareness of health disparities among racial and ethnic minorities, said Dave Langdon, a spokesman for the Louisville Metro Health Department.
>
> In Louisville those disparities include a 43 percent higher rate of diabetes for black residents in 2004, a 37 percent higher heart disease death rate for black residents in 2003 and a 30 percent higher mortality rate for black residents for the same year, according to the health department.
>
> "Part of the idea of the day is to bring people in for screenings so if they have health issues they know about it," Langdon said. "And to close that gap," added Virginia Bradford, coordinator of the advocacy group Kentucky African Americans Against Cancer.
>
> Bradford said one explanation for the gap is that minorities lacking health insurance delay seeking treatment.
>
> For Fox, who is African-American and feels she didn't catch her mother's diabetes early enough, it was more "a combination of fear and thinking you can control these things on your own. You kind of ignore the early signs. You try to resolve the problem yourself," she said.
>
> "Event aims to close health care gap," *Courier-Journal*, 2/15/07

In the end, the article offers no real explanation for why Blacks would delay treatment more than Whites, other than personal, psychological or cultural shortcomings.

Important Note. This is not a problem specific to the *Courier-Journal*. A typical report in the *New York Times* is just as likely to reinforce the Right Choices model and to reinforce negative racial stereotypes when reporting on race-based disparities. For example, in the article, "In turnabout, infant deaths climb in South," the journalist includes information on external factors, but constantly undermines this with images of personal responsibility:

> Oleta Fitzgerald, southern regional director for the Children's Defense Fund, said: "When you see drops in the welfare rolls, when you see drops in Medicaid and children's insurance, you see a recipe for disaster. Somebody's not eating, somebody's not going to the doctor and unborn children suffer." Visits with pregnant women and mothers in several Delta towns suggest that many poverty-related factors — including public policies, personal behaviors and health conditions — may contribute to infant deaths.
>
> Krystal Allen . . . was 17 when she had her first baby. When he was 4 months old, she said, he developed breathing problems. Ms. Allen took the child to an emergency room, where he was put on a vaporizer and given an antibiotic and a prescription and they were sent home, where they slept for a few hours. "When I woke up I thought he was sleeping, and I was getting ready for church," Ms. Allen said. "But he was dead." Now 21, a mother of two with a third on the way, Ms. Allen lives in a sparsely furnished house in Hollandale with her unemployed boyfriend and his mother. Her children live with her parents.
>
> Ms. Allen greeted visitors with breakfast in hand: a bottle of Mountain Dew and a bag of chips.
>
> Janice Johnson, a social worker with Delta Health Partners, urged her to eat more healthily. "I'm going to change my diet one day," Ms. Allen replied.
>
> *New York Times*, 4/22/07

The accompanying photo of an overweight Black woman, with the soda and chips before her, vividly emphasizes what readers will see as the primary cause of this woman's problem – her own bad habits. The fact that this particular woman not only already has a social worker, but is ignoring her advice drives home the idea that it is not more public policies and resources which are needed, but better choices and behaviors.

Although the article asserts in places that the cutbacks in services (54,000 dropped from CHIP and Medicaid rolls in Mississippi alone) play a role, the article closes with a clear message that social policies are less significant than the need for people to just make the right choices:

> Barbara Williams, another veteran counselor of the Cary center, made an unannounced visit to a cluster of trailers in Anguilla occupied by the extended Jackson family. "I've been following this family for 18 years, and they're in a bad cycle," Ms. Williams said, noting that three generations of women had dropped out of high school. As Ms. Williams entered one crowded trailer a young woman tried to hide, then stood defiantly. The woman, Victoria Jackson, 22, already has three small children and was five months pregnant. No, she said, she

> has not signed up for Medicaid and she has not seen a doctor, and she brushed aside offers of help. Ms. Williams, visibly upset, said later, "Victoria never gives a reason why she doesn't see a doctor. I guess she thinks she's gotten away with it three times already."
>
> *New York Times,* 4/22/07

Income-based disparities

Perhaps to avoid the problem of racial stereotyping, journalists often reduce race to economics:

> The conference, sponsored by the Foundation for a Healthy Kentucky, was designed to explore disparities involving minority populations. But speakers and participants said many of the health problems that disproportionately affect minority Kentuckians also affect low-income white residents.
>
> "Kentucky's health disparities examined," *Courier-Journal,* 9/15/04

The shift in focus from "Black failures" to the more structural issue of poverty could be seen as a step in the right direction, but there are several significant problems with the approach:

- The equation of minority status with low-income status is itself a common racist stereotype, which this technique reinforces.
- To the extent that racism is a contributing factor, this technique obscures the possibility that current racism and the legacy of racism play a role in disparities.
- Perhaps most importantly, poverty itself is often seen as the result of poor choices on the part of individuals (see Findings 2).

