Seeing Upstream

Mapping the Gaps between Expert and Public Understandings of Health in the United Kingdom

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A FrameWorks Map the Gaps Report

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Introduction

From five-a-day campaigns to debates about the future of the National Health Service (NHS), it is easy to assume that people already know everything there is to know about what shapes the health of the nation. Yet the public view of health is largely focused on individual lifestyle choices rather than environmental and social factors. While the public understands that money, work and environments play a role in shaping health,[i] people assume health is mainly determined by choices within individuals' control. As a result, people have difficulty seeing how social and environmental – or upstream – factors fundamentally determine health outcomes and produce inequalities in health.

THE SOCIAL DETERMINANTS OF HEALTH - DEFINITION

Throughout this report, we use the term "social determinants of health". These are sometimes also called the wider determinants of health. When we use the term, we are referring to the social, cultural, political, economic, commercial and environmental factors that shape the conditions in which people are born, grow, live, work and age.

The common language that both experts in the social determinants of health and members of the public use to talk about health results in communication breakdowns. For example, both experts and the public talk about how access to education shapes health; yet when experts talk about education, they have in mind good quality training and instruction for all, whereas the public thinks about awareness campaigns and behaviour change. When experts talk about the importance of control over one's life, they have in mind empowerment that gives communities a say over their environment, while the public thinks about an individual's responsibility to make good choices and remain disciplined in leading a healthy life. Both experts and the public talk about the food industry's role in shaping diet; but while experts see a wide array of ways in which industry shapes and restricts eating options, the public thinks narrowly about chicken shops and fast food, and quickly pivots to individuals' responsibility to resist such temptations and make healthier choices.

To broaden public understanding of the determinants of health, communicators must know how the public currently understands and thinks about health and the factors that shape it. This report presents research findings from a project commissioned by the Health Foundation, as part of their long-term strategy to bring about healthier lives for people in the UK.[ii] The report charts the UK's public understandings of health and examines how these ways of thinking differ from those of experts in the social determinants of health. By comparing these perspectives, we

identify the gaps that communicators must address to foster a deeper understanding of how environments shape health. Importantly, understanding public thinking reveals strategies that communicators can use to build a more robust discussion of the changes that must be made to improve population health.

Communicating effectively about people's health in the United Kingdom first requires a clear sense of the core ideas the public must grasp to understand what shapes health and how to improve it. The report begins with a distillation of this 'untranslated story' of the social determinants of health in the United Kingdom. This untranslated story represents the content to be communicated to the public with a reframing strategy. It reflects the understanding of experts in the social determinants of health—including what a healthy society is; what health inequalities are; what types of health inequalities exist in the United Kingdom, what factors determine health outcomes in the United Kingdom and what can be done to make UK society healthier.

We then describe the cultural models[iii] – common but implicit patterns of thinking and assumptions – that underlie how the British public understands and reasons about health. Working from over 1,000 pages of interview transcripts, we identify the range of different ways of thinking about health that are available to the public. Some of these ways of thinking are productive and can be used to communicate key ideas, while others are unproductive and obscure important health principles. Identifying these cultural models enables us to develop reframing strategies that change public discourse and thinking about health, and increase support for critical programmes and policies.

Finally, we map the gaps between the perspectives of experts in the social determinants of health and of the UK public, examining points where these understandings overlap and others where they diverge. This highlights the key challenges in communicating about health and its determinants in the United Kingdom. We conclude with a set of preliminary framing recommendations.

A description of the research methods used and participant demographic information can be found in the Appendix.

The Expert View of Health in The United Kingdom

This section presents the themes that emerged from analysing 14 one-hour interviews with experts in the social determinants of health in the United Kingdom. This set of evidence-based messages represents the *untranslated story* of health in the United Kingdom: the core set of understandings that those involved in the social determinants of health want to communicate to the public about this issue.[iv] The untranslated story is organised around four questions:

1. What is a healthy society?
2. What are health inequalities and what inequalities exist in the United Kingdom?
3. What factors determine health outcomes in the United Kingdom?
4. What can be done to make UK society healthier?

What Is a Healthy Society?

A healthy society recognises that health is integrated wellbeing. Experts argue that health must be defined positively – that it goes beyond the presence or absence of disease. Experts describe a healthy society as one in which all its members can experience mental and physical wellbeing, feel good about their life and function fully on a daily basis, in spite of any illness they may experience. They explain that in a healthy society, people can make meaning of their lives, and have a sense of control in confronting challenges and achieving goals.

A healthy society focuses on health creation. Experts argue that a healthy society treats health as an issue that is shaped by social and environmental factors, and that encompasses more than health care and medical treatment of illness. They explain that a *pathogenic* approach to health – the primary focus of which is the treatment of illnesses – obscures the role of social circumstances and physical, social and commercial environments in determining health. In contrast, a *salutogenic* approach to health focuses on *health creation*, and on fostering assets for wellbeing in an integrated way and at a population level.

A healthy society is an equal society. Experts explain that a healthy society has relatively similar health outcomes across the population, and that this requires power, money and resources to be relatively equally distributed. According to experts, inequalities in power, money and resources affect all areas of people's daily lives and result in population health inequalities. They argue that the best way to reduce inequalities in health outcomes in the United Kingdom is to reduce inequalities in power, money and resources in the country.

What Are Health Inequalities and What Inequalities Exist in the United Kingdom?

Health inequalities are differences in health status and outcomes in a population that are linked with social class; gender; race or ethnicity; education or income; disability, geographic location or sexual orientation. Experts explain that health inequalities can be measured in a variety of ways, including life expectancy, morbidity rates (the rate of diseases in a population), adult and infant mortality rates and disability rates. According to experts, these differences in health outcomes are likely avoidable manifestations of structural inequalities in power, money and resources. The more socially disadvantaged a group, the more likely its members are to experience poorer health outcomes compared to the rest of the population.

Inequalities in power, money and resources produce high levels of health inequalities in the United Kingdom. Experts explain that health inequalities exist in the United Kingdom along a variety of dimensions (for example, social class, race or ethnicity, income, gender). They stress that these inequalities span the whole population along a gradient: Experts illustrate this point further with two key examples – health inequalities based on *wealth*, and on *race* or *ethnicity*:

- Experts explain that wealth inequality *across race or ethnicity* in the United Kingdom leads to significant differences in health outcomes at every age and for all major diseases. They show that within many UK cities or boroughs (for example, Glasgow and Blackpool), the difference in life expectancy between the poorest and wealthiest communities can be as much as 17 years, rising to as much as 25 years for people without disabilities.

- According to experts, inequalities based on race or ethnicity also lead to health disparities: individuals from Black and minority ethnic (BME) groups are more likely to experience poor health outcomes and disability than the rest of the UK population. BME groups have higher rates of diabetes, cardiovascular disease and mental illness. These disparities are the complex consequences of the ways in which racial/ethnic discrimination affects socioeconomic mobility, creates poor living conditions for communities and has direct psychological effects on BME groups.

What Factors Determine Health Outcomes in the United Kingdom?

Social and environmental determinants are key risk factors for ill health in the United Kingdom. Experts explain that social and environmental determinants are *the causes* of ill health. They are far-ranging and include factors like poverty; poor early childhood support and

education; poor education and educational outcomes; poor work conditions; absence of neighbourhood and community networks; poor public transport infrastructure; poor-quality housing; lack of access to green spaces; 'food deserts' (where grocery stores are far away and people have limited access to transportation to reach them) and lack of affordable healthy food; and discrimination (most notably on the basis of race or sexual identity). These social and environmental factors affect people's health in three distinct ways:

- They structure choice and opportunities in ways that negatively affect people's health, shaping things like diet, exercise or drinking. According to experts, these individual behaviours result from a series of factors that limit individual control and make certain behaviours more likely. For example, rather than being an exclusive function of choice and individual behaviour, the risk for obesity is heightened by access to cheap high-calorie, high-fat and high-sugar foods in people's immediate social, physical and commercial environments, by the absence of a transport network conducive to walking and exercise, and by the lack of access to green spaces.

- They produce material and social conditions that have a direct negative effect on people's lives. For example, crowded housing has a direct detrimental effect on mental wellbeing. The risk for respiratory illnesses, infectious diseases and cancer is also increased by cold damp housing, air pollution and social environments that condone or promote smoking habits.

- They generate high levels of chronic stress and other forms of psychological pressure, like social isolation, fear, shame or loss of self-esteem. These psychological pressures have direct effects on mental and bodily functions (for example, chronic stress puts the body into 'survival mode' and increases the risk of heart disease) and affect individuals' physical and mental health through the adoption of poor health behaviours. For instance, experts show that work conditions that do not provide employees with sufficient financial stability, and in which there is a strong imbalance between effort and reward, and pressure and flexibility, have strong detrimental effects on people's mental and physical wellbeing.

Social determinants are mutually reinforcing, exacerbating long-term inequalities and worsening health outcomes. Experts argue that social and environmental factors not only *co-occur* but also are often *causally* linked, which reinforces their effect on health outcomes. Poor educational attainment, for example, generates chronic stress for struggling students, which affects their short- and long-term health outcomes. But as one expert put it, doing poorly at

school can also 'stack the odds against you', leading to poor educational outcomes that limit an individual's life choices in terms of further education and employment. This, in turn, limits housing options, strength of social networks and access to healthy food and green spaces, which increases the probability of health issues and curbs opportunities to create health.

Positive social and environmental factors create better health outcomes for the population. According to experts, positive social and environmental factors yield positive health outcomes in three ways:

- They create opportunities and empower people to make healthy choices. Being free from poverty and having enough resources, for instance, makes it more likely for people to have access to healthy food, green spaces and a transport network conducive to walking and exercise. When people have a stronger degree of control over their lives, they are also more likely to generate and carry out solutions to the issues that threaten their health.

- They produce material and social conditions that create health for the population. Having access to safe, affordable housing, for instance, protects people from respiratory illnesses and some cancers, as well as from fire hazards and other life-threatening risks connected to unsafe housing.

- They create positive psychological states that contribute to good health outcomes. For example, improved educational outcomes strengthen people's social networks and connections, which have direct positive effects on mental and physical health. Experts point out that people who are socially connected are also more likely to care for their health and that of their community, because they have more reasons to value the lives they lead.

Policy shapes health by structuring the physical, social and commercial environments people live in. Experts explain that national and local policymaking shape the social and environmental determinants of health in two ways:

- Policymaking shapes health by determining factors like work conditions, the distribution of wealth and access to quality housing and education. Experts stress that all policies have a significant impact on the health of the population one way or another, regardless of their specific focus. Education and health policy are two examples of this effect.

- Tensions within local and national government about policymaking priorities can complicate the task of creating and protecting the population's health. For example, depending on the priorities of government officials, chicken shops may be seen as a health hazard, a source of significant contributions to the economy or a place for young people to congregate.

Commercial practices shape health by structuring individual choice and behaviour. Experts argue that, by determining how and where food, alcohol and tobacco are produced, distributed and advertised, commercial practices have a strong influence on the health of the population. Decision-making in the food industry, for instance, contributes to the creation of food deserts, and to the lack of access and affordability of healthy food in certain parts of the country. This restricts dietary options to calorie-dense processed foods in certain places, which yields worse health outcomes for particular populations. Advertising practices can also yield worse population health outcomes, as an increase in snack-food advertising leads to increased consumption of unhealthy food.

A disproportionate focus on the National Health Service (NHS) budget leads to a lack of investment in other public services needed to protect long-term population health. Experts explain that systematically prioritising the NHS's yearly budget over other budgets means public services that can improve and protect health in the long term, by addressing upstream factors, remain chronically underfunded. For instance, spending on Sure Start children's centres in 2015–2016 was down 47 per cent from 2010 (adjusted for inflation), and one-third of the centres have closed since 2011. Experts describe this allocation of funds as highly inefficient, as health care has significantly less impact on health outcomes than initiatives and services focusing on the social and environmental drivers of health, or public health programmes designed around early detection, intervention and prevention of health issues. Experts also warn that too strong a focus on treatment and individual health behaviours can reinforce the understanding of poor health as individual weakness. This can further increase existing inequalities, which in turn makes for poorer health outcomes for the population.

Nonmodifiable determinants like genetics play a much smaller role in shaping health outcomes than modifiable social determinants. Experts put genes at the bottom of the list of risk factors for ill health in the United Kingdom. They argue that while certain diseases are undeniably genetically based, the magnitude of recent epidemics of noncommunicable diseases (like obesity or diabetes) cannot be explained on the basis of genetic changes in the population. According to experts, such patterns must be understood in terms of social and environmental factors, such as the food industry's recent and continuous push for increased consumption of

processed foods and sugary drinks, as well as a decrease in physical activity due to the evolution of urban planning, transport systems and sedentary working conditions.

What Can Be Done to Make UK Society Healthier?

Involve all of society's stakeholders in designing and implementing policies that reduce health inequalities. Experts argue that the reduction of health inequalities in the United Kingdom can only be achieved on the basis of strong partnerships between central and local government, members of the private sector, local communities and individuals. Such multilevel collaborations allow policies and services to work together more effectively towards the same goals; they also empower the population by working with them as equals in the decision-making process.

Reduce inequalities in power, money and resources, with a stronger policy focus on social justice, at all levels of government. Experts argue that a series of objectives must be met to reduce health inequalities in the United Kingdom: giving every child the best possible start in life; creating job opportunities and fair working conditions for all; ensuring a healthy standard of living for the whole population; developing health-creating physical environments, empowering communities and strengthening health prevention. Experts illustrate this point further with two key examples—taxes and benefits, and early childhood education:

- Experts argue for a system of taxes and benefits that would bring people out of poverty and redistribute wealth more equitably across the United Kingdom. This would allow people to be safe from poverty; to have access to healthy food choices, safe housing and recreational opportunities; and to be able to lead a life they value. These factors would, in turn, lead to better health outcomes for the population.

- According to experts, it is also essential to develop policies that strengthen support for children in the *first thousand days of life,* and that ensure all children have access to a good education system in early childhood and beyond. Such measures support healthy childhood development, which yields protective health benefits at the biological level, and ensure younger generations can acquire the skills and attributes that will give them a stake in their future. This will result in better health outcomes for the population.

Make people's health a touchstone for all future policies implemented in the United Kingdom. Experts advocate for an integrated approach to health in all policy decisions, reaching far beyond the Department of Health. Using the examples of the *Public Health (Wales) Act* and

Well-being of Future Generations (Wales) Act, they explain that this can be achieved by requiring all policy proposals to demonstrate tangible benefits for the health and wellbeing of the population and future generations. They also argue for making Health Impact Assessments[v] a statutory requirement for all public bodies. According to experts, such an integrated approach would not only maximise health creation and mitigate threats to health in governmental decisions but also increase public understanding that issues like housing, transport, education and urban planning are essential factors in determining health outcomes in the United Kingdom.

Support policy initiatives that develop people's sense of collective control and empowerment. Experts agree that communities can and should be more involved in identifying, planning, designing and carrying out solutions to social issues and inequalities. Communities that can participate in decision-making at local and national levels have more control over their lives and their social, physical and commercial environments, which yields better health outcomes for them. This may take the form of neighbourhood budget initiatives, in which communities choose how to use their resources to meet their own set of priorities, or programmes like 'Connecting Communities', [vi] which aims to get residents and providers working together as equals to solve problems and improve local conditions. Developing similar programmes across the country would improve communities' resilience and organising power in the long term. As one expert put it, empowered communities don't have things done *to them*; they are enabled to do *for themselves* and have a voice in the democratic process. As these types of initiatives help develop a community's control over its circumstances and environment, they ultimately lead to better health and wellbeing for the community.

Adopt social policies that apply to the whole population, with special emphasis on those who need the most help. Experts argue that social policymaking should not be *solely* targeted towards the groups and communities that struggle the most, as it currently is. Decision-makers should abide by the principle of *proportionate universalism*, according to which social policymaking should benefit the entire population, with a stronger emphasis on those groups that need it the most. According to experts, the narrow focus of current policies on those in need strengthens existing stigma around poverty, which further reinforces inequalities within the system, thereby yielding poor health outcomes for the population. In contrast, experts argue that addressing social issues *across the nation* will contribute to reducing inequalities, which will in turn improve health outcomes for the whole country.

Shift the NHS's focus from treatment to prevention, and invest more significantly in public health initiatives. Experts explain that, to promote and create good health, the United Kingdom needs a radical shift from treatment to prevention and towards an integrated approach to public

health. They argue that prevention must become a more prominent mission of the NHS, as the priority currently given to treating illnesses does not improve the long-term health outcomes of the population and is not cost-effective. According to experts, budgets devoted to integrated approaches to public health – beyond the NHS – must be significantly increased to allow for effective health creation.

Adopt regulations that promote healthy behaviours without stigmatising individuals. Experts argue that public health regulations targeting individual health behaviours should promote positive behaviours without stigmatising individuals. This means creating and designing physical, social and commercial environments that promote healthy behaviours by making the healthy choice the easiest, or the default choice, for the entire population. Experts also suggest adopting a more systemic approach to taxation as a way of curbing unhealthy behaviours without implying that individuals are to blame. For instance, the current taxation of tobacco products implicitly places responsibility for tobacco use and its subsequent effects on individuals rather than the industry. Instead of solely taxing consumer purchase of cigarettes, which sanctions individuals, experts propose the introduction of a tax on the tobacco industry.

The Untranslated Expert Story of Health in the United Kingdom

What Is a Healthy Society?

- A healthy society recognises that health is integrated wellbeing.
- A healthy society focuses on health creation.
- A healthy society is an equal society.

What Factors Determine Health Outcomes in the United Kingdom?

- Social and environmental determinants are key risk factors for ill health.
- Social determinants are mutually reinforcing, exacerbating long-term inequalities and worsening health outcomes.
- Positive social and environmental factors create better health outcomes for the population.
- Policy shapes health by structuring the physical, social and commercial environments people live in.
- Commercial practices shape health by structuring individual choice and behaviour.
- A disproportionate focus on the NHS budget leads to a lack of investment in other public services needed to protect long-term population health.
- Nonmodifiable determinants like genetics play a much smaller role in shaping health outcomes than modifiable social determinants.

What Are Health Inequalities and What Inequalities Exist in the United Kingdom?

- Health inequalities are differences in health status and outcomes in a population that are linked with social class; gender; race or ethnicity; education or income; disability, geographic location or sexual orientation.
- Inequalities in power, money and resources produce high levels of health inequalities in the United Kingdom.
  - Wealth inequality (across race and ethnicity) leads to significant differences in health outcomes at every age and for all major diseases.
  - Individuals from BME groups are more likely to experience poor health outcomes and disability than the rest of the UK population.

What Can Be Done to Make UK Society Healthier?

- Involve all of society's stakeholders in designing and implementing policies that reduce health inequalities.
- Reduce inequalities in power, money and resources, with a stronger policy focus on social justice, at all levels of government.
- Make people's health a touchstone for all future policies implemented in the United Kingdom.
- Support policy initiatives that develop people's sense of collective control and empowerment.
- Adopt social policies that apply to the whole population, with special emphasis on those who need the most help.
- Shift the NHS's focus from treatment to prevention, and invest more significantly in public health initiatives.
- Adopt regulations that promote healthy behaviours without stigmatising individuals.

Public Understandings of Health in the United Kingdom

In this section, we present the dominant cultural models – the shared but implicit understandings, assumptions and patterns of reasoning – that shape public thinking about health in the United Kingdom. These are ways of thinking that are *available* to the public, although different models may be activated at different times. It is important to emphasise at the outset that people are able to think about health in multiple ways; they toggle between models, thinking with different ones at different times, depending on context and conversational cues. Some models are dominant and more consistently and predictably shape public thinking, while others are recessive and play a less prominent role. Some models are productive, facilitating a fuller understanding of health and support for the policies and programmes that experts recommend, while others are unproductive, impeding understanding and getting in the way of people's support for solutions.

In addition to these cultural models, there are *cognitive holes* around certain issues: areas where the public lacks models or ways of thinking about an issue. These cognitive holes represent areas where understanding must be filled in. By seeing the models available to the public and the cognitive holes, communicators can frame messages to activate productive models, background unproductive ones and fill in understanding where needed.

Here, we first describe the cultural models the public uses to think about what health is and how it works. In the next two sections, we explore two strains in public thinking: an individualistic strain (which is dominant) and an ecological strain (which is more recessive but still available). Specific cultural models comprise these strains, which have particular implications. Finally, we explore public thinking about solutions – about what can be done to improve health in the United Kingdom – and discuss how this thinking stems from the cultural models available to people.

CULTURAL MODELS

Cultural models are deep-seated patterns of thinking about a given topic that are shared across a culture or a population. They are taken-for-granted, automatic assumptions that people rely on to interpret, organise and make meaning of the world.

Everyone holds multiple cultural models about one given social issue – some are more in the spotlight (*dominant* models) and some are more in the background (*recessive* models).

COGNITIVE HOLES

Cognitive holes are areas where the public lacks cultural models or ways of thinking about an issue. They represent those aspects of an issue where public understanding must be filled in by new communications strategies.

Cultural Models of Health

The *Absence of Illness* Cultural Model

Members of the British public implicitly define health by what it is *not*, rather than by what it is and involves. In this way, health is the absence of illness. Health is assumed to be the default state of the body and the mind before the inevitable accumulation of pathologies and dysfunctions over time.[vii] Because people define health negatively, in conversations about what good health involves, participants consistently brought up illness and poor health.

> **Participant**: I think good health is waking up in the morning and feeling happy and not being full of aches and pains. Good health is never having to go to the doctors. Ironically, good health is never having to use the NHS. I say ironically because of how much I respect the NHS, but, if I never have to use it, […] that's good health.[viii]
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> **Researcher**: What springs to mind if I say the word *health*?
> **Participant**: I'd say bad health springs to mind.

Reasoning with this model, participants assumed that the young are healthier than the old – having lived shorter lives, they have had less time for illness to build up. They also understood long life as the absence of illness over a long period of time, and death as an event that necessarily occurs as the result of an illness.

In interviews, participants frequently connected health and happiness, suggesting that people who experience good health are happy people. Members of the public model health and happiness in similar ways; they assume that just as health is the absence of illness, happiness is the absence of problems. From there, it follows that health (the absence of illness) is one of the key conditions that make happiness (the absence of all problems) possible.

> **Participant**: I think [someone with good health] would be a happy individual. I think that they would have spring in their step, as they say. I think they would be contented with life. I think that they would have less complaints than people with bad health.
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> **Researcher**: What are the effects or consequences of somebody being healthy or how healthy someone is?
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> **Participant**: They'd probably be happy and able to do a lot of things, get out in the fresh air, work, go on holidays, and, yeah, be lively. Maybe they'll encourage other people by being so fit and healthy.
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> **Participant**: When I think of health, I think of my children and raising them to be healthy children – happy children as well.

Prototype of Ill Health: Chronic, Noncommunicable Physical Illness

When thinking about health, chronic, noncommunicable physical illnesses like diabetes, heart disease and cancer were top-of-mind for participants, as was obesity, which was also understood as an illness.

> **Researcher**: If I was to ask you to name some different health issues, what would you include?
> **Participant**: Cancer, heart, blood pressure, arthritis, rheumatism, that sort of thing. The usual suspects, I suppose.
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> **Researcher:** If you were to name some different health issues, what would you include in there?
> **Participant**: Blood disorders, problems with the blood. Problems with the heart […]. Stuff like that. […] Maybe even being overweight. You know? Majorly overweight, I mean mortally [sic] obese. That would be another one. That's what comes to mind at the moment.

Participants frequently brought up mental health issues as well – particularly more common issues, such as depression and anxiety – although these typically came up after physical illnesses were discussed and were subordinate to physical health in people's thinking. Infectious diseases were almost wholly absent from people's talk, and even AIDS was very rarely mentioned in the interviews. People did not, however, reject mental health issues or infectious diseases as health issues. They did not think that these aren't *really* health issues, which suggests that their prototype of ill health is reasonably expansive and flexible.

> **Researcher**: What springs to mind when you think about good health?
> **Participant**: We're talking about physical health here, are we not, then?
> **Researcher**: It could be both.
> **Participant**: If we go back to the well-rounded person, I would say somebody who is in good physical and mental health. […] I know lots of people who've suffered from anxiety and stress and things like that. And the mental health […] is just as important as the physical health.

The *Health Is Medical* Cultural Model

When talking about health, participants' attention repeatedly focused on medicine and doctors. This tendency is grounded in not only the *Absence of Illness* model but also a distinct model of health as a *medical* issue. For the public, the concept of health is deeply and implicitly understood to be about the field of medicine. When thinking with the *Health Is Medical* cultural model, technological and medical advances were top-of-mind for participants, who therefore assumed

that the field of medicine can effectively *control* health. The model includes two related assumptions about how medicine can control health:

- **Medicine offers innovative ways of treating illness.** As a result of this assumption, medical and technological advances allowing for new treatments were top-of-mind for participants.

- **Medicine can tell us how to maintain health (that is, avoid illness) through daily behaviours.** Doctors and health professionals are treated as scientific authorities on health-related issues. For instance, participants argued that it was possible, if not easy, to achieve good health by abiding by scientific guidelines.

> **Participant**: What do I think about when I hear the word 'health'? New and emerging cures for diseases are being created all the time.
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> **Researcher**: What is poor health to you?
> **Participant**: It's when you're outside the parameters that the doctors and the health profession recommend that your physical body should be within… It's like your pulse rate, your heart rate and things like that, they should be in certain ranges.

Because the public understands health as a medical issue, health care and the NHS are at the foreground of thinking about health. When reasoning with this model, the British public assumes that the health of the population is primarily determined by the quality and efficiency of its health system, and the quality and pace of medical and technological advances. The prominence of the NHS in discussions about health is reinforced by widely shared pride in it as a major post-war achievement for the country.

> **Participant**: [T]he NHS is really important to a lot of people in the country. It's quite good that we have free health care. If you were ill, you wouldn't have to worry about having thousands of pounds in your pocket. You just go to the doctor, you go to the hospital, […] you just get seen, they look after you, you go home.
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> **Participant**: The NHS […] provides a basic level of health care that everyone in the country can access as and when they need it. […] So it means that we can all stay as healthy as possible and we all get looked after when needed.

The *Health Is Independence* Cultural Model

When asked about health, participants sometimes focused on motor and functional capacities: Being healthy means being able to *get things done*, and to do so without help. Being healthy is equated with being able to move and be active, being productive and useful to society. When thinking with this model, health is identified with the capacity to work, carry out daily tasks and move about unhindered, and ill health is thought of as the inability to do those same things.[ix] This way of thinking stems from the *Absence of Illness* cultural model; health is understood as a type of *freedom* from illness, which involves the ability to act and achieve goals unhindered and unaided.

The *Health Is Independence* model has a clear moral dimension: If people are unable to fulfil their societal role as independent individuals, they are thought of as a burden on their family, community and country. In other words, according to the *Health Is Independence* model, having poor health means not only being forced to depend on other people to function in society but also being a drain on society's resources. While the model does not necessarily result in *explicit* blaming of individuals for their own ill health, it *implicitly* denigrates people with ill health for being a burden.

> **Researcher**: What does it mean to have good health?
> **Participant**: My physical capabilities […] to do things in life. To be able to lift, to be able to move, to be able to cover distance. […] Whether my mind feels that it's capable of applying itself to a task. […] The ability to take on things and to carry out tasks you set yourself, physically and mentally, week on week.
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> **Researcher**: What does it mean for people to be unwell?
> **Participant**: They are not able to do tasks as quickly as they would like, or as much as they would like. They are not able to focus on the task at hand. It could be that they need help from others to get anywhere. Like, for example, if you are disabled, you need someone to take you from A to B. Drive you around, put you in wheelchairs, things like that. […] So they end up being a burden on other people at times.
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> **Participant**: Bad health means that you can't have a job […]. Bad health means that you are a drain on someone, be it personal or be it society. And it's not your fault usually. [*chuckle*] You can't help having bad health.

The *Health Is Mechanical* Cultural Model

According to this cultural model, health works as a mechanical system of inputs and outputs. When reasoning with this model, people assume that an individual's health outcomes are

determined by the amount and quality of what goes into the body – of what the individual consumes (for example, nutrients, calories, oxygen). The *Health Is Mechanical* model assumes that the amount and quality of what people put into their bodies determines how healthy they are going to be. When using this model, participants not only discussed food and drink but also mentioned the effects of pollution on health, as they reasoned that air, water and soil pollution influence health 'inputs' – the quality of the air we breathe, the water we drink and the food we eat.

> **Participant**: It's all about what you're putting into your body and what's coming out.
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> **Researcher**: How would not having fresh air affect somebody?
> **Participant**: Well, just staying indoors, having breathing air in the house doesn't make you feel as good as when you get out into the countryside and breathe clear air. It's good for your lungs. Because your lungs need fresh air, nonpolluted air, to help them be healthy.
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> **Participant**: I tend to use the analogy, 'garbage in, garbage out'.

Implications for Communicators:

- **The *Absence of Illness* cultural model makes health creation difficult to think**. Because this model defines health as *absence* of illness, rather than as a positive state, it makes it difficult to understand health as something that can be actively created. To increase understanding of health creation and its importance, communicators need strategies to background the *Absence of Illness* model and to foster an active, positive understanding of health as something that can be built, rather than as the passive absence of disease.

- **The public's prototype of chronic, physical noncommunicable illness shapes what people think about when you say 'health'.** While the public is able to think about a range of health issues, including mental health issues, simply talking about 'health' brings to mind diabetes, cancer, heart disease and obesity. The good news for communicators is that this prototype of ill health is reasonably expansive and flexible, and it doesn't lead people to reject other issues – like mental health issues or infectious diseases – as not *really* being health issues. Communicators can focus attention on health issues that don't match the prototype by making these issues explicit in their communications. And because the public already recognises that noncommunicable illnesses are key health issues, communicators can also go beyond raising awareness about their existence and relevance, and instead focus on fostering an ecological understanding of their causes.

- **The *Health Is Medical* cultural model narrows people's focus to treatment and individual-level prevention.** When reasoning with this model, the British public focuses predominantly on medicine's ability to *treat* health issues, and assigns a key role to efficient health services and quality medical research in shaping health. While the model allows for limited thinking about prevention at the individual level – following good medical advice about diet and exercise, for example – it obscures the need for systemic prevention initiatives, like early detection and early intervention. Because it is so focused on the role of medical treatment, the model also makes it hard for people to recognise the need for and value of health creation and public health initiatives that fall outside the scope of medicine as it is narrowly understood.

- **The *Health Is Independence* cultural model contributes to the stigmatisation of ill health.** While a functional understanding of health is not inherently stigmatising, it leads people to adopt a moral view of poor health as a burden on society. Communicators must be careful in using language about 'functioning', as it is likely to inadvertently cue this model and reinforce stigmatisation. Research is needed to determine how to promote a functional understanding of health that is not weighted with these stigmatising moral associations.

- **The *Health Is Mechanical* cultural model is likely to reinforce individualistic understandings of health, but, with the right framing, it has potential.** Because of its focus on individual-level inputs and outputs, this model is likely to focus people's attention on individual behaviours, like eating and drinking. Once at this level, many of the broader social and contextual factors that experts wish to elevate will be hard to grasp and difficult to appreciate. However, with the right framing, this model seems promising. The focus on inputs creates space for communicators to engage people in thinking about environmental influences. While the model is currently applied to a narrow set of such influences (that is, different types of pollution), it would be interesting to see how broadly it can be stretched, and which types of social determinants can be effectively framed as environmental inputs.

Cultural Models of the Determinants of Health: The Individualistic Strain

As noted above, the British public has a variety of available models to think about what shapes health. These models can be divided into an individualistic strain, which assigns a central role to individual choice and willpower, and an ecological strain, which sees health as (at least in part) a product of social and environmental influences. The individualistic strain is dominant, and

largely unproductive in relation to communicating the expert story presented above, while the ecological strain is recessive but more productive.

We begin by presenting the models that make up the individualistic strain. While these models share crucial affinities, which warrant thinking of them as a *strain* or *family* of models, each model provides a distinct way of thinking about health, foregrounding particular considerations, relying on specific assumptions and yielding distinctive – if overlapping – implications.

Below, we discuss the specificities of each model, and highlight what they have in common – including their joint tendency to obscure systemic influences on health and to stigmatise poor health.

The *Health Individualism* Cultural Model

This cultural model plays a dominant role in shaping the way in which the British public thinks and talks about health. At the core of this cultural model is the fundamental assumption that health outcomes are driven by individual choice. *Health Individualism* leads people to focus on the crucial role played by individual 'lifestyle' choices, like diet, exercise, (not) smoking and (not) drinking, as well as mental and emotional 'self-care', such as meditation.

> **Researcher**: What's a person with good health like?
> **Participant**: Somebody in good health who is aware of their intake, what they're eating, what they're drinking. I wouldn't say somebody who is super-fit, who runs marathons or something like that. Obviously, they're in good health, but I would just say the average person who is aware of what they eat, drink, smoke, if they smoke and has [sic] the information available to make the right choices. You can only take people so far, and then it comes down to free will.
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> **Participant**: Health to me is being healthy, fit and active. And making sure that you're not letting yourself get unhealthy to cause problems further down the line […]. Or health can be a lot to do with your mental wellbeing, and looking after yourself spiritually and keeping yourself grounded and not getting stressed and things like that.

According to the *Health Individualism* model, because individual choice determines health outcomes, individuals are responsible for their own health. People should consciously choose to make healthy choices – and if they are in poor health, it is typically assumed to be their own fault.

> **Researcher**: In the UK specifically, who would you say is responsible for making sure that people have good health?
> **Participant**: I think the people themselves initially. They should be taking care of their own health.

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Researcher: Who is ultimately responsible for people being healthy?
Participant: I think mostly it is down to the person to eat well, to find the opportunity to exercise regularly, and so on.

The *Mentalism* Cultural Model

Mentalism goes hand in hand with *Health Individualism*. *Mentalism* is used to reason about *why* people do – or don't – make certain choices. Using this model, people reason that the choices individuals make are primarily – if not exclusively – determined by individual discipline and will. This focus on willpower reinforces the sense that each individual is morally responsible for their own health.

Researcher: And why is that some people don't take care of themselves?
Participant: Maybe they can't be bothered. It seems too much effort. Sometimes it's just easier to eat bad foods and lay on the sofa. I guess some people just don't have the motivation, even though they know that they need to look after themselves in order to live longer. Some people just don't care.

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Participant: [I]t all comes down to Joe Public wanting to do it and having the willpower to do it. That's what it's all going to come down to.

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Participant: Yeah, that 'responsibility' word – it starts with you, and it ends with you. Nobody else is responsible for you – nobody.

The model appeared at multiple points in participants' talk, including talk about their own 'odd splurge'. Participants reasoned that it is acceptable to give in to temptation occasionally, as long as people are still able to exert willpower on command. On the other hand, consistent failure to exert control over one's behaviours was understood as a sign of weakness or laziness – especially as people believe that information about healthy choices and behaviours is readily available, thanks to the ubiquity of health promotion campaigns in the country.

Participant: I think it's up to the individual to be in control. And I think that there will be times in your life when you will go out of control. And you will overeat because something will have happened that will have kicked that off. But as long as you've got the basic building blocks to get yourself back on track, I don't think it's bad to have the odd splurge from time to time. As long as you know that you can get back to where you were.

Our data suggest that the public also uses the *Mentalism* cultural model to think about mental health issues. Relying on this model, they assume that issues such as depression and anxiety are determined by individual mindset and willpower, and that most people could get better if they just 'got over it' or tried harder to adopt a more positive outlook on life. Participants argued that the most effective way of dealing with mental health issues is to change one's perspective on life, to try to have a positive attitude and stay away from stressful situations.[x]

> **Participant**: Sometimes you have an issue, you deal with it, you move on. Let's move on with things. The stress element is dealing with issues and closing issues in your life and then moving on from those issues.
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> **Participant**: So, poor health, again, is like […] someone who just magnifies even the smallest hurdles or the biggest hurdles. They focus on those rather than the other things. And they can't seem to use those experiences to further the good things or the better feelings.

There was also a more direct link between individual will and character, and health. People explained how good health is characterised by acceptable visible standards of weight, fitness and appearance. Such elements are assumed to reflect the individual's will to take care of themselves. Poor health is characterised by an absence of energy and will to 'care', which manifests in visible signs – from hunched shoulders to lack of personal hygiene to being overweight. This visible state of good or ill health is understood as an outward manifestation of inner strength, resolve and willpower.[xi] People's thinking about obesity epitomises this model. At its core, obesity is understood as the visible manifestation of inner character failings.

> **Researcher**: Thinking about somebody who's in good health, what comes to mind?
> **Participant**: I think people who are in good health are usually a sensible weight, they have a degree of radiance about them. They usually look like they take care of themselves. You know, if you meet somebody who's a real 10, they're almost breathtakingly active.
> **Researcher**: And how about somebody who's in poor health?
> **Participant**: Just the opposite, really. Somebody who doesn't radiate at all. Perhaps almost closing in on themselves. Perhaps a general air of looking a little bit unkempt. Of someone who can't be bothered.
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> **Participant**: In order to stay healthy, a certain degree of physical activity and good diet would be required. If those basic principles are not followed, then a person would get larger, physically larger, and therefore have a lot of associated illnesses.
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> **Participant**: We all need to exercise more and lose weight, stop being so fat and lazy.

The *Genetic Exception* Cultural Model

People use genetics and fate to explain exceptions to the rule – the cases where health cannot be explained by individual choice. The assumption is that for some health issues, outcomes are simply the result of the genetic hand a person was dealt.

> **Researcher:** If you had to give me a list of reasons why someone has good health or bad health, what would be on there?
> **Participant**: Luck and lifestyle. […] You don't really choose who you're born to. For example, one of my friends has got MS. And his father had MS. And until recently, they didn't regard it as a hereditary disease, but now they're coming round to the opinion that it is. And I think you're genetically predisposed to certain illnesses, and unfortunately, you can't do anything about the genes that you're born with. So I think there's luck.
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> **Participant**: I think, naturally, the body […] has all these muscles and organs and […] eventually, regardless of how well you are, things over time do start to deteriorate. […] I've known people that have never smoked before in their life, but then got lung cancer. So it's not one thing leads to another. I think sometimes you're just a bit unlucky.

The *Genetic Exception* model reinforces the power of the *Health Individualism* and *Mentalism* models by providing a way of explaining outlier cases that does not directly violate the primacy of individual choices and willpower as explanations for the majority of health outcomes.

Because the public thinks health outcomes are determined by *either* individual choice and willpower *or* by genetics, people make a sharp distinction between self-inflicted and accidental illnesses. This allows them to draw a line between the 'deserving' and 'undeserving' ill. The public believes that individuals who have failed to exercise their individual willpower – and who suffer from self-inflicted and avoidable cases of ill health (for example, lung cancer or obesity) – are less deserving of care than individuals suffering from illnesses caused by genetics (for example, MS or leukaemia), who cannot be held responsible for their poor health.

This line of reasoning is particularly salient in thinking about the 'NHS crisis'. Knowledge of the serious financial strain the NHS is currently under leads people to assume that health services are no longer in a position to accommodate the needs of all patients. When health care is seen as a limited commodity, and people can distinguish health issues for which people's choices are responsible from those that are beyond blame, it becomes easy to reason that the deserving ill must be prioritised over those who suffer as a result of bad choices and lack of will.

> **Participant**: We're told about the NHS at a young age […] and we understand how to use it. […] It's become a right to use that. But we don't think on a Friday night after I've gone out for 10 pints, my responsibility to that system so it can function properly means that maybe I don't drink excessively and then having to fight off falling over, and have to use the hospital. I think we've got to, as a society, understand what our responsibilities are to enable these systems to work to everyone's benefit.
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> **Researcher**: And what is stopping you from getting a GP appointment?
> **Participant**: Poor health in general, I suppose – it's people's lifestyle choices. Because the self-inflicted-type patient is stopping people like me who can't help it.

Implications for Communicators:

- **Individualistic cultural models make it difficult for the public to think about social determinants of health.** Because these models focus attention on individual-level factors (choices, behaviour, personal character or genes), they obscure the critical role played by social determinants and systemic factors. Cultivating a full understanding of the social determinants of health will require backgrounding these individualistic models in people's thinking to make room for them to see the role of social and systems-level factors in shaping health and health outcomes.

- **The *Health Individualism* and *Mentalism* cultural models stigmatise ill health.** These cultural models understand ill health as the result of a failure to make good choices or to exert willpower. This can lead people to conclude that those with ill health are culpable for their own problems and unworthy of treatment and public spending. While experts emphasise that health creation requires giving people a 'sense of control' over their lives, communicators must tread with caution when using such language, as it is likely to cue unproductive thinking about decisions, self-control and a narrow sense of personal responsibility. To avoid reinforcing stigma, communicators need strategies that place individual behaviour in context and deepen understanding of the relationship between environments and individual choices. This is perhaps the most important framing challenge identified in this work: as long as people focus on the individual level and see choice and will as the most important determinants of health, social factors will, at best, remain in the background.

- **Crisis messaging about the NHS is likely to activate the dichotomy between 'deserving' and 'undeserving' patients**. Communicators should tread carefully in discussing the 'NHS crisis'. Doing so reinforces the view of health care resources as limited and pushes people into seeing the NHS as a zero-sum game. From this perspective, people are

motivated to distinguish between the deserving and undeserving ill and draw distinctions between who should get these resources and who shouldn't.

- **Public thinking about genes and fate makes prevention hard to think**. Because people have a deterministic understanding of genetics, when genes are implicated as a cause of an illness, ideas of prevention seem inappropriate. How, after all, can we prevent something that results from the genetic hand we are dealt? Communicators need strategies for explaining how genes and environments interact, to make it possible for people to understand how prevention can work for health issues – even those that have a significant genetic component.

Cultural Models of the Determinants of Health: The Ecological Strain

While the individualistic strain is dominant in public thinking about the determinants of health, a recessive ecological strain also exists. This strain is made up of models that allow people to recognise the ways in which money, community and commercial and physical environments shape health outcomes. As we discuss, these models focus attention on certain dimensions of the environment and provide, at best, a partial understanding of *how* context shapes health. And even within this ecological strain, there is a residual degree of individualism, as ultimate causal responsibility remains with individual choice.

As with the individualistic models, the ecological models make up a family of models that have things in common but also distinctive implications. Despite their limitations, these models provide a promising starting point for communicators, and have the potential to be leveraged and expanded to enhance understanding of the social determinants of health.

The *Consumerism* Cultural Model

The core assumption of the *Consumerism* cultural model is that money can buy good – or better – individual health. In people's minds, money gives people choice and allows for the adoption of healthy individual behaviours. Individual wealth is exchangeable for the best foods, gym and recreational access, quality housing, a healthy neighbourhood and so on. In other words, how many pounds someone has in their pocket, as one participant put it, determines how much health they can buy – how much they can spend on healthy purchases, which in turn directly shapes how healthy they are.

> **Participant**: Generally speaking, rich people don't tend to get very ill a lot, because they have the very best. They will have private care. They have doctors. They have people looking out for them. They have maids that clean the house. They have people to babysit their kids. […] Extra set of eyes on your kids, on you, extra few brains to offer medical advice if needed.
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> **Participant**: [People with money] might be able to buy the more healthy options. Trying to eat healthily does cost more money than the junk food.

It is important to note that even though the public frequently uses the *Consumerism* model, it is a relatively weak model in the sense that people quickly default back to *Health Individualism* or *Mentalism*. For example, after suggesting that the cost of food is an important factor in dietary habits, in the next breath, participants were back to asserting the primacy of choice and will and explaining that what people eat remains within individuals' control.

> **Participant**: I think you always have a choice. […] Sometimes you just have to work a little bit harder and look around more, try and get deals, spend a bit more time trying to think about it. […] And I think anyone on any budget could work a way out to eat relatively healthy food or significantly less bad food. I believe that you have a choice if you wanted to have a balanced diet.

The *Direct Effects* Cultural Model

When members of the British public think about how social and environmental factors shape health, they frequently rely on a simple model in which environments have explicit, direct and tangible effects. For instance, when asked about the effects that housing can have on health, people discussed how dampness can lead to respiratory problems; when discussing work conditions, they talked about risks of accident, or about how coal particles in the work environment cause black lung. The tacit assumption is that one central way in which environments affect health is by exposing people to conditions that directly cause injury or illness.

> **Participant**: What are the core aspects of health? I'd say probably diet and exercise really. And stay away from bad working environments. Don't work down a mine for 40 years shovelling coal. You'll come out with black lung.
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> **Researcher**: Do you think housing has an impact on health generally?
> **Participant**: I suppose it does. It does have an impact if you haven't got enough money to heat the property properly. It might become damp or mouldy, which can affect your health if spores are getting into your lungs or it's cold in winter. Just that, really.

Following a similar logic, people sometimes see that stress – itself a product of environments – can have direct physical consequences, ranging from eczema to heart attacks. The exact mechanisms through which stress directly affects health are, however, not well understood by the public. As a result, this is a relatively weak assumption for people, who continue to reason that it is primarily up to individuals to remove themselves from stressful situations and make the necessary changes in their lives.

> **Researcher**: How are stress and health connected, exactly?
> **Participant**: I guess what they say is it can have different effects on people's bodies. […] It can sometimes lead to heart attacks and stuff, because […] if somebody feels they're at a breaking point and you're feeling really stressed, your heart's working probably extra harder than normally. And sometimes, it just gives out. Because, you know, your heart can only do so much as well. And that is probably why people that had a heart attack say it was a wake-up call, and they have to change things in their life. They start to eat healthy, they try to reduce the stresses. So if their job is really stressful, reduce their hours. Or look for a different role, something that's less strenuous on them. […] So sometimes [stress and health] can be connected. But I don't know the full extent of how or why.

The *Behavioural Constraints* Cultural Model

According to the *Behavioural Constraints* cultural model, social and environmental factors affect individual health outcomes by restricting or encouraging particular behaviours. For instance, people reason that a time-consuming job can make it harder for someone to eat well, or that an office job reduces opportunities to exercise. Following the same logic, people argue that stress – itself a product of social and environmental factors – affects health by affecting behaviours, and makes it difficult for people to adopt healthy habits.

> **Participant**: People with office jobs are not very active. Like I said earlier, you sit down from 9 to 5, and then you go home and sit in your armchair for the evening, watching TV. And then you go to bed, and you lie in bed. Where's your exercise?
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> **Participant**: You see an awful lot of stress that's brought on by difficulties at one's work. Like you feel slightly imprisoned by a situation, and […] that adds a pressure and a stress to other aspects in your life, where you then may lean on some form of comfort escapism, in the form of drugs, in the form of food, in the form of promiscuity, in the form of many different forms of solace, momentary solace in that stress.

Like the *Consumerism* model, *Behavioural Constraints* is a relatively weak model in people's thinking. After suggesting that environments constrain behaviour, participants quickly defaulted back to the deeper, more dominant individualistic cultural models, and suggested that if people try they can always adopt healthy habits.

The *Cultural Norms of Health* Cultural Model

When explaining differences in health outcomes, participants sometimes appealed to cultural norms. According to this assumption, different 'cultures', communities or family units set different norms about what is 'normal' and what is 'healthy', which in turn shape personal choice and individual behaviour for the members of that group in an almost inescapable way.

> **Researcher**: How does your childhood and the way you were raised determine how healthy you are?
> **Participant**: Because you're with your parents, your immediate family being the loudest influence in your life, in setting tones and ideas for your life, and the culture around your life, what you think, creating parameters and a barometer of where or how you should manage your life. How much you can chew and what you should chew and what you do and don't do. All of these drivers in the very early age tend to stay with you for a long time. They reach a certain part of you that, as you get older, it's harder to reach. You know, it's quite embedded.
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> **Participant**: I think there is a problem within white, working-class communities, that there's a lot of health problems in those areas. In relation to drugs, but also general lifestyle. There are some people in those communities that don't work. […] I think there's just a culture at the moment where a lot of people are just after free handouts. […] It's unhealthy, and it's unproductive. I think if you're not working, you're sitting around watching telly. You're just hanging about doing nothing. I think that has a big impact on your health and your life expectancy. Not just in terms of your mental health, but probably your physical health as well if you're not keeping active.
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> **Researcher**: Why do you say people in Peru are healthier?
> **Participant**: I think it's their ethos. They want to live more in harmony with their environment. […] They seem to have a slower pace of life and it seems to be more in sync with nature. They seem genuinely happier and healthier. […] I think they're more outdoors. They're farmers, some of them. But in the cities, as well, they seem to just be more active. I don't know why. […] Well, obviously, I don't think there are gonna be any computer programmers there, so I'm not comparing [with the United Kingdom]. It's just a sort of general statement.

While the public, like experts, recognises that certain neighbourhoods, cities, regions or countries have worse or better health, when thinking with the *Cultural Norms of Health* model they understand these differences in wholly cultural terms rather than seeing their structural sources. The public suggests that, generally, people in the North of the United Kingdom have poorer health than those in the South, and that people living in the South Wales Valleys have poorer health than people living in North Cardiff. Similarly, they agree on a hierarchy of health among developed countries, which places the United States at the bottom, regions like Scandinavia and the Mediterranean at the top and the United Kingdom somewhere in the middle. But because

people make sense of this ranking on the basis of the *Cultural Norms of Health* model, they argue that differences in health outcomes are due to cultural differences, not structural inequality.

> **Participant**: I think we are better off than in many countries, but I also think that if you look at places like Scandinavian countries, if you look at areas in France, who have a much more relaxed way of life... You take it to the Mediterranean lifestyle and diet is healthier than ours is. Germany, I think, has a better attitude […] people respect things a lot more.
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> **Participant**: One of my friends has got this theory that if you live in CF14 [North Cardiff], it's illegal to be fat. And that's a sweeping generalisation, but they're not fat. You know? I don't mean that they're all, you know, skinny little size eights, but they're not overweight. It kind of intrigues me that I'll go to this Asda in Aberdare, and everyone is fat. It's almost 'spot the thin person'. And then you go to, say, Marks & Spencer's near me, and you don't see fat people. I think that's awful, but it's true. […] And I don't know what it is, whether it's education or knowledge or… I don't know.

The *Humans Are Social Animals* Cultural Model

On occasion, participants suggested that community membership has benefits for people's health and wellbeing. Drawing on the assumption that human beings are naturally meant to be around and interact with other human beings, participants reasoned that being part of a community can contribute to wellbeing and mental health. If human beings' natural mode of existence requires social interactions, it follows that social connections are needed for people to lead fulfilled, healthy lives. While this was a recessive way of thinking, participants were nonetheless able to think and talk about how community connections could benefit individual health, and how loneliness – perceived as unnatural – is bad for health in general and mental health in particular. In some cases, participants attributed the health benefits of community connections to positive feelings of 'belongingness'; in others, they explained the benefits of social connections in terms of having people around to identify problems and support behaviour change.

> **Participant**: I don't even know if this true, but I heard a thing that loneliness is just as big a killer as smoking. […] Generally, humans need people. They need to feel something. They need to feel appreciated to some degree, wanted, acknowledged, heard, just to have someone to tell about your day.
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> **Researcher**: How does people's relationship to community affect health?
> **Participant**: I think they need to have that relationship. […] Closed-off-ness – that's not a word – it's a negative, mentally mainly. […] I think it's actually a physical thing, a scientific and technical thing: levels of cortical serotonin. I don't know the chemicals, but, I mean, it's just a feeling, isn't it? Some people are

obviously very good by themselves, but still, everyone has to have physical and emotional contact with other people.

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Participant: From a health point of view, I think interacting with people in communities is good for people's mental health, especially if loneliness is an issue. They may not even realise they have an issue. By interacting with people in the community, they may then take a positive step to seeking some help. Which then takes a positive step to readdressing their lifestyle, if they've got lifestyle issues.

The *Threat of Modernity* Cultural Model

When discussing what shapes health, people often argued that a vaguely defined 'modernity' has a negative influence on health. People explained that technological advances reduce individual drive by making life too 'easy'; that modern media and advertising increase levels of stress and pressure people into unhealthy consumption; and that modern work is time-consuming, stressful and sedentary.

Participant: If you look back to my parents' generation, the Second World War generation, they were much more healthy than we are. But they didn't have the same pressures exerted on them with advertising and such. And I think there's a lot around advertising and how you're supposed to feel if you eat certain things. And lifestyle. Now it's thrust upon people. And let's say a lot of it they don't realise it's happening, subliminal. […] And I think that's why we're probably more stressed out as a generation. So, my children will be even worse than my parents' generation because of that.

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Participant: When we were growing up, having dinner was a family thing. […] You'd sit around, you enjoy the food, you have conversation with each other. […] Whereas now […], when you go out to a restaurant, children aren't sitting there talking to their parents, they're just sitting there engrossed in iPads and phones. They're not thinking about what they're eating. […] And because they're so switched off from the whole reality, they start becoming lazy.

The *Threat of Modernity* cultural model cues nostalgic thinking about the need to return to 'the good old days' when life was easier and healthier, or to a more 'natural' way of living, as practiced by people in countries and cultures perceived as more 'primitive' or 'nature-oriented' (for example the Amish community, Peru or Italy).

Researcher: Are there any particular communities that you think have good health?
Participant: I can think of the one in America with the Amish community. You see them around, simple, horse and carriage, grow their beetroots, and they're just laughing all the time. I don't think they're laughing at each other or what they're wearing, but they make everything, you know? They do it all themselves. So, I think they're just happier.

The *Government Is Responsible* Cultural Model

Although members of the British public often assign ultimate responsibility for health outcomes to individuals, they also understand that government has a central role to play in taking care of people's health. The basic assumption that government has some responsibility for health outcomes was hardly ever questioned in the interviews; participants treated it as uncontroversial common sense.

> **Researcher**: What is the role of the government in making sure people are in good health?
> **Participant**: One part is awareness. The other part is the NHS – obviously huge. It accounts for just under a third of all government spending. So, obviously, the government is responsible for that. Anything I can't do, the government should be responsible for. I can't install a pacemaker. I can't set a broken bone. I can't stitch up a giant gash in my neck.
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> **Participant**: I think [physical activity] should be made more accessible for people to do it.
> **Researcher**: And who do you think is responsible for making that happen?
> **Participant**: It's got to be the government, but it also can be the local council, because they are the ones that got to find the budget from somewhere, same as the government, to fund for the free activities or building of certain things, like certain areas for kids to play.
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> **Researcher**: What role should the government play in health?
> **Participant**: In a nutshell, they have the keys. They have the ability to decide on where people's taxes are spent. And they have the ability to decide how many houses are built; they have the ability to decide how many jobs are created. They have the ability to decide everything – how much money is given to education, how much money is given into health care.

The Cognitive Hole of Power Relations

While people have a sense that discrimination and stigma can be a *consequence* of certain types of health problems (for example, obesity or mental health issues), they generally don't think of discrimination, racism and other types of power imbalances as *determinants* of health. Prior FrameWorks research[xii] has shown that the British public doesn't see discrimination as a cause of bad economic outcomes; in much the same way, people do not see it as a cause of poor health outcomes. The public lacks a way of making sense of systemic imbalances in power and systemic forms of discrimination; as a result, people have a hard time thinking about how inequalities in power might affect health outcomes.

Implications for Communicators:

- **The *Consumerism* cultural model allows people to see that money plays a role in shaping health but obscures important ways that wealth influences health.** Reasoning with this cultural model, people can see that lack of funds leads to poorer health outcomes. However, it remains difficult for people to see the role that social capital, access to a good education system or employment have on health. While the model provides a potential entry point for discussing how wealth inequalities shape health outcomes, communicators need to explain the fuller range of mechanisms at play to deepen public understanding of the relationship between wealth and health.

- **The *Direct Effects* and *Behavioural Constraints* cultural models provide productive starting points.** While these models do not provide ways of understanding the more complex interactions through which external factors can 'stack the odds' against individuals, they are potentially useful communications starting points. Communicators must leverage and expand these models. For instance, communicators can build on the link people already see between housing, physical environments and opportunities for physical activity by explaining the wider role that physical environments can play in shaping health (for example, by supporting social connections, facilitating employment opportunities or educational success, or reducing stress linked to safety, housing insecurity and discrimination).

- **The *Cultural Norms of Health* cultural model obscures structural inequalities and contributes to the stigmatisation of ill health.** By backgrounding the structural sources of health disparities between communities and attributing poor health to 'bad' cultures or values, the model leads people to blame communities for their own poor health. Communicators need strategies that activate the more productive models discussed above while bringing into view the ways in which social structures and power relations shape health. Such messages need to provide alternative explanations for geographical differences in health outcomes – differences that the public recognises but explains via 'cultural' differences and particularities.

- **The *Humans Are Social Animals* cultural model can help broaden public understanding of the connections between community and health creation.** While this is a recessive model, it gets people thinking about the importance of social connections in determining health. Communicators can build on this cultural model to explain how social capital and community empowerment can create health for people in the United Kingdom.

- **The *Threat of Modernity* cultural model leads to fatalistic thinking about health in the United Kingdom**. The model leads people to conclude that UK health problems could only be solved by a return to the past. Because this is an unrealistic solution, this way of thinking yields a sense that current health problems are an inevitable feature of modern life. Communicators should steer clear of arguments about the health of previous generations or the way things used to be, which are likely to cue this model and result in fatalistic thinking.

- **The *Government Is Responsible* cultural model is productive but needs reinforcement.** Because people recognise that the government has a responsibility to take care of people, communicators do not need to devote great energy towards making this point. However, this responsibility needs to be deepened to help people understand all the ways in which the government could support better health outcomes in the United Kingdom, beyond strengthening the NHS and providing better funding.

Thinking about Solutions

During the interviews, participants were able to generate a set of solutions that they thought could improve health in the United Kingdom. Each of these ideas is informed by one or more of the cultural models discussed above.

Solution #1: Education and Awareness

Participants frequently suggested that providing more information about health behaviours and raising awareness of health risks is critical to improving health in the country. This idea flows directly from *Health Individualism*. If health is determined by individual choices, then the best way for society to improve health is to provide people with the necessary information to make the right choices.[xiii] People put special focus on the role of schools in educating younger generations about health and individual responsibility, so that good habits are cultivated early in life.

> **Researcher**: What do you think needs to happen for people in the UK to have better health than they do?
> **Participant**: Better education. […] What I mean by better education is better healthy lifestyle education, better encouragement within schools to the whole active lifestyle thing, the whole diet side of things.
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> **Participant**: Obviously, the 'five-a-day' thing and the 'get up and exercise more' things in terms of physical health. Because I think that's a big thing; making the public aware – not just the people who've got the problems, just everyone generally.

Solution #2: Governmental Regulations of Commercial Practices

While participants widely agreed that the government has an important role in funding services (for example, the NHS and the education system), when asked how government could improve health in the country, people focused on placing more restrictions on unhealthy commercial practices. This solution grows directly out of the *Consumerism* model.

> **Participant**: Anything else the government could do? I would say, identify bad practice and punish it with fines. That would pretty much be it. That would pretty much be the only thing there, as far as I can see. That's having more regulations.
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> **Participant**: The sort of change that is required at the governmental level […]. It would be the wider things that are needed to encourage people to make better choices, or the infrastructure changes which will help people make better choices. It is a role the government could play very easily by just making those decisions and implementing them. […] Like, for example, a local authority may choose to not allow another fast food restaurant to open in an area which already has enough.

Participants' individualistic cultural models constrained the types of regulations they thought should be implemented. They argued that government's regulatory power should not take over individual responsibilities. Making explicit or implicit references to the 'nanny state', people explained that government should be careful not to indulge what some saw as the public's laziness and moral flaws or to encroach on individual freedom by legislating into the private sphere. These constraints placed on governmental action were more salient in discussions about the role of the central government than local government initiatives, which, as we discuss below, were perceived more positively.

> **Participant**: They should continue to try and educate and inform the public respectfully and accurately. Don't do this nanny state thing like I talked about. That's where you go too far. The nanny state would be like: 'You must go outside and exercise for an hour a day. And we're going to watch you from guard towers. And we're going to put a tag on your ankle.' But it's not implausible if you think of how I used to be able to buy a [type of] chocolate bar that I can't buy anymore, because they decided I shouldn't be allowed to choose that chocolate bar because it could make me fat.
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> **Participant**: Now we've gone nanny state with the cigarettes to too much of a degree now. They're banning television adverts, billboards and sports sponsorships. The health warnings on the boxes – the graphic pictures. Once you've seen it once, you automatically train yourself not to even think about it.

> So, it's on there. It doesn't mean anything. And now, you can't buy 10 grams of rolling tobacco or 20. You have to buy 30. You can't buy 10 cigarettes. You have to buy 20. So really, it's getting ridiculous.

Solution #3: Local Initiatives

Participants sometimes mentioned local council and community initiatives as a way to improve health in the United Kingdom. While this is a recessive solution for members of the British public – participants generally only touched on it briefly before going back to discussing individual behaviour – the idea that local authorities could effect change in citizens' lives is available to people. Similarly, drawing on the *Humans Are Social Animals* model, people can see how strengthening communities would improve health and wellbeing.

> **Participant**: It would probably be beneficial to people, especially for mental health, for loneliness issues and things like that, if they can access community projects. Not just sport. It could be book clubs. Amateur dramatics, darning projects, environmental projects.
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> **Participant**: I think these things should be done locally more. By local government and associations of people within the community. Government maybe just needs to set the direction […]. I think you need to have it as close to the people as possible.

The Cognitive Hole of Health Creation and Public Health

Members of the British public have a hard time thinking about solutions that take an integrated approach to health, across sectors and government departments. They do not see how governmental actions targeting the social determinants of health could contribute to health creation, and how government should collaborate with communities and private actors to improve health outcomes. Public health initiatives targeting the social determinants of health, like *Health in All Policies*, are simply not part of current public thinking.

Implications for Communicators:

- **When communicators talk about the role of education in improving health outcomes, they need to make it clear that they do not only mean 'health education'.** When members of the British public think and talk about *education* as a way to improve health outcomes in the United Kingdom, they only have 'health education' in mind. When talking about the long-term health benefits of a good education system for all children, communicators should be clear about what they mean by *education* and explicit about the relationship between education, life opportunities and health.

- **Communicators must expand public understanding of the role that government can play to improve health outcomes – beyond NHS funding and limited regulation of unhealthy commercial practices or environments.** Future communications need to focus on getting the public to see how government can improve health by working across sectors and departments to effectively address the social determinants of health.

- **Communicators can build on the public's positive perception of locally based solutions to address the role of community empowerment in creating health.** Communicators must pull forward this recessive and thin pattern of thinking about local initiatives and fill it in by explaining how involving communities more actively in decision-making, at the local and the national levels, can yield better health outcomes. This strategy would also allow communicators to address the importance of local initiatives without cuing concern about the nanny state.

Mapping the Gaps: Key Communications Challenges

In this report, we have reviewed how experts in the social determinants explain health in the United Kingdom and described the patterns of thinking that shape how the British public understands the topic. In this section, we identify the overlaps between these expert and public perspectives and map the gaps between them to reveal important communications challenges and opportunities.

Overlaps in Understanding between Experts and the Public

There are important points of overlap between how experts in the social determinants and the public understand health in the United Kingdom. These overlaps represent common ground that communicators can build on to impart key ideas about health and increase support for programmes and policies. Experts in the social determinants and the public share the following understandings about health in the United Kingdom:

- Health includes both **mental health and physical health**.
- **Chronic, noncommunicable illnesses** have become a key health issue.
- **Stress** plays an important role in determining health outcomes (although experts and the public are only partially aligned on the health effects of stress).
- **Social and environmental factors** can have a **direct effect** on health. For instance, poor housing conditions can cause respiratory issues for people, or workplaces can create risks for accidents.
- **Social and environmental factors**, like work conditions or housing, can influence individual health by **constraining individual behaviour**.
- There is a **causal link** between **wealth and health outcomes**, and people who are poor are likely to have worse health than people who are wealthy. (As we note below, beneath this overlap lies a deeper gap about the nature of the link between wealth and health.)

- There are **geographical disparities in health**, both within the United Kingdom and globally**.** The public is able to situate health inequalities on a map much as experts do, both nationally and internationally.

- **Government** – both central and local – has a role to play in improving health in the United Kingdom.

These are areas where public thinking is productively aligned with expert ideas. Communicators can build on this common ground to communicate key ideas from the field of public health and move public thinking in positive directions.

Gaps in Understanding between Experts and the Public

In addition to these overlaps, there is a set of significant gaps between how experts in the social determinants and the public understand health in the United Kingdom. These gaps represent key areas that must be addressed in reframing health in the United Kingdom:

1. **Type of Issue: Societal v. Individual**. For experts, health is an issue that must primarily be understood at the societal level. Experts argue that health is a product of societal systems and that solutions must, in turn, be designed at the level of society. For the public, on the other hand, health is primarily understood at the individual level: individual behaviour and choices are seen as the main source of health issues and the main site for solutions. This gap is at the root of all the other gaps between experts and the public on this issue.

2. **Good Health: Integrated Wellbeing v. the Absence of Illness**. Experts define good health broadly. For them, having a healthy society means people can experience physical and mental wellbeing, make meaning of their lives and have the sense of control needed to pursue life goals. In contrast, members of the public understand good health as nothing more or less than the absence of illness. This understanding is, on one hand, narrower than experts', since it doesn't include wellbeing in the full sense. At the same time, this understanding excludes the idea – embraced by experts – that people can be healthy even if they are ill. This deep gap around the definition of health is critical, since it produces differences in thinking about goals.

3. **Individual Behaviour: Endpoint of Causal Chain v. Source of Problems**. According to experts, individual behaviours should not be seen as the source of health issues, but rather

as the *endpoint* in a long chain of causes and consequences that produce health outcomes. In other words, individual behaviour is strongly constrained and shaped by social and environmental factors. In contrast, members of the public understand individual behaviours and lack of willpower as the ultimate source of most health issues. Getting the public to understand how deeply context shapes individual behaviours should be a key goal for communicators.

4. **Interactions between Social and Environmental Determinants: Critical v. Off the Radar.** Experts explain that social and environmental factors often interact with one another in ways that 'stack the odds' against people. While the public recognises that these factors play a role in shaping health outcomes, they don't understand how these factors interact and amplify effects. This gap leads to a fundamental underappreciation of the power of social determinants.

5. **Inequalities in Power, Wealth and Resources: Key Determinant v. Not on the Map.** Experts explain that inequalities in power, wealth and resources lie at the root of health disparities. They argue that the best way to reduce inequalities in health outcomes in the United Kingdom is to reduce inequalities in power, money and resources. The public, by contrast, is largely unaware of how discrimination, racism and other power imbalances shape health. They understand the link between wealth and health only in terms of individual purchasing power, and fail to see how economic inequality is bound up with other forms of inequality. Generating a structural understanding of inequality is a foundational task to be addressed in future reframing work.

6. **Genetics: Minor Influence v. Powerful Explanation.** Experts insist that genetics only plays a minor role in shaping current health outcomes in the United Kingdom. By contrast, the public sees genetics as a key determinant of health. In public thinking, genetics is the main factor other than individual behaviour that explains health outcomes. In other words, the public gives significantly greater weight to genetics than experts do.

7. **Health Creation: Essential v. Blind Spot.** Health creation lies at the heart of expert thinking. According to experts, societies should embed health in policymaking across governmental departments and empower communities to play a significant role in decision-making. They argue that public health efforts cannot stop at health promotion and traditional awareness campaigns, which can be counterproductive and strengthen the sense that individuals are to blame for their own health issues. Yet health creation is a blind spot for the British public. People's cultural models conspire to prevent them from

recognising that good health can be actively created, and that this must happen through community and societal actions across spheres of life.

8. **The NHS: Limited Influence v. Paramount Role**. Experts argue that the way to a healthy society is through increased investment in public services that protect and improve the health of the population over the long term. In this view, while the NHS is important, the protection of the NHS budget at the expense of other health-creating services puts the wellbeing of the population at risk. By contrast, health care and the NHS are at the forefront of public thinking about health. The public assumes that medical treatment is critical to improving and controlling health. This gap must be addressed by communicators looking to gather public support for a major shift in policy focus and government funding – away from treatment and towards health creation.

9. **Role of Government: Expansive v. Limited**. Experts argue that central and local government have a varied and expansive role to play in the reduction of health inequalities in the United Kingdom. That role includes fostering strong partnerships with the private sector, local communities and individuals; putting in place policies aimed at reducing inequalities in money, resources and power; and making health a touchstone for all policies implemented in the country, across departments (*Health in All Policies*). While the public recognises that the government has a responsibility to protect individuals from unhealthy environments, people mostly see the government's role as funding and managing the NHS, plus limited regulation of commercial practices.

Initial Recommendations and Future Research

Communicators face serious challenges in cultivating broad public support for the policies and programmes needed to improve health in the United Kingdom. While the public's understanding of health is textured and multifaceted, the most dominant cultural models make it harder for people to support meaningful change. People's understanding of health as absence of illness, and the strong association of health with medicine, focus attention on health *care* and make it hard for people to grasp what health *creation* involves. The dominant individualistic strain in public thinking undermines support for policies and initiatives that focus on the social determinants of health. And the strong focus on individual choice and responsibility contributes to the stigmatisation of ill health.

Yet these unproductive cultural models sit alongside more productive – though typically recessive – ones, which can be leveraged and expanded to shift public thinking. Communicators can potentially capitalise on the existing association between health and happiness, as well as the productive *Humans as Social Animals* model, to broaden understanding of what health is and how health creation works. Members of the public already recognise that social and environmental factors shape health outcomes in certain ways, and communicators must find ways to cue and expand this existing ecological strain in public thinking. By helping the public better understand the multiple and overlapping ways in which systemic factors shape health, both directly and indirectly, communicators can widen and deepen the public's sense of what can and should be done to address population health in the long term.

The analysis of cultural models presented in this report yields a set of recommendations about how to communicate with the public about health and the social determinants of health. As we note below, more research must be done to understand which specific reframing strategies can best address the gaps we have outlined. Nevertheless, the following recommendations offer a provisional strategy that communicators and advocates can use now to improve their communications practice.

- **Be careful when using words like 'function' and 'control'.** Both experts and the public use these words, but each group understands them differently. In the minds of the public, 'function' means not being a burden (which cues a moral interpretation of poor health), and 'control' means willpower. The public is likely to interpret brief references to functioning, and to what experts call 'a sense of control', individualistically. Communicators should either avoid using such terms or explicitly specify a broader

understanding of these concepts when introducing them, to avoid unintentionally cuing unproductive thinking.

- **Explain what you mean by *education***. This is another instance where experts and the public use the same word to refer to two distinct concepts. The public assumes that, in the context of health, *education* refers to 'health education' narrowly conceived. When communicators talk about how quality school education improves health, they should clarify that this is what they mean by *education*.

- **Avoid comparing health in the United Kingdom today to health in other times and places**. Doing this is likely to trigger the public's assumption that rising rates of ill health stem from a cultural and moral decline associated with 'modernity'. Because the ways of modernity are assumed to be irreversible, this is likely to lead to fatalistic thinking about the impossibility of improving the current situation, and to undercut the sense of collective efficacy required for people to mobilise in support of social change.

- **Don't gesture towards the importance of individual responsibility and individual behaviours**. Communicators often assume that it is wise to open a discussion by meeting people where they are, acknowledging their concerns before pivoting and making their point. For example, before explaining the importance of taking a social determinants approach, communicators might start with something like the following: 'Individuals certainly need to do their part – try hard to eat well and exercise regularly, avoid unhealthy habits like smoking or drinking, and cultivate a sense of personal responsibility for their own health. This is likely to backfire. Although this strategy aims to defuse sources of resistance, it is likely to remind people of – and actually reinforce – their default, unproductive ways of thinking. Strategic acknowledgement or countering of opposing messages works in certain cases, but communications research has frequently found this to be actively counterproductive.[xiv] Without specific evidence that it works in this context, this strategy should be avoided.

- **Avoid crisis messaging**. Rising rates of diabetes, cancer and obesity in the United Kingdom tend to be framed as 'epidemics', and strain on the NHS is framed as an 'emergency'. Both situations are frequently referred to as 'health crises'. Crisis language like this is common among communicators and advocates across social issues. This framing strategy is adopted because it captures advocates' own sense of the scope of the problem, and because it seems like this language will increase people's sense of urgency and motivation to engage. However, research in communications science, including

multiple FrameWorks research projects, has found that crisis messages typically backfire by reinforcing people's sense of fatalism. This results in lower support for solutions and rapid disengagement from the issue.[xv] Communicators should thus avoid characterising rising rates of a given illness, or strain on the NHS, as *crises*.

- **Use step-by-step causal chains to explain how social determinants affect health in the United Kingdom.** Explaining the causal links between different social and environmental factors and health outcomes is critical for expanding the public's understanding of their role. For example, communicators might explain – in a simple, step-by-step fashion[xvi] – how limited access to a good education system can 'stack the odds against someone'. Communicators must make each causal link in the chain explicit: how, for example, lack of access to a good education system leads to limited employment options; how this in turn affects people's housing conditions and nutrition; how all of these conspire to decrease individual agency; and how these conditions yield specific effects on physical and mental health. By using causal chains to explain social determinants, communicators can deepen understanding of their role. This can help defuse the power of individualistic cultural models and generate public support for initiatives aimed towards health creation across the United Kingdom.

- **Provide examples of health creation and an integrated approach to public health across sectors to broaden people's view of solutions.** Examples must illuminate the role that health-creating policies and community empowerment can play in improving health outcomes for the whole population. Communicators should make a point of discussing policy initiatives that go beyond health education and awareness campaigns (which the public already supports and recognises as important), and explain how more integrated public health strategies could help to improve and create health. Examples should be carefully created to avoid assessments of the worthiness or deservingness of specific individuals or communities. Examples of solutions should be used in conjunction with causal chains that explain how social determinants shape health, so that people can see how the solutions address the root causes of health issues.

These recommendations provide initial strategies that communicators can use to create more effective messages about health and the social determinants of health. Further research is needed to identify communications tools and strategies capable of overcoming the deepest and most challenging gaps we have identified above. The following set of tasks comprises a prospective 'to do' list for future framing research:

- **Expand the public's definition of health**. Communications strategies are needed to help the public recognise that good health is a positive state of integrated wellbeing, rather than an absence of illness, and that good health can actually be achieved in spite of illness. Cultivating this understanding is a crucial precondition of generating support for public health initiatives designed not to *treat*, but to *create*, health in the country.

- **Foster a structural understanding of how inequalities in money, power and resources shape health**. Future research is needed to develop ways of deepening people's understanding of how wealth shapes health, and to generate understanding of wealth as one of a series of important inequalities that structure outcomes for people in the United Kingdom. Generating this understanding is essential to help people see how policies aiming to reduce social and economic inequalities are needed to improve health.

- **Deepen the public's understanding of the overlapping and mutually reinforcing nature of the social and environmental determinants of health.** Cultivating a better understanding of how social and environmental determinants are causally linked and mutually reinforcing is necessary to enable productive thinking about how health in the United Kingdom can best be improved. Research is needed to ascertain how such relationships can be most effectively explained.

- **Build a sense of collective responsibility for health outcomes in the United Kingdom.** Research is needed to identify the best way of getting the public to see that responsibility for health outcomes lies with society as a whole, not just with individuals. Meeting this challenge is necessary to build public support for the policies and programmes that experts advocate for.

- **Generate public understanding of the importance of health creation and an integrated approach to public health across sectors**. Research is needed to identify the best ways of explaining how health creation and an integrated approach to public health can improve health in the United Kingdom. This is a fundamental task that is necessary to build support for both health creation initiatives and placing health at the centre of all policies in the United Kingdom.

- **Cultivate a sense of collective efficacy**. Communicators need effective ways of combating fatalism about improving health in the United Kingdom. Increasing the public's sense of efficacy – the belief that collective actions can produce real change and make a difference – is vital to increase support for the policies and programmes that experts recommend.

Addressing these challenges will require communications tools of varying types. Values are likely needed to shift attributions of responsibility for health from individuals to society, and to promote a sense of efficacy about improving health in the country. Explanatory tools – such as explanatory metaphors, explanatory chains and examples – are needed to expand people's understanding of what health is, what shapes health in the United Kingdom and how a shift in focus from health care and treatment to health creation could improve the country's health. Exemplars of integrated public health initiatives may be useful in generating understanding of this approach and raising its profile. And messengers may be valuable in shifting people's understanding of where and how health can be effectively built. Further research is needed to develop and test these types of communications tools.

Conclusion

The findings presented in this report indicate that experts in the social determinants of health and advocates in the United Kingdom face significant, durable challenges in communicating with the public at large. Effective communication requires careful attention to the default cultural models that shape public understandings of health and the determinants of health in the United Kingdom. The central finding of this report is that while the public recognises that money, community and commercial and physical environments play a role in shaping health, people nonetheless see individual behaviour, character and choices as the primary determinants of health.

This report offers an initial set of communications recommendations that can help begin to shift public thinking. These recommendations seek to leverage and expand the more productive ecological strain that already exists within public thinking, and to push individualistic forms of understanding to the background. While further research is needed to identify a comprehensive reframing strategy, the findings and recommendations presented here provide the foundation for developing a strategy capable of changing the conversation around health in the United Kingdom.

Appendix: Research Methods and Demographics

Expert Interviews

To explore experts' knowledge about the core principles of health and the social determinants of health, FrameWorks conducted 13 one-on-one, one-hour phone interviews with participants whose expertise included research, practice and policy. Interviews were conducted from May to July 2017 and, with participants' permission, were recorded and transcribed for analysis. FrameWorks compiled the list of interviewees, who reflected a diversity of perspectives and areas of expertise, in collaboration with the Health Foundation.

Expert interviews consisted of a series of probing questions designed to capture expert understandings about what a healthy society is, what types of health inequalities exist in the United Kingdom, what factors determine health outcomes in the United Kingdom and what can be done to make UK society healthier. In each conversation, the researcher used a series of prompts and hypothetical scenarios to challenge experts to explain their research, experience and perspectives, break down complicated relationships and simplify complex concepts. Interviews were semi-structured in the sense that, in addition to pre-set questions, researchers repeatedly asked for elaboration and clarification and encouraged experts to expand on concepts they identified as particularly important.

Analysis used a basic grounded theory approach.[17] Researchers pulled common themes from each interview and categorised them. They also incorporated negative cases into the overall findings within each category. This procedure resulted in a refined set of themes, which researchers supplemented with a review of materials from relevant literature.

Cultural Models Interviews

The cultural models findings presented in this report are based on a set of interviews with members of the public. To understand the British public's current thinking, FrameWorks conducted 21 in-person, 2-hour interviews with members of the public in August and September 2017 in London, Cardiff and Sheffield. Data gathered from these in-depth interviews were supplemented with material from interviews in the London boroughs of Southwark and Lambeth, conducted during the same period for a related project on obesity and the social

determinants of health for Guy's and St Thomas' Charity. Material from the Southwark/Lambeth interviews was used to confirm the patterns and tendencies identified in our primary data.

Cultural models interviews – one-on-one, semi-structured interviews lasting approximately two hours – allow researchers to capture the broad sets of assumptions, or 'cultural models', which participants use to make sense of a concept or topic area. These interviews are designed to elicit ways of thinking and talking about issues – in this case, issues related to health. Interviews covered thinking about health in broad terms before concluding with a discussion of the social determinants of health specifically. The interviews touched on prevalence, causes and effects, responsibility for the issue and solutions to it. The goal of these interviews was to examine the cultural models participants used to make sense of health, so researchers gave them the freedom to follow topics in the directions they deemed relevant. Researchers approached each interview with a set of topics to cover but left the order in which these topics were addressed largely to participants. All interviews were recorded and transcribed, with participants' written consent.

A market research firm recruited all participants, based on a series of criteria, ensuring the demographics of the sample were similar to those of the UK population. While a sample of 36 participants is too small to ensure the sample is perfectly *statistically* representative, its demographic variability is adequate to ensure the identified patterns in thinking are truly shared across different groups within the United Kingdom.[18] While larger sample sizes are needed to investigate variability *within* a population, or to allow for statistically significant comparisons between groups, the goal of cultural models analysis is to describe common ways of understanding within a population. As a result, for cultural models research, sample size is determined by the concept of *saturation*:[19] A sample is considered to be of a satisfying size when new data do not shed any further light on underlying patterns of thinking within a population. For this project, our analyses confirmed that a sample size of 36 interviews was sufficient to reach a point of saturation as far as cultural models of health in the United Kingdom were concerned, and the subsamples (UK general population and Southwark/Lambeth) were of sufficient size to allow for a measure of comparison between these overlapping groups.

The Health Foundation sample included 9 women and 12 men. Of the 21 participants, 16 self-identified as 'white' (for example, English, Welsh, Scottish, Northern Irish, British Irish), 1 as 'Black' (for example, African, Caribbean, Black British) and 4 as 'Asian' (for example, Indian, Pakistani, Bangladeshi, Chinese). Two participants described their political views as 'Labour or left-leaning (on the Left)', 7 as 'conservative (on the Right)' and 12 as 'middle of the road (moderate)'. Seven participants reported living in a suburban or rural area, and 14 in an urban area. The mean age of the sample was 39 years old, with an age range of 24 to 64. Education was

used as a proxy for socioeconomic status; 9 participants held a GCSE (or equivalent) or below, 7 had completed university studies and 5 had completed postgraduate studies. Ten were married, and 7 were parents of at least one child.

The Southwark and Lambeth sample included 7 women and 8 men. Of the 15 participants, 9 self-identified as 'white' (for example, English, Welsh, Scottish, Northern Irish, British Irish), 5 as 'Black' (for example, African, Caribbean, Black British) and 1 as 'Asian' (for example, Indian, Pakistani, Bangladeshi, Chinese). Eight participants described their political views as 'Labour or left-leaning (on the Left)' and 7 as 'middle of the road (moderate)'. All participants resided in the boroughs of Southwark and Lambeth. The mean age of the sample was 42 years old, with an age range of 22 to 59. Average annual household income ranged from £23,000 to £36,000. Seven participants held a GCSE (or equivalent) or below, 6 had completed university studies and 2 had completed postgraduate studies. Four were married, and 6 were parents of at least one child.

Findings were based on an analysis of these interviews. To analyse the interviews, researchers used analytical techniques from cognitive and linguistic anthropology to examine how participants understood issues related to health.[20] First, researchers identified common ways of talking across the sample to reveal assumptions, relationships, logical steps and connections that were commonly made, but taken for granted, throughout an individual's talk and across the set of interviews. In short, the analysis involved patterns discerned from both what *was* said (how things were related, explained and understood) and what was *not* said (assumptions and implied relationships). In many cases, analysis revealed conflicting models that people brought to bear on the same issue. In such cases, one of the conflicting ways of understanding was typically found to be dominant over the other, in the sense that it more consistently and deeply shaped participants' thinking.

Analysis centred on ways of understanding that were shared across participants. Cultural models research is designed to identify common ways of thinking that can be identified across a sample. It is not designed to identify differences in the understandings of various demographic, ideological or regional groups (which would be an inappropriate use of this method and its sampling frame).

About the Health Foundation

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

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

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

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

Learn more at www.health.org.uk

About the FrameWorks Institute

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

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L'Hôte, E., Fond, M., & Volmert, A. (2018). Seeing upstream: Mapping the gaps between expert and public understandings of health in the United Kingdom. Washington, DC: FrameWorks Institute.

Endnotes

[i] For recent studies of lay understandings of social inequalities in health, see notably Smith, K.E. & Anderson, R. (2017). Understanding Lay Perspectives on Socioeconomic Health Inequalities in Britain: A Meta-Ethnography. *Sociology of Health & Illness* 40(1), 146-170. See also Popay, J., Bennett S., Thomas C., Williams G., Gatrell A. & Bostock L. (2003). Beyond 'Beer, Fags, Egg and Chips'? Exploring Lay Understandings of Social Inequalities in Health. *Sociology of Health & Illness* 25(1), 1–23; Blaxter, M. (1997). Whose Fault Is It? People's Own Conceptions of the Reasons for Health Inequalities. *Social Science & Medicine*: *Health Inequalities in Modern Societies and Beyond* 44(6), 747–756.

[ii] For more information on the Health Foundation's long-term strategy to promote healthy living in the UK, see https://www.health.org.uk/publication/healthy-lives-people-uk/

[iii] Quinn, N. & Holland, D. (1987). Culture and cognition. In D. Holland & N. Quinn (Eds.). *Cultural Models in Language and Thought* (pp. 3–40). Cambridge: Cambridge University Press.

[iv] This expert view of health is from people working across and familiar with the social determinants of health. It includes academics and people who lead system change. This perspective is just one part of the wider discourse on the public's health. For this reason, the public are likely to be exposed to many different expert views concerning their health. This report focuses on how public understandings of health differ from those of experts in the social determinants of health, and not experts on public health more generally. The Health Foundation fully acknowledges that lived experience is a form of expert knowledge. While this couldn't be reflected in the report, they want to explore lived experience as a form of expert knowledge in the future.

[v] "A process through which evidence (of different kinds), interests, values and meanings are brought into dialogue between relevant stakeholders (politicians, professionals and citizens) in order imaginatively to understand and anticipate the effects of change on health and health inequalities in a given population". In Elliott E., Harrop E., and Williams G.H. (2010) Contesting the science: public health knowledge and action in controversial land-use developments, in P. Bennett, K Calman, S Curtis and D Fischbacher-Smith (Eds) *Risk Communication and Public Health (second edition),* Oxford: Oxford University Press.

[vi] http://www.c2connectingcommunities.co.uk/

[vii] See Crawford, R. (1984). A cultural account of 'health': Control, release, and the social body. In McKinlay, J. *Issues in the Political Economy of Healthcare* (pp. 133–143). London: Tavistock.

[viii] All participant interview excerpts have been edited to remove any personally identifying information and improve readability. To conduct the analysis, researchers worked from verbatim transcripts of the interviews.

[ix] For a discussion of health and productivity, see Herzlich, C. & Pierret, J. (1987). *Illness and Self in Society*. Baltimore, MD: Johns Hopkins University Press.

[x] For a similar, more detailed analysis of the *Mentalism* model applied to mental health, see L'Hôte, E., Fond, M. & Volmert, A. (2017). Beyond awareness of stigma: Moving public understanding to the next level – Mapping the Gaps between expert and public understandings of mental health in Colorado: *A FrameWorks Strategic Report*. Washington, DC: FrameWorks Institute.

[xi] For a historical discussion of health as a reflection of character, see Sontag, S. (1979). *Illness as Metaphor*. New York, NY: Vintage Books.

[xii] Volmert, A., Gerstein-Pineau, M. & Kendall-Taylor, N. (2016). Talking about poverty: How experts and the public understand poverty in the United Kingdom: *A FrameWorks Research Report*. Washington, DC: FrameWorks Institute.

[xiii] This pattern of thinking obscures the fact that public information campaigns designed to improve individual behaviour always benefit members of the middle classes more than poorer sections of the population, and can unintentionally exacerbate experiences of stigma and shame for people with poor health. On this issue, see, for instance, Smith & Anderson (2017); see also Herzlich & Pierret (1987), 234**.**

[xiv] In our work on criminal justice reform in the United Kingdom, we found that acknowledging the value of punishment is unhelpful, but that raising opponents' points and actively countering them can be helpful. Moira O'Neil, