

Getting Stories to Stick:

The Shape of Public Discourse on Oral Health

A FrameWorks Research Report

Sponsored by the DentaQuest Foundation

Moira O’Neil, PhD, *Director of Research Interpretation and Application*

Abigail Haydon, PhD, *Fellow*

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Introduction

In recent years, advocacy groups have called attention to the problems with our country’s oral health care system from a range of perspectives. Children’s oral health advocates emphasize that inadequate oral health care compromises healthy development and leads to negative health, learning, and behavioral outcomes across the life course. Aging advocates, meanwhile, lament that oral health interventions typically focus on children and devote little attention to older adults—despite dramatic changes in American demographics.ⁱ Advocates with expertise in health disparities stress the high rates at which poor people of color experience negative oral health outcomes, such as untreated tooth decay, oral cancer, and periodontitis.ⁱⁱ Others focus on rural areas and point to the acute provider shortages in these areas. As one scholar put it: “Residents of the United States who need teeth extracted may soon have to do it the old-fashioned way—with pliers, whisky, and elbow grease—because there may not be enough dentists to go around.”ⁱⁱⁱ

These varied perspectives attest to one undeniable fact: We are facing oral health problems that affect nearly everyone in the country. States are still able to decline to provide dental benefits to Medicaid recipients, even though early, high-quality oral health care has been shown to prevent multiple negative health outcomes. Several prestigious universities have closed their dental schools because of the high cost of university-run dental clinics, which has exacerbated dentist shortages. And access to advances in dentistry remains uneven, leaving certain parts of the country and certain populations without access to high-quality care.

Despite the size and scope of this problem and the alarms being sounded, oral health care advocates continue to struggle in marshaling public support for the policy changes that are required to address oral health issues at a population level. Members of the public do not consistently connect oral health to other health issues. They tend to think about poor oral health outcomes as the narrow product of individual behaviors and fail to recognize the social determinants of oral health. They view disparities in oral health outcomes through individualistic perspectives and see them as private problems rather than collective, public health concerns. These deeply patterned ways of understanding block efforts to move oral health up the policy agenda.

Building public support—and ultimately changing oral health care policies—requires that we tell a new story. This report takes a step toward that end. It identifies the frames that are embedded in media coverage of oral health and oral health care, and analyzes the framing approaches that advocacy, direct service, and research organizations use in their communications materials. The report compares framing strategies from both of these domains in order to identify how organizations can shift media narratives to build public support for better oral health care policies. Findings from these analyses are used to provide experts and advocates with a detailed understanding of the communications environment they are working in and how communications practices are likely to impact public thinking about oral health.

Armed with a better understanding of the contours of public discourse around this issue—and how it shapes public thinking—experts and advocates will be better able to position messages to drive positive change.

The research presented here was conducted by the FrameWorks Institute and sponsored by the DentaQuest Foundation. It is one piece of a larger, multi-method project to design and test framing strategies to improve public understanding of oral health issues, build support for policies that will improve oral health outcomes, and fuel a movement for change on this vital social issue. In the first part of this project, FrameWorks researchers identified differences between the ways that experts and members of the public understand issues related to oral health. This report draws on that research in order to examine the effects of media and advocacy discourse on public thinking and make recommendations for how to communicate more effectively on oral health issues.

Executive Summary

Our research shows that members of the public have limited understanding of oral health issues. They don't see its connection to overall health; struggle to appreciate its effects on individuals, families, and society; can't imagine how oral health problems can be prevented; and don't perceive addressing oral health issues as a collective responsibility. Perhaps most fundamentally, the public does not understand the relationship between disparities in oral health and systemic inequalities. To better understand why these gaps in understanding exist, and to help advocates communicate more effectively, FrameWorks researchers analyzed a sample of 307 organizational and media materials about oral health care issues that appeared between July 2015 and July 2016.

In this analysis, researchers identified patterns in framing and storytelling that compete to shape public thinking and action on oral health issues. This research revealed that advocates and experts are using a set of productive framing strategies in their public-facing communications. However, these strategies are not making their way into the larger public discourse—these frames are not part of media stories. Advocates need to address this absence by developing “stickier” narratives that will be more likely to enter and shape public discourse and thinking on oral health issues. The research also identified a set of communications practices in media and advocacy materials that have counterproductive impacts on public engagement with and negatively affect support for oral health issues.

Potentially productive communications strategies in advocacy materials include:

- **Organizational materials consistently focus on oral health as a public health, rather than individual health, issue.** Advocacy organizations frame oral health as a public health issue in several ways. They focus on the prevalence of oral health issues at the population level and they position the dental profession as a key pillar in a robust public health system.
- **Advocates connect oral health to overall health.** Organizational materials consistently explain how problems in oral health are connected to other health issues that go beyond the mouth, including behavioral and mental health issues.
- **Organizational materials foreground and explain systems-level prevention.** Oral health advocates consistently assert the importance of prevention and extend these discussions beyond individual-level actions. They focus on solutions that address the social determinants of poor oral health, including water fluoridation and access to quality oral health care providers. In contrast, media materials tend not to address prevention. When they do, it is in the context of individual behaviors.

- **Advocacy communications focus on the systemic sources of inequality.** Organizations consistently call attention to systemic sources of inequality that drive disparities in oral health outcomes. They tell stories about the drastic shortage of oral health care professionals in low-income communities and explain how insurance systems shape oral health outcomes. The media are also attuned to the sources of inequality that relate to oral health care, but reporters tend to address these subjects through stories of individuals who lack access to care. This type of coverage and mode of storytelling focuses people’s attention on individual causes of and solutions to oral health issues and impedes support for the structural changes that are necessary to increase equity.

Unproductive communications strategies include:

- **The media attribute oral health problems to individual behavior and suggest these problems are best solved through individual behavior change.** Whereas advocacy organizations talk about oral health as a public health issue, the media focus on individual actions—like brushing, flossing, and adherence to a regimen of regular dental visits.
- **Advocacy organizations and the media tend to evoke multiple values in a single communications material.** Many of the materials analyzed forward a multitude of different rationales for why oral health care is a matter of concern. This likely contributes to non-experts’ confusion about the issue and undermines attempts to dislodge the assumption that oral health care is an individual-level issue.
- **The media forward a consumerist perspective of oral health care.** A large share of advocacy and media messages on oral health focus on cost and affordability of care. Media coverage frames these discussions in *consumerist* ways. Oral health care, in these discussions, is presented as a consumer good that individuals purchase in a marketplace governed by the laws of supply and demand.
- **Organizational communications about disparities often lack a solutions statement.** As noted above, organizations focus on explaining systemic disparities, but they do not consistently include solutions in these discussions. Without a clear understanding of both the problem and what can effectively address it, members of the public become fatalistic about the possibility of improving equity in oral health outcomes.
- **Organizational communications assert the importance of prevention but do not explain how prevention works.** In earlier phases of this research, FrameWorks found that people may understand prevention inside the dentist’s office, but they don’t have a broader picture of what it looks like in their homes, schools, workplaces, and communities. Organizations may contribute to this lack of imagination by failing to explain what a public health prevention approach looks like and how it works to improve outcomes.

Next Steps and Initial Recommendations

In general, organizations that advocate for oral health issues define these issues as public problems in need of systemic solutions. However, this message is not finding its way into the media or reaching the public in ways that shift the national conversation. FrameWorks is addressing this challenge by developing and testing a story that sticks. This story will help shift the public discussion about oral health by connecting it to compelling values and explaining its systemic aspects with easily understood explanatory metaphors.

In advance of these upcoming findings, the analysis of media and advocacy materials presented in this report yields initial strategies that advocates can use to begin to improve their messaging. The following recommendations emerge from this analysis:

- **Advocates must tell complete stories.** These include the constituent elements of an effective narrative: a value, a causal explanation, a desirable outcome, and a solution statement that matches the scope of the problem and provides concrete steps to achieve better outcomes for everyone.
- **Advocates need to avoid using multiple values in order to concentrate the power of their message.** The field will benefit from uniting around and repeating a common value. Doing so will make it easier over time for people to access a productive answer to the question, “Why do oral health care issues matter?”
- Rather than just identifying the systemic factors that shape oral health, **advocates must explain how these factors shape outcomes.**
- **Advocates need to explain how prevention works** to improve oral health outcomes; simply asserting its importance is not enough.

Methods

Four questions guide this research:

1. What narratives do advocacy organizations tell about oral health, and how are these narratives structured?
2. What stories do the media tell about oral health, and how are these narratives structured?
3. What are the similarities and differences between these sets of stories?
4. What strategies can advocates use to expand and shift stories in more positive directions?

Data

Media Sample

The media sample includes articles from national newspapers and television broadcasts. Sources include the *Arizona Republic*, the *Cincinnati Enquirer*, CNN, the *Columbus Dispatch*, the *Dallas Morning News*, the *Denver Post*, the *Detroit Free Press*, Fox News Network, the *Los Angeles Times*, the (San Jose) *Mercury News*, MSNBC, the *New York Post*, the *New York Times*, the (Minneapolis) *Star Tribune*, the *Tampa Tribune*, and the *Washington Post*. Sources were selected based on circulation levels, location, and ideology (as measured by editorial endorsements in the 2008 and 2012 presidential elections).

Using LexisNexis, FrameWorks researchers searched and downloaded articles using a strategy designed to capture a broad range of topics that concern oral health care.^{iv} This search resulted in the identification of 1,073 stories. A randomized subsample of 250 articles was selected, and duplicate articles (the same article published in multiple news outlets) and media pieces that did not deal substantively with oral health were discarded. The process resulted in a final sample of 123 articles, each of which was coded and analyzed.

Advocacy Materials Sample

FrameWorks researchers also gathered materials from advocacy organizations. In collaboration with staff at the DentaQuest Foundation, FrameWorks researchers created a list of advocacy, service provider, and research organizations working to improve oral health.^v We then sampled four to 12 communications materials from each organization. These materials included press releases, reports, and “About Us” webpages. These particular types of materials were selected because they contain content about each organization’s mission and are directly related to oral health. The total organizational sample consisted of 184 materials from 22 organizations.

Analysis

Each media and advocacy document was coded to identify the presence or absence of the following narrative components:

Narrative Component	Description	Examples of Codes
Topical Area	What is the document about? What is the primary issue or topic being discussed?	<ul style="list-style-type: none"> - Individual behaviors that affect oral health - Prevalence of oral health conditions - Disparities in oral health care
Cause	Why do oral health problems happen? Why is intervention necessary?	<ul style="list-style-type: none"> - Individual behavior - Insurance coverage issues - Lack of professional development
Effect	What are the results of oral health problems?	<ul style="list-style-type: none"> - Poor overall health - Cosmetic problems - Societal/public health impacts
Solution	What is being done/should be done to promote good oral health?	<ul style="list-style-type: none"> - Preventive actions - Public education or awareness campaigns - Individual-level action
Value	Why should we care about oral health?	<ul style="list-style-type: none"> - Human potential - Prevention - Prosperity
Demographics Mentioned/Target of Intervention or Topic	What specific groups are mentioned?	<ul style="list-style-type: none"> - Low-income people - Children/adolescents - Pregnant women
Messenger	Who is directly quoted in communications about oral health?	<ul style="list-style-type: none"> - Health care professionals - Parents - Researchers

After coding the data, analysis proceeded in three phases:

1. Identification of Communications Practices.

FrameWorks researchers used three types of analysis to map how oral health is currently framed by media and organizations in the field. The first was an analysis of the frequency with which specific narrative components appear in media and organizational materials (results are summarized in tables). The second was a cluster analysis, which analyzes the likelihood that specific narrative components will co-occur in a single material. We used a version of cluster analysis called multidimensional scaling (MDS). This algorithm places the narrative components (e.g., topics, values, causes) on a two-dimensional grid. Components placed closer together on this plot co-occur more frequently in the sample than components placed farther apart. In short, *this technique allows us to identify the component parts of specific narratives and to determine how frequently they occur together within media and organizational discourses*. Finally, we conducted a qualitative analysis of the materials, which identified the implicit patterns of discourse conveyed by the materials. Taken together, these analyses identify a set of communications practices that are currently competing to shape public understanding and action on oral health.

2. Comparison.

After identifying the central tendencies in media and organizational discourses, and measuring their relative dominance, we compared the results between the media and organizational samples to identify similarities and differences between the stories told by the media and those told by organizations in the field of oral health.

3. Cognitive Analysis.

Finally, we examined the implications of our findings against the background of the public's deep assumptions and implicit understandings about oral health, which were identified in an earlier stage of research.^{vi} This analysis makes it possible to identify how media and organizational frames are likely to affect public understanding of oral health issues. In the concluding sections, we offer initial recommendations based on this analysis.

Findings

Below we report findings from two separate but interrelated analyses. In the first analysis, we examine the frame elements that are used in media and advocacy materials. This allows us to see the circulating frames that shape public and policy-maker opinion on oral health issues. In a second analysis, we look at how these elements come together to form stories—which frame elements tend to co-occur or “cluster” with other elements. While this second analysis shows a clear set of narrative clusters—groups of frame elements that tend to occur together in media and advocacy materials—it also shows a notable absence of *complete* narratives, as the clusters identified are missing key components of a complete story.

Narratives are powerful framing tools that help people organize, remember, and recall information. In keeping with the scholarly literature on narrative and framing, FrameWorks defines a complete narrative as one that describes a problem or issue, states why this 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 concrete actions that can be taken to create change in relation to the problem. Our analysis reveals that materials from both media and advocacy organizations lack key elements of this narrative structure. As we discuss below, this tendency to tell partial stories has implications for those communicating about oral health issues.

Figures 1 and 2 summarize each of the narrative clusters identified in the media and organizational materials.

Figure 1: Media Clusters



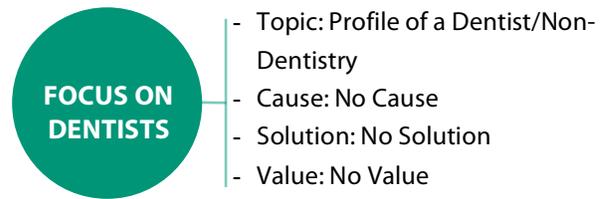
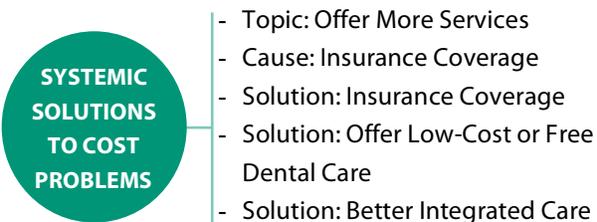
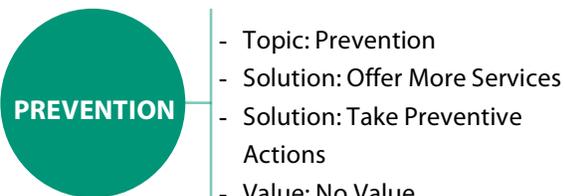
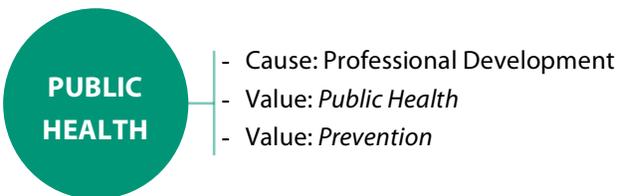
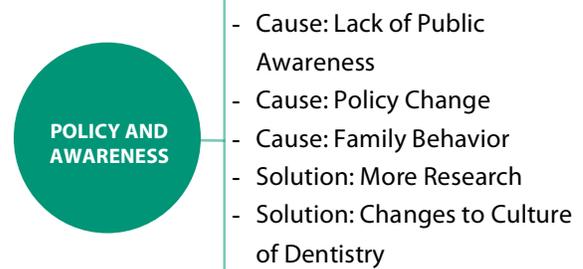


Figure 2: Organizational Clusters



What Are the Stories About?

Finding #1: Advocacy materials focus on oral health as a public health issue, while media coverage centers on personal behaviors.

Media and advocacy coverage of oral health differs substantially in content and scope. Media stories in the sample analyzed here focused on individual behaviors and insurance. They devoted very little discussion to population-level considerations such as the prevalence of oral health conditions (5.7 percent, compared to 52.7 percent in advocacy materials) or social determinants.

In contrast, advocacy materials emphasize the prevalence of chronic or acute oral health conditions and focus on populations such as pregnant women and those in rural areas (groups who were largely absent from media stories). Almost 90 percent of advocacy materials analyzed mentioned specific demographic groups, compared to just 45 percent of media materials. The focus on demographics reflects advocates’ population-level perspective and attention to systemic and equity issues. Finally, disparities in oral health care outcomes are a prominent concern in advocates’ materials yet are rarely addressed by media (45.9 vs. 8.1 percent). Advocacy materials, in short, take a broader view of the scope and significance of oral health issues than do media stories.

Table 1: Topical Area

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
Individual behaviors	35.8	37.5
Prevalence of chronic/acute oral health conditions	5.7	52.7
Profile of a dentist practicing dentistry	8.9	2.2
Non-dentistry-related profile of a dentist	53.7	1.6
Oral health and early childhood development	5.7	31
Oral health care cost/insurance coverage	23.6	45.7
Disparities in oral health care	8.9	45.1
Connection between oral health and overall health	8.1	41.8
Oral health care delivery in alternative settings	8.9	24.5
Oral public health/prevention practices	5.7	67.4

Table 2: Demographics Mentioned

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
Low-income people	18.7	44.6
High-income people	7.3	3.8
People of color	7.3	14.1
White people	2.4	3.3
Children/adolescents	15.4	71.2
Older adults (55+)	4.9	17.9
Rural communities	0	10.9
Urban communities	1.6	2.7
Pregnant women	0.8	16.8
No specific demographic cited	54.5	13

Finding #2: When discussing oral health *disparities*, media stories focus at the individual level, while advocacy materials tell stories about systems, quality, and access.

Media and advocacy materials tell stories about disparities in oral health in very different ways (see Figures 1 and 2). Media stories in the *Disparities cluster* tend to frame disparities in oral health as the result of individual behaviors; that is, they locate both the causes of, and the solutions to, poor oral health at the individual level. They typically do so by relying on individual case studies. While some of these case studies in the media focus on cost of treatment, potentially a systems-level factor, these cost discussions are framed as a matter of individual choices. The excerpt below exemplifies this tendency.

MINIMUM WAGE EMPLOYEE [audio]:

I only go to the doctor if I need to go or I have no other choice to go, I'll go. I needed a root canal for one of my back teeth. And it was like, well, you know, if you get a root canal it's—I think they told me it was—it was like \$300 or something, but they needed a down payment. I couldn't—I have to pay the whole thing or put down half, down payment. So I'm just like, "OK, well, how much would it be to pull a tooth or whatever?" They are like, "Well, it's free to pull a tooth. But we would rather not pull a tooth because it's savable." And then I'm like, "Well, I would rather you pull it because it's like, I can't pay for it. But it's bothering me and I don't want the pain. So I would rather you just pull the tooth." It's not really what you want to do, but it's what you have to settle for because you can't afford to get the right dental care.^{vii}

Advocacy materials in the *Disparities cluster*, on the other hand, discuss disparities in terms of structural and systematic factors that influence access to quality oral health care across the population. For example, the following passage about regional disparities in oral health outcomes focuses squarely on access and availability of services and tells a systems story.

Poor and underserved people fundamentally lack access to quality, affordable oral health care. They struggle to gain access to dental providers and a way to pay for dental services. Only about 6 percent of dental hygienists have taken advantage of the opportunity to become ECP [Extended Care Permit] hygienists, and thousands of Kansans visit emergency rooms each year with dental pain.^{viii}

Finding #3: The dental profession is missing from media stories but is an important part of one prominent advocacy story.

While there are frequent stories about dentists in the media, relatively few of these pieces focus the dental *profession*. In other words, media stories in the *Focus on Dentists cluster* are typically not about dentists acting in their capacity as oral health professionals, but rather about dentists who have made the news for other reasons—typically for some type of socially unacceptable behavior. Stories about Walter Palmer—the dentist who hunted, killed, skinned, and beheaded Cecil, a beloved lion in Zimbabwe—were examples of this more general pattern in media coverage of oral health issues.

In contrast, there is a narrative within advocacy materials—the *Public Health cluster*—that focuses explicitly on the professional development of dentists. These stories frame dentists not as individuals seeking financial gain or as perpetrators of immoral behaviors as they are generally represented in the media, but as key parts in a well-functioning public health system. The following passage includes some potentially counterproductive framing practices, but shows how, in advocacy materials, dentists are not only concerned with treating individual patients or growing their practices, but with advocating for preventive population-level measures.

As a dentist in Salem, Massachusetts, and as a dental student in Philadelphia, I was able to observe firsthand the value of community water fluoridation. When I first came to Massachusetts, Marblehead, Swampscott, and Lynn did not have fluoridated water supplies. I was overwhelmed by some of the decay I saw in patients coming from these communities and did not immediately realize this was because Salem was fluoridated and these communities were not. A few years ago, I volunteered on the MDS Mobile Access to Care Van in communities without fluoride, and I was suddenly back 30 years to when I began to practice. This experience on the MDS [Massachusetts Dental Society] van was what opened my eyes to the fact that fluoride is still the most cost-effective means to provide prevention across a wide socioeconomic stratum. We are depriving the poor if we do not support community water fluoridation.

How Do Oral Health Issues Work?

Finding #4: Advocacy materials generally explain the causes of oral health problems, while media coverage rarely includes explanations.

In general, media articles do not attempt to explain issues related to oral health. In fact, less than one-third of the media articles analyzed included any causal statement. In contrast, almost three-quarters of the advocacy materials in the sample included explanations of why oral health problems are occurring. Almost half of the advocacy materials attribute oral health problems to lack of access to quality oral health care, indicating that organizations are consistently telling a systems-level story.

Table 3: Causes of Oral Health Issues

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
Individual behavior	10.8	32.6
Family behavior	2.4	20.7
Insurance coverage	10.6	32.1
Policy change	4.9	17.9
Intergenerational/transmittable disease	1.6	6.5
Access to health care professionals	12.2	47.8
Lack of public awareness/understanding	2.4	17.4
Access to professional development for health care providers	0	12.5
No cause cited	66.7	27.7

Finding #5: While advocacy materials generally provide causal explanations for oral health problems, specific discussions of prevention lack explanation.

Despite a strong focus in advocacy materials on prevention and assertions of the importance of a preventive approach, there is little explanation of how this approach works to improve oral health outcomes. This is exemplified in the *Prevention cluster*, which featured stories like this:

Preventing and treating dental disease in pregnant women can promote healthier pregnancies and lead to better oral health for thousands of children. Results from Washington’s latest 2010 Smile Survey show we need to focus more on prevention—nearly 40 percent of children in our state start kindergarten having experienced tooth decay. Research shows that for children, early prevention can substantially reduce future dental costs.^x

Finding #6: Media discussions of cost focus on individual consumer choice and market principles, whereas advocacy messages focus on recalibrating systems to lower costs.

Media materials that discuss oral health care costs typically do so in terms of individual choice and decision-making (the *Consumerist cluster*). That is, the media present a market-based model of oral health care in which problems associated with high costs are best handled by consumer decision-making and a more competitive market. In the following passage, the author evokes the *Consumerist* model in explaining why people might delay essential oral health procedures. While the passage is sympathetic, the author nevertheless uses a strong consumerist frame:

One possibility is that when she says she's nervous about surgery, what she means is she has a pathological fear, not just that she doesn't want to do it. Or she might be thinking: "There are deductibles on these things, they're quite expensive, I don't have the money right now." Medical and dental insurance doesn't mean that she's not going to have to pay anything. So the right way into this is to have a conversation with her in which you discuss fully what all the issues are. ...^x

When advocacy materials deal with costs (the *Systemic Solutions to Cost Problems cluster*), they propose systemic solutions, such as increasing access to insurance, increasing access to lower-cost oral health care services, and creating and maintaining a better system of integrated care between oral and overall health. They do not focus these discussions on individual decisions, but rather adjustments to the overall system in which individuals operate.

To ease these financial and health burdens, Massachusetts needs more providers who can deliver cost-effective dental care to those who most need it, especially in settings beyond the traditional dental office. New legislation, S. 1118/H. 249, introduced by state Senator Harriette Chandler and Representative Smitty Pignatelli, would authorize a new type of mid-level dental professional, the dental hygiene practitioner (DHP), in Massachusetts. DHPs would increase dental access for vulnerable populations and make care more affordable. This important bill presents a critical opportunity for Massachusetts to close gaps in dental access for seniors, low-income families, children, and people with special needs.^{xi}

What Are the Effects of Oral Health Issues?

Finding #7: While advocates talk about the relationship between oral health and overall health, media materials do not make this link.

The media do not make connections between oral health and overall health. Three-quarters of media articles analyzed did not describe any effects of oral health conditions, and those that did failed to extend their focus beyond the mouth.

Advocacy materials broaden the view beyond the mouth, discussing how poor oral health can affect overall health (40 percent) and various aspects of people’s lives (work, school, etc.). Some advocacy materials also focus on the societal impacts of oral health problems and disparities (20 percent).

Table 4: Effects of Oral Health Issues

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
Poor oral health	12.2	60.3
Poor overall health	5.7	41.8
Problems at work	1.6	14.1
Problems at school	2.4	23.4
Cosmetic issues	7.3	10.3
Societal/public health impact	2.4	22.8
No effects cited	75.6	28.8

What Should We Do about Oral Health Issues?

Finding #8: Solutions statements are generally prominent parts of advocacy stories but are often absent from media materials.

Media articles tend not to discuss solutions. Most media articles (66 percent) in the sample did not mention solutions to the oral health issues they discussed. When media articles did discuss solutions, they tended to focus on providing additional dental health services (18 percent of articles) and making individual- and family-level behavior changes (11 percent). On the other hand, solutions were present in almost 95 percent of advocacy materials in the sample. The solutions discussed in these advocacy materials tended to focus on preventive actions and policies at the population level (55 percent of materials).

Table 5: Solutions

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
Public education campaigns	4.1	42.4
Individual/family actions	10.6	33.2

Dental health services	17.9	65.2
Preventive actions	4.9	55.4
Insurance policy change	4.9	34.2
Dentistry cultural change	3.3	16.8
Lower-cost oral health care	4.9	25
More/better integrated care	0.8	29.3
Research	0.8	15.2
No solution cited	65.9	5.4

Finding #9: Despite a strong focus on solutions, when advocates tell stories about disparities, they tend not to include discussions of solutions.

When advocates tell systems-level stories about disparities they tend to leave out a call to action or a clear statement about what should be done to address inequities in oral health care. That is, advocates describe systemic inequality in oral health care, but they do not regularly include concrete steps to address it. The following example illustrates how organizations tend to forward messages that describe the scope of disparity issues, but fail to include systems-level solutions to create a more equitable oral health care system.

The Centers for Disease Control and Prevention (CDC) ranks Missouri 47th in access to oral health care. The Pew Charitable Trusts gives Missouri a “C” for children’s oral health and a “D” for use of dental sealants. Sixty-three percent of Missouri Medicaid-enrolled children receive no dental care, and Missouri is one of four states without a dental sealants program for students in high-risk schools. Forty-four percent of skilled nursing facility residents were assessed as having untreated decay. A 2012 MSN Health article noted the city of St. Louis as having the worst oral health of any American city. Kansas City was ranked the 9th worst city. A recent *USA Today* article focused attention on the increased use of expensive emergency rooms to address dental pain when regular dental care is not available. The need for change is great. The oral health of Missouri is poor.^{xii}

Why Do Oral Health Issues Matter?

Finding #10: Values are infrequently used in both media and organizational materials.

Neither the media nor advocacy organizations make much use of values statements. Advocacy materials in the sample evoked the values of *Prevention* in 13.6 percent of documents and *Public Health* in 10.3 percent of materials, while the media used these values 1.6 and 0.8 percent of the time, respectively. Compared to other issues on which FrameWorks has conducted similar analyses, this is an infrequent use of values.^{xiii}

Table 6: Values Statements

	Media (percentage of materials mentioned)	Organizations (percentage of materials mentioned)
<i>Prosperity</i>	1.6	3.8
<i>Human Potential</i>	1.6	4.9
<i>Crisis</i>	0	2.7
<i>Public Health</i>	0.8	10.3
<i>Prevention</i>	1.6	13.6
<i>Fairness across Places</i>	3.3	3.8
<i>Innovation</i>	0	1.6
No value cited	87.8	76.6

Finding #11: When they do employ values, media and advocacy organizations employ multiple values in the same communication.

The cluster analysis indicates that in the relatively rare cases when media and advocacy organizations do include values statements, they employ multiple value statements in a single document to explain why oral health is important (see the *Values clusters* in Figures 1 and 2). The following advocacy communications illustrate this tendency. This passage focuses on the importance of prevention, includes discussion of cost efficiency, and veers into crisis framing.

“It’s always a good idea to visit the dentist regularly for examinations and cleanings and to make sure you don’t develop periodontal disease or have dental caries,” advised Tiffany Buller-Shussler, DDS. “A checkup today prevents more costly, uncomfortable treatment tomorrow.” In addition to higher bills for unpleasant procedures, untreated dental problems can lead to more serious health concerns such as inflammation; untreated gum disease can lead to inflammation of the gums. These inflammatory bacteria then enter your bloodstream and travel throughout your body. Research has linked this process to a number of serious medical conditions such as diabetic complications, atherosclerosis (hardening of the arteries), and the risk of heart disease and stroke.^{xiv}

Cognitive Implications

Based on FrameWorks’ analysis of the cultural models that the public employs to reason about oral health, exposure to the organizational and media narratives described above is likely to activate the following particular ways of thinking about immigration reform.

1. **The public will “fill in” incomplete narratives.** Many of the public’s most dominant ways of thinking about oral health are in contradiction to expert messages and impede communications. When advocates (and the media) tell incomplete stories, they invite these understandings to fill in and shape people’s thinking in unproductive ways. For example, the lack of clear solutions statements in advocate stories about disparities is likely to be filled in by a sense of inevitability about inequities and feelings of fatalism about the prospect of solutions. The lack of solutions statements is also an invitation for the public to apply their individual-level lens on responsibility and blame individuals themselves for disparities in oral health outcomes. In these ways, the lack of solutions messages actually makes people more convinced that this social issue is beyond remedy, which is clearly not the advocates’ intended takeaway. Another conspicuously incomplete story is the failure to explain how prevention works to improve outcomes. By leaving this narrative slot open, organizations are contributing to the public’s inability to see the importance of prevention and hampering support for prevention-based policies. **Oral health advocates need to tell complete stories and focus specifically on deepening public understanding of how things work and providing concrete and actionable solutions.**
2. **The individual focus of oral health discussions in the media reinforces public understanding.** FrameWorks research shows that the public understands oral health in terms of the “Teeth Triangle”—brushing, regular cleanings at the dentist, and specialty dental care for cavities and root canals. By focusing overwhelmingly at the individual level, media coverage strengthens this view of oral health and keeps a systemic or population-level perspective out of public view. **Advocates need to push to get more and better systems stories and discussions of social determinants into the media’s coverage of oral health issues.**
3. **The media’s attention to behavior change will invigorate the public’s default model of *Health Individualism*.** Language about individual choice and decision-making are at the core of media stories about oral health, and there is a strong tendency to cast oral health outcomes as simply a matter of making good personal choices. This invigorates the public’s dominant perspective that oral health outcomes are the narrow and exclusive responsibility of individuals. When this way of thinking is operative, people have difficulty engaging in discussions about the systems-level dimensions of oral health issues and the policy changes required to improve outcomes. **Advocates should focus on contextualizing individual decision-making and make it clear that all decisions are made in systems that constrain or facilitate choice. Advocates need to advance a “what surrounds us shapes us” message.^{xv}**
4. **The absence of solutions in most media discussions of oral health issues reinforces fatalistic thinking.** Experts and advocates emphasize the importance of policy change to address societal problems related to oral health—including changing laws to increase access to dental insurance coverage, improving training for oral health care professionals, and expanding the number and type of settings where people can access high-quality oral health care. Members of the public,

however, rarely hear about systemic solutions from the media and are not consistently exposed to solution-oriented discussions that go beyond individual-level changes. This makes it hard for people to imagine what societal-level solutions look like or to understand their importance. **Advocates are telling solution-based stories, but they need to find ways to get these messages to stick in the media. One way of doing this is to develop examples that show how systems-based solutions work to improve outcomes for individuals, families, and communities in meaningful ways.**

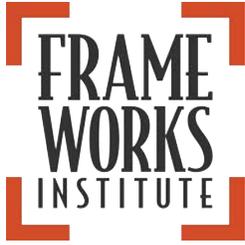
5. **Both the general absence of values and, when used, the combination of multiple values in a single communication, leave the public without a sense of why oral health matters.** Values help people understand why issues matter and drive engagement in social issues. Both the general lack of values and, when present, the invocation of multiple values in the same communication leave people unsure of whether and why oral health matters. The result is that people fill in this information with the ideas that are most readily available to them—in this case that oral health is an individual, largely cosmetic issue that ultimately is not *that* important. **Advocates need a clear, consistent answer to the question of why oral health is an important *social* issue.**
6. **Media coverage of the cost of dental care encourages consumerist thinking and will dampen the salience of oral health disparities and depress support for equity policies.** Media coverage of oral health costs is likely to activate *Consumerist* thinking, priming people to see the world as a marketplace—a place where individual actors pursue their own self-interest by purchasing goods and services that maximize individual benefits while minimizing individual costs. *Consumerist* thinking naturalizes the market for dental care and disparities in oral health. This type of thinking leads people to conclude that it is inevitable that people with more money will get better care, because in a market you get what you can afford and have no right to what you can't. This way of thinking prevents the public from seeing the need to address oral health disparities or see how effective social policies can intervene in the health care market to improve equity in oral health outcomes. Advocates need to be clear about the ways that policies can shape the market and the importance of doing this to create more equitable outcomes. The current market is not natural—it is structured in ways that create and perpetuate inequities in oral health outcomes.
7. **Advocacy materials deploy potentially effective frames, but these frames have failed to stick in the media.** Advocates' communications focus on areas where public understanding is in greatest need of expansion. For example, advocates tell systemic stories that explain causes, effects, and solutions; they frame oral health as a public health issue with societal implications; and they explain the relationship between oral and overall health. However, the lack of media pick-up of these advocacy frames suggests the need for additional communications work. Further research is required to identify strategies that can help move these stories and frames beyond the advocacy discourse such that they stick and influence the larger public discourse on oral health issues. **Advocates need new ways of telling stories as well as new channels of dissemination in order to more effectively push and lodge their frames in the larger public discourse.**

Conclusion

This analysis presents both good and bad news for advocates. The good news: The vast majority of advocacy communications advance productive frames on oral health issues. For example, advocacy communications include robust stories about systematic inequalities in access to oral health care and discuss the societal impacts of oral health problems. Furthermore, a subset of these communications put forward messages that push the public past their default focus on individual behaviors like brushing, flossing, and regular checkups, encouraging them to consider more social and public health causes and effects. Advocacy materials do important work in explaining how oral health and overall health are connected, and establish dentistry as an important pillar of the public health system. The presence of these types of frames in the advocacy discourse is a critical step toward addressing the gaps between expert and public thinking about oral health and oral health care.

The less favorable news is that these stories are not gaining traction in the media—which is where people are likely to hear and learn about oral health. The media discourse does not connect oral health to overall health, fails to discuss the societal impacts of oral health outcomes at length or in depth, and stops short of portraying dentistry as a public health profession. More broadly, media stories reinforce narrow individualistic perceptions of oral health and fail to frame oral health problems as systemic issues with collective implications.

FrameWorks is in the process of testing narrative strategies, including the use of explanatory metaphors, values, and explanatory chains, that will help experts and advocates more effectively bring the expert story of oral health into the public discourse.



About FrameWorks

The FrameWorks Institute is a nonprofit 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 multi-method, multidisciplinary approach to empirical research. FrameWorks designs, conducts, publishes, explains, and applies communications research to prepare nonprofit organizations to expand their constituency base, to build public will, and to 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 FrameLab study engagements. In 2015, it was named one of nine organizations worldwide to receive the MacArthur Foundation’s Award for Creative and Effective Institutions. Learn more at www.frameworksinstitute.org.

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Endnotes

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- ⁱⁱ Centers for Disease Control and Prevention. “Disparities in Oral Health,” accessed January 4, 2016, http://www.cdc.gov/oralhealth/oral_health_disparities/.
- ⁱⁱⁱ Roger Collier, “United States Faces Dentist Shortage,” *Canadian Medical Association Journal* 181 (2009): E253-E254. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2780510/>
- ^{iv} The search terms included: oral health; dental health; oral health service*; dental disease; oral disease; disease + mouth; health + mouth; dental coverage; dental benefit*; dental insurance; oral care; dental care; dental treatment; oral health care; dental health care; dentist*; oral surg*; dental clinic; dental office.
- ^v The following 22 organizations were included in the analysis: Academic Pediatric Association; American Dental Association; Better Oral Health Massachusetts Coalition; Children’s Dental Health Project; Children Now; Center for Oral Health; Head Start National Center on Health; Maryland Dental Action Coalition; Massachusetts Dental Society; Michigan Oral Health Coalition; National Academy for State Health Policy; National Conference of State Legislatures; National Network for Oral Health Access; Oral Health America; Oral Health Colorado; Oral Health Kansas; Missouri Coalition for Oral Health; Oral Health Nevada; Oral Health Watch; Pew Charitable Trusts; U.S. National Oral Health Alliance; Virginia Oral Health Coalition.
- ^{vi} Andrew Volmert, Marissa Fond, Abigail Haydon, Moira O’Neil, and Marisa Gerstein Pineau, “*It’s a rite of passage*”: Mapping the gaps between expert, practitioner, and public understandings of adolescent substance use (Washington, DC: FrameWorks Institute, 2016).
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- ^{xii} Missouri Coalition for Oral Health, “The Need for Change is Great.” <http://www.oralhealthmissouri.org/the-need-for-change-is-great.php>
- ^{xiii} Moira O’Neil, Adam Simon, and Abigail Haydon, *Stories Matter: Field Frame Analysis on Immigration Reform* (Washington, DC: FrameWorks Institute, 2014).
- ^{xiv} “Resolution: Better Dental Health in 2016,” *The Cincinnati Enquirer*, Nov. 19, 2015.
- ^{xv} See www.calendow.org for additional information on and examples of this framing strategy.