Findings 2: How Louisville Residents Respond to "External Factors" as an Explanation

From the perspective of experts and insiders, of course, the causal story of Right Choices is a very incomplete and even misleading model of how health outcomes come about.

One of the central points that health advocates often try to make, in various contexts and in various words, is that there are broader, systemic, external factors that contribute to the health disparities among different groups.

In this section we consider how Louisvillians respond to these points, and the reasons why they respond the way they do.

External Factors

From an insider perspective, a variety of "External Factors" contribute to people's health outcomes, including their socio-economic status, their race, physical surroundings, and so forth. The collective correlation between these factors on the one hand, and health outcomes on the other, are summed up in what experts refer to as the health "Gradient."

While the Gradient itself is not causal but correlational in nature, experts do believe in a set of causal mechanisms, which sometimes get communicated in expert materials. Here are several examples of causal stories that experts might sometimes try to convey to the public:

External Factor	→	**Negative Effects**	→	**Negative Outcomes**
Poverty	→	unhealthy diet	→	high rates of diabetes
Racism	→	less access to care	→	high death rates for cancer
Social exclusion	→	stress	→	high rates of hypertension

As causal stories, used by communicators to explain differences in health outcomes among different groups, these stories must *compete with the Right Choices* model (which feels right and complete), if they are to change perspectives and lead to support for policy change.

Unfortunately, in the end, none of these three important External Factors – poverty, racism, social exclusion – is very successful at competing with the Right Choices causal model.

There are several related reasons these arguments tend to fall on deaf ears with the Louisville public:

- Causal stories relating to the factors are *cognitively weaker* (less familiar, harder to understand, more complex, etc.)
- The External Factors are understood as *excuses* people use for their own failures.
- The External Factors are understood as *outcomes* (of people's choices), rather than causes.
- The External Factors are understood as barriers *that successful people overcome*.

In short, the current explanations of External Factors offer causal stories that are much less compelling than the Right Choices model, and the default model ends up not only "winning" in people's minds, but preventing the External Factor stories from being properly heard and understood. In fact, new information (e.g. about health disparities) is often re-interpreted as *confirmation* of the Right Choices model.

External Factors simply rejected

Most basically, Louisvillians prefer to reject claims based on demographic factors. Presumably this is largely because the Right Choices model is simply so powerful. It may also be because it is uncomfortable to consider such possibilities. ("Is Louisville really such an unfair, maybe even racist place? And if so, what should I be doing about it?")

The woman below rejects the idea that health disparities come about from differences in wealth or social status. Instead she prefers to think about the mindsets of individuals, and how some people at every economic level have the right and wrong set of priorities:

> *It's easy to just blame everything on rich people and be like, "yeah, they're lucky." But no, … because they're having to work all the time and they're not watching what the kids are eating and they're not watching the amount of activity... What I do notice is it's about a 50/50 split with the impoverished people that I know, as far as [whether] they're very cautious of what they're going to eat – what type of diet and lifestyle that they're going to have. Because they know they can't afford to get sick. And also in our [community] I think it's pretty evenly distributed across the board. I don't think that it's an economic thing. I believe that it is really based on choice.*
>
> Liberal white woman, age 30

The difficulty people have accepting and focusing on External Factors is also illustrated in the reporting about the Center's mission. In the article, "Smoking on the rise," Dr. Troutman is quoted mentioning such factors. Not only does the journalist not explain or elaborate on them, the article immediately negates them entirely with an illustration of the Right Choices model in the person of a fried-chicken-eating Black man with high cholesterol:

> Troutman, who is nationally known for his work fighting racial health disparities, said there are complex factors behind the problem such as poverty, access problems and discrimination.

> Jesse Penick, a 41-year-old African American getting a checkup at the Portland clinic this week, said he has suffered from chest pains and high cholesterol levels. In nice weather he rides his bike to stay healthy, but cannot resist eating such foods as pork chops and fried chicken. "It's kind of hard to eat right," he said.
>
> *Courier-Journal, 12/24/05*

An average reader is likely to imagine quite clearly how Mr. Penick's personal choices have led to his poor health, without making any real connection to the external factors mentioned by Dr. Troutman.

Another article, "Conference at U of L spotlights African Americans' health," mentions poverty as an "underlying issue," but clearly emphasizes the Right Choices causal model to explain race-based disparities:

> The city is developing the Center for Health Equity, which is designed to promote good health habits and attack underlying issues, such as poverty. The goal is to close a wide racial health gap where black residents of Louisville fare much worse than whites on many measures of health. They die from diabetes at a rate more than twice as high, for example, and they die from stroke at a 44 percent higher rate ... That makes health a natural topic for the conference, which has focused on such issues as black women and parenting ... One of about 400 people expected to attend the conference is Sharon Mickens, a 54-year-old Louisvillian who ... said she wants to visit the conference's health fair, learn more about exercises to help her lose weight and get tips on persuading the men in her life to take greater control of their health.
>
> *Courier-Journal*, 3/17/06

Although there is a mention of poverty as an "underlying issue," this mention is drowned out by the strength of the default causal model. This is typical of the newspaper reporting that we analyzed. Although there was *no explicit rejection* of the experts' External Factors model, it is simply passed over with little or no comment and then supplanted with information that reinforces the Right Choices model.

Poverty and racism as excuses

If individual choices are the true causal factors behind health outcomes, then reference to any other factors is just excuse-making. An elicitations subject active in poverty relief organizations was well aware of the challenges that poor people face, but went out of her way to emphasize that they can still be healthy, and that people who claim otherwise are making excuses:

> *You can go and get fresh vegetables. You can still make a way if you try. I've seen people do it. It's an excuse a lot of times for social activist groups and public rights groups that old people can't afford good [food]. But they can make those choices ... You might have to take TARC an extra twenty minutes to go to a better grocery store that's going to be cheaper ... It's all based on your choices.*

Liberal White woman, age 30

The same pattern applies to racial discrimination:

> *Q: Do you think that ending prejudice and discrimination is the best way to close this gap in health?*
>
> *A: It would help. But a lot of times I think <u>we use that almost as an excuse</u> ... [We] have to get over the making excuses and just do what we know we got to do. I can't sit and say, "Well, they wouldn't let me go walk every evening because I'm Black." … Nobody's making me go buy cigarettes … I'm not that naïve. But I feel like … we're going to have to make better choices. People have to make better choices. And it's not always about somebody else putting up a barrier against you. Some of the choices that you're making yourself are having an effect, you know.*

Conservative African-American man, age 48

Although this man admits that ending racial discrimination would help, he is much more engaged with the idea that Blacks create health outcomes through their own choices.

External factors as outcomes rather than causes

The fact that poverty, social exclusion and poor health "go together" can make perfect sense given the Right Choices model. For many Louisvillians, "Making the Right Choices" *explains why* some types of people end up better off and why some end up poor and on the margins of society.

> *You have a choice of whether you want to work for very little or whether you want to provide for yourself and I think everybody in this world has that opportunity to make the right choice for them whatever it is. When you make that choice you deal with it.*

Conservative Native-American woman, age 51

According to this broader model of personal responsibility, the same lack of judgment that lands people in the lower economic brackets, for instance, leads to poor health-related choices.

> *They're low income maybe and money is not being spent for food and the care of their family. It's been used for other things ... like drugs, smoking, [alcohol], and all that ... They will use their money for stuff like that instead of food for their family and that's sad.*

Liberal white woman, age 71

Newspaper reporting easily reinforces the idea that people's choices create or maintain their poverty. For instance, poverty is often associated with health via behaviors like high-smoking rates; juvenile delinquency; substance abuse and so on.

> The consequences of childhood poverty often extend to adulthood and beyond. Children who grow up poor are more likely to drop out of school, become teen parents and become unemployed as adults, according to Kentucky Youth Advocates.
>
> State has slight dip in child poverty, *Courier-Journal*, 2/15/07.

These are the quintessential "bad choices" that seem to cause both poor health and poverty. Mentions like these are almost certainly *not* read as evidence that people are facing an unfair or inequitable situation. Instead, they are likely to be read as confirmations of the Right Choices story.

In the elicitations, even racial discrimination and segregation are often discussed as outcomes of people's choices. The man below argues that discrimination exists (and is justified) because the actions of African-Americans ensure that they will stay outside the mainstream:

> *I don't really think that there's that much discrimination out there. No. I think a lot of discrimination is more self-imposed ... In terms of Blacks, I think a lot of it comes down to education. If they're not getting good education … if peer pressure is such that if they're speaking what's considered to be proper English, then they're being considered an Uncle Tom ... They get 25 years old and they don't have an education, they don't know how to speak properly. Mainstream isn't going to take them in, because they're not mainstream ... I don't think that's necessarily discrimination. People of color and people of foreign backgrounds find that they can be successful, but I think a lot of it's just a matter of choice.*
>
> Conservative White man, age 29

Poverty and Racism as obstacles that successful people overcome

Even when Louisvillians acknowledge that external factors can have an effect on health outcomes, they still interpret the relevance of these factors in terms of the Right Choices model. In essence, the external factors are obstacles to be overcome by making the right choices.

> *Maybe the ones who are in the upper class might have better health ... [But] I think it would have to [be] the ones who really want to be healthy. I know I'm not in the lower class and I'm not in the high class, but I sure work to keep myself healthy.*
>
> Liberal White woman, age 71

The African-American woman below is clearly aware that a person's environment has a strong impact on the individual, but circles back to the ideas of responsibility and choices:

> *You can tell by where they are how the kids are going to come up. I'll give you an example: When our offices were off Dixie Highway ... watching the women who were from that area who were my age and those women looked so hard ... It was the area ... How hard you live, the things you're exposed to. We had friends that did drugs for years and years and years. Of course, they don't do drugs now, but they did ... Kids that were 4-5 years behind me in school, and honey they look way older than me. The only difference is probably life choices. What you chose in your life. That goes back to responsibility. Of course, part of that's environmental.*
>
> Conservative African-American woman, age 52

Even people who acknowledge that racism, poverty and social exclusion are real and not self-created are likely to see the problem as a "mixture" of external factors and poor choices. And as long as the Right Choices model remains the model that is "top of mind", and the one that seems to explain things most clearly, people will have a strong preference to slip back into it, whenever they are confronted with the External Factors model.

Newspaper reporting clearly contributes to this way of thinking. A favorite and familiar "character" in newspaper accounts is the individual who serves as a positive example or role model, because they have been able to overcome their difficulties. For instance, in the "Faces of AIDS" series, the article starts with an inspirational story of this type:

> Annette Brooks stepped away from her cooking when the kitchen phone rang. Get to St. Joseph Hospital right away and speak with your ex-husband's doctor, the voice said. When she arrived, the doctor's words hit like bullets. "Mrs. Brooks, your ex-husband has full-blown AIDS," she recalls him saying. "He's an intravenous drug user. You need to be tested." That Saturday 12 years ago, Brooks began her journey with a disease she soon learned was also attacking her body. Her new path would teach her about choices – whether to give up or find purpose in hardship, whether to love and go on living or start dying. Along the way, she would find something she never expected: a new beginning.
>
> "Women and Aids," *Courier-Journal,* 2/16/07

Unfortunately, inspiring as these stories can be on one level, they reinforce the idea that problems are solved best by heroic individuals who can overcome obstacles – rather than by addressing the underlying problems that make such heroism necessary.

Previous research has shown that journalists share most of the same conceptual models as their readers, and the Louisville research offers plenty of evidence that this is the case when it comes to the Right Choices story.

Findings 3: Responses to the "Bad News" About Health Disparities

Communications from health advocates often emphasize the disparities in health outcomes among different groups, citing statistics to show that the differences in our relative health are real and important. The elicitations research, however, shows that stressing negative health outcomes among different groups – higher rates of disease, higher rates of mortality, low levels of access for health care and so on – leads to counter-productive understandings rather than to engagement. Put briefly:

Evidence about health (outcome) disparities is not compelling evidence of an inequity.

Because of how the Right Choices model guides their thinking, Louisvillians interpret the "bad news" of Health Disparities in terms of the priorities and habits of individual people, rather than any sort of inequity in external conditions that might call for public policies. As a result, equity and fairness are understood differently by experts and average people.

No evidence of unfairness or inequity: health outcomes are earned.

Public health advocates usually emphasize negative *outcomes* like high rates of death and disease in order to impress upon people that there is something seriously flawed in our society that needs to be dealt with through policy. Advocates see disparities among social groups as plain evidence of structural, systemic unfairness that systematically discriminates against some subsets of people, while privileging others.

Average people, on the other hand, thinking in terms of the Right Choices model, often draw entirely different conclusions from the "bad news" about poor health outcomes. In their view, negative health outcomes are unfortunate, of course, but they can be the result of a system that is working as it ought to. "Bad" behavior is punished (e.g. gluttony leads to obesity; risky behaviors lead to HIV-AIDS) and "good" behavior is rewarded (e.g. good diet leads to fitness; people who work hard earn health insurance).

> *I know the type of food that you eat contributes to heart disease, cancer and all that, 'cause I've experienced it within my family. I have seen family members die early ... There were five of us and they're all gone except me and they did not change their way of life. Especially eating and smoking ... That's what changed my mind about the type of food and it's been twenty years. All I eat now is fowl and fish and vegetables, well-cooked.*
>
> Conservative African-American woman, age 81

> *Say the system put out what everybody needs health-wise, we would still have people that wouldn't take advantage of it. Our drug addicts so forth, and so on.*
>
> Conservative White woman, age 71

The fact that some people live and others die is unfortunate and saddening, but this is not evidence for any kind of system breakdown – the Right Choices model says that it is the individual who needs to change, not the system.

> *If I chose to smoke that would be a decline in my health. If I got myself out of bed early in the morning and worked out that would be a good thing. And trying to find a job that does offer free healthcare or help with healthcare...*
>
> *Q: Are there things about society at large that either help or hinder you as far as being healthy?*
>
> *A: Not that I could really think of. There are options out there, you know, plenty of alternative options.*
>
> Liberal White woman, age 23

> *Take responsibility for yourself! Maybe you're smoking eight packs of cigarettes a day, you know? Adults need – and we all do – need to take more responsibility for ourselves.*
>
> Conservative African-American woman, age 52

Because they don't understand how external factors affect individuals, Louisvillians assume that everyone already does have the same *opportunity* to be healthy – and if they choose not to take advantage of that opportunity, then that is their problem.

> *Unless you're almost living in a cave, it would be hard not to ... know that there are things that you could do to either stay healthy or improve your health. And then it's up to the person. [But] a lot of people say, well, you know, I don't care, I'm going to die someday anyway. That's the idea that some people have. They want to have what they want when they want it and you're not going to change that.*
>
> Moderate White woman, age 75

In sum, lay people tend to interpret information about health disparities using the Right Choices model – instead of establishing that there is systemic unfairness, this evidence about different *outcomes* is just as likely to confirm negative stereotypes.

"Unfairness" as violation of the Right Choices model

When Louisvillians think about *unfairness* in health outcomes, four kinds of examples spring to mind, all of which have to do with the Right Choices story not playing out how it is "supposed to."

Importantly, these understandings about unfairness focus almost entirely on the narrow questions of healthcare and health coverage – dollars and cents issues where people can easily think about who should get what and why.

The four examples of unfairness are:

People who make "bad choices" get rewarded and people who make "good choices" don't.

People found it unfair that poor, unemployed people often got help with medical care, but hard-working people (who still couldn't afford care) were left out.

Q: Is there inequity in terms of health care?

A: I think there's inequities in healthcare, 'cause it seems like they may give help to minorities or poorer income people and if you're a little bit above that and you may have a little bit of savings, then you don't qualify for a lot of things even though you may still be struggling ... I don't think that's right.

Moderate White woman, age 75

Somebody that don't work and has no intentions of working walks in here and tells me, "I'm sick and I need a doctor and I don't have money for medicine." And I've gone out here and I've worked. I've made the money and maybe there's things I need myself, but I'm doing without because I feel like I can't really afford it. I don't feel like I owe them to send them to the doctor. . . No. No. They're freeloaders.

Conservative White woman, age 71

The Right Choices model is essentially "turned on its head" in these cases, and people see the results as "unfair."

Because of external factors, hard-working people are getting less and less access to health care.

People understood that access to health care was declining, not because people were choosing to opt out, but because insurance and care was becoming more and more expensive.

They say that there's how many millions of Americans that can't afford for health insurance coverage, but it used to be just the poorer income families. Right now it's even moved up to middle class and upper middle class.

Moderate White woman, age 75

In this case, people were making the right choices, but were not reaping the benefits that they deserved. Importantly, this was one case where newspaper reporting consistently emphasized external factors, rather than Right Choices. The *Courier-Journal* consistently referred to "the working poor" and the restructuring of the economy (from manufacturing to service, for example).

People are being kept from making the right choices (when it comes to health care)

When people thought about the problem of health insurance, they often commented on the fact that when people don't have insurance they are much more likely to make poor choices: to not go to the doctor, to not take medicines, to just let things go.

> *I can only imagine when you're seeing a family member— a mom or a grandmother or even a child who is starting to have signs that they're sick and your first instinct isn't to just go to the doctor, it's, "Can we go? If we do go, can we afford what they're going to tell us we need to do?" So, you put it off. You put it off. Is that fair? No. It's gross and it's an injustice.*
>
> Liberal white man, age 27

In a related way, people believed that the way that health insurance was structured nowadays discouraged people from improving their lot more generally.

> *I have a lot of friends who have children who just started to make enough money to pay their bills and got their Passport[3] cut off. So, once you can technically make enough money to pay for your food and lodging they cut off your healthcare . . . It's actually counter productive in a way for a lot of the people that are on public aid to try to better themselves, because their public healthcare will be taken away.*
>
> Liberal white woman, age 30

Again, people are seeing unfairness in the fact that the Right Choices model is not functioning as it ought to – i.e. by rewarding good behaviors with good results.

People who shouldn't have to "earn" the right to health care are forced to do without.

Certain categories of people (children, elderly, disabled) are understood to fall outside the Right Choices model in important ways, and shouldn't have to go without care.

> *I think [programs that help people get health coverage are] necessary. It's really important that especially the kids would have insurance. And then a lot of the elderly people that don't have insurance . . . When they get to the age where they can't handle their problems at home and they can't afford nursing homes. I understand now that they send them back . . . A lot of people just can't help themselves and they don't have the means to, because insurance is high. It's really expensive.*

[3] Passport Health Plan is the operating name for University Health Care, Inc., a Medicaid managed care plan that serves the Medicaid and KCHIP populations in the Commonwealth of Kentucky.

Conservative African-American woman, age 81

Unfortunately, none of these conclusions about inequity are exactly in tune with the ideas that experts have. None of them focuses on the deeper causes of health disparities (i.e. beyond differences in health care), and most of them work *against* the idea that there are fundamental inequities that disadvantage minorities, for instance.

OPPORTUNITIES

In addition to the "bad news" the report has focused on so far, the elicitations research suggested a number of opportunities for creating a more productive public conversation about health disparities.

In particular, it will be critical to find better ways of conveying *causal stories that can compete with the Right Choices model of how health outcomes happen*.

Constructive news coverage

It should be possible to take greater advantage of the Center's relationship with the *Courier-Journal*, by advancing more compelling causal stories that can compete with the Right Choices perspective.

Although newspaper reporting has a very strong tendency to reinforce the Right Choices model at the expense of the External Factors model, there are some glimmers of helpful reporting in the media sample.

Re-positioning the "Face on the story"

It's a nearly universal journalistic convention to "put a face on the story" by illustrating points with individuals, and again and again the media sample shows this technique undermining experts' efforts to draw attention to how external factors also play a role. There were a very few examples, however, where the technique was less of a problem. For instance, in the article, "Fighting medical inequities," the journalist makes use of an individual character sketch, but the description illustrates *the struggle to confront health disparities*, rather than the struggle to eat right or make better decisions.

> She's glad to be part of a program run through Louisville's new Center for Health Equity, which is designed to attack such health disparities. "People think it's too hard to make things better," said Jamillya, a runner involved with the center's Tommie Smith Track and Field Program. But it won't be, she said, "if we help get a whole lot of people involved."
>
> *Courier-Journal,* 2/16/07

This is a crucial difference from most articles, where the Individual Illustration nearly always turns people's attention firmly toward the Right Choices model, regardless of what the experts might be saying. [4]

[4] This particular article had other problems, including the fact that the journalist illustrated the article with photographs and headings showing young Black girls running and stretching. The analysis here is not meant to hold this example up as a model, but instead to point out some positive elements.

Keeping the focus on external factors

The same article relies on quotes from public health officials that consistently stress the underlying problems and make almost no mention of problematic individuals or their choices.

> The overall death rate for African-Americans in Louisville in 2003 was 30 percent higher than the rate for white residents. Heart disease death rates were 37 percent higher, and infant mortality rates were almost twice as high. Troutman said these sorts of statistics are tied to factors such as socioeconomic inequities and discrimination, which persist despite progress in civil rights. Troutman and Lauri Andress, the equity center's director, said they are dealing with these entrenched problems by going beyond traditional health department methods like exercise programs and disease-prevention messages. For instance, Andress said, the Tommie Smith initiative won't simply be a track and field program . . . [but] will also look at factors that may make physical activity more difficult, such as unsafe streets or a lack of sidewalks.
>
> *Courier-Journal,* 2/16/07

"Exercise programs" and "messages" – solutions that are very compatible with a Right Choices perspective – are only mentioned as traditional approaches that the department is "going beyond."

Supplying alternate causal stories

In the article discussed above, the fact that levels of physical fitness are lowered by "unsafe streets" and a "lack of sidewalks" contains a kind of implicit causal story that will make sense to many people. Generally, however, communicators do not consistently supply people with causal stories that can compete with the powerful Right Choices model.

An "exception that proves the rule" can be found in the article, "Blacks' health disparity discussed." The journalist lays out a causal story for how a disparity in the way different groups are treated by the health profession leads directly to a disparity in health outcomes for these groups. In this case, a particular kind of race and class discrimination leads directly to higher death rates for cancer – through no fault of the individual patients:

> Slide after slide of statistics from national health studies bolstered [Dr. Wayne] Tuckson's contention that poor, black and less educated people receive less health care than others, with dire results. For example, one study found that 47percent of black cancer patients received less than 85percent of a full dose of chemotherapy, compared with 31percent of white patients. The cancer death rate among African Americans in 2003 was 233 deaths per 100,000 people, compared with 189 deaths for whites.
>
> *Courier-Journal,* 2/15/07

Importantly, the article makes it clear that these outcomes are not about people choosing to make use of – or not make use of – the medical resources around them – people simply "receive" less complete treatment. There is little room for the Right Choices model to "sneak into" people's thinking. On the other hand, the quantitative information is not presented in a

particularly clear or effective way, and the example given doesn't tell anything like the whole story of race-based inequities. Nevertheless, it points to the kinds of careful framing that advocates need to use when they try to convey causal stories about inequities to the public.

It is clear that an important challenge for experts in the public health field will be to find ways to ensure that their messages are not systematically undermined as they are "translated" by journalists in their reporting. To some extent this means developing communication strategies that can more clearly convey the expert model of External Factors in ways that can resist being "swallowed up" by the reigning dominant model of Right Choices.

Areas for further research

The elicitations research focused on exploration of the patterns of thinking that Louisvillians currently bring to the topic of health disparities, but it also suggests some areas where it there is potential for developing communications strategies that can improve the public conversation on the topic.

1. Stressing Opportunities vs. Outcomes

The elicitations demonstrate that focusing on outcomes is not an effective way to move people's thinking in productive directions, since the Right Choices model "hijacks" this data and creates from it an unhelpful story about mistakes made by individuals.

Emphasizing disparities in opportunities *to be healthy is, at least in principle, a much more effective approach.*

Average people support the idea that everyone ought to have an equal opportunity to achieve good health. On the other hand, with the exception of access to health insurance, average Louisvillians think that people *already do* have fairly equal opportunities good health. This impression persists because the public health community has not so far offered compelling messages to convince people otherwise.

For this reason, finding more effective causal stories that relate External Factors to health outcomes should be a high priority for the Center and other health advocates.

2. Explaining the Role of External Factors

An effort to systematically and emphatically present external factors as clear causal chains rather than just listing outcomes might have potential move people's thinking in the right directions. For instance the idea that poverty leads to an unhealthy diet, which in turn can lead to diabetes could be made more clearly into a causal chain that doesn't call in the Right Choices model so strongly. For example, rather than the problematic term "poverty", it could be said that "a lack of healthy, high-nutrient food in poor neighborhoods" makes it very difficult for people to eat healthy – and as a result we always see higher rates of diabetes in such neighborhoods.

There are already a number of contexts where Louisvillians readily recognize external factors that affect health. Each of these might be built on as a basis for clear communications about causal factors beyond the individual.

- Rubbertown. The familiar and vivid image of belching smokestacks in West Louisville drives home to people that the quality of your environment has health impacts. The fact that this part of town is where poor people and African-Americans are known to live leads many to recognize an external explanation for some health disparities.
- The Built Environment. Sidewalks, parks, recreation centers and so on are easily seen to have health impacts, and this aspect of people's material circumstances might be another strong basis for communications about inequities.
- Vibrant Communities. People believe that the kinds of living environments that are healthiest are vigorous, diverse neighborhoods where people walk around and are physically and socially active; where people feel secure enough to interact with and support one another; and where people of diverse backgrounds intermix.

Further research would show whether these insights could be built upon in order to move people beyond the Right Choices model.

3. Health as an Exceptional Case

The dominant model, Right Choices, is clearly a variation of other powerful American cognitive and cultural models that stress the importance of individual effort and personal responsibility – ideas like "American Individualism," the "Land of Opportunity," "Just Deserts," and so on. However, there is some evidence that people are not entirely comfortable with sickness or lack of medical care as "fair" outcomes.

It may be that the stakes are too high – the punishments for "failure" too extreme to be acceptable. Going without the latest video game or a good car is one thing, but quite different from going without medicine or access to a doctor.

Elicitations subjects were supportive, for instance, of the idea of some kind of universal health care. Even if they didn't have a clear idea about its practicality, they were likely to agree in principle that no one should go without health care.

This kind of thinking could potentially be the basis for new and broader perspective about what *everyone* needs, and should reasonably expect to have, in order to be healthy.

4. Money and Access to Health Care

Louisvillians already accept the External Factors perspective when it comes to the relatively narrow topic of health insurance.

They see the growing ranks of the uninsured as a problem beyond the power of even virtuous, hardworking people to overcome. The problem isn't that people are choosing not to buy insurance.

On this issue, Louisvillians' thinking has moved towards expert, big-picture terms. People may attribute the underlying cause of the problem to corporate greed, minimum wage policies, economic restructuring, outsourcing and so on, but they *do not* attribute it to people's poor decisions. They also understand that government and social policies are

important to solving this kind of problem – e.g. they readily accept the idea that an increase in the minimum wage might improve people's health by allowing them to access more health care.

Further research might show whether this is just a narrow and exceptional issue, or whether it can serve as a wedge to bring an External Factors model further into the public consciousness.

CONCLUSION

As on many other issues, communicators hoping to change the Louisville public's perspectives on health inequities are faced not only with the challenge of raising awareness, but with displacing a dominant understanding that currently drives people's thinking away from expert perspectives, and derails communications in important ways.

The Right Choices model tells a clear and compelling causal story about how health outcomes can be so different for different people (and groups), and why they *should* be different. Competing with this kind of entrenched understanding is a tremendous challenge that requires much more than facts and figures.

To make headway and engage public support, the Center will need to continue working to develop compelling messages that reorganize the conversation both in terms of different values (e.g. equal *opportunity* for good health) and different understandings of how health outcomes happen.

The challenge is daunting, but to the extent actors in Louisville are successful, their strategies can be models for communicators elsewhere on this critical topic.

THE AUTHORS

Cultural Logic, founded by anthropologist Axel Aubrun and linguist Joseph Grady, is an applied cognitive and social science research group that helps organizations frame their messages for maximum impact. Working with a network of experts and partner organizations we focus on research relating to public interest issues.

Cultural Logic investigates the shared understandings – cognitive and cultural *models* – that underlie opinion and behavior, applying the latest findings from the cognitive and social sciences to generate analyses of how people think and talk about specific cultural domains such as teenagers, global warming or health insurance. Research approaches include cognitive interviews, rapid ethnographic assessments, "TalkBack" testing of language and framing, and cognitive analysis of media and other public discourse.

Cultural Logic's research has been presented at the Aspen Institute's Wye River Conference Center, the White House Conference on Teenagers, the Rockefeller Brothers Fund's Pocantico Conference Center, the Benton Foundation, the Ford Foundation, and the W. T. Grant Foundation, among other forums.

Axel Aubrun, Ph.D. co-founder of Cultural Logic, is a psychological anthropologist whose academic research and publications take an interdisciplinary approach to problems of communication and motivation. Aubrun has been a lecturer in cultural anthropology at the University of California.

Andrew J. Brown, Ph.D. is a cultural anthropologist and Research Director at Cultural Logic. Andrew's research has looked at the interaction between culture, rhetoric and public discourse. His work has included cross-cultural research in the US, Ireland and the former Soviet Union. Brown has taught at Colby College and the University College Cork.

Joseph Grady, Ph.D. co-founder of Cultural Logic, is a linguist whose academic research and publications focus on the relationship between metaphor and other aspects of thought and communication. Grady has taught linguistics at Georgetown University and the University of Maryland, and also spent a number of years as a consultant helping to analyze and develop brand names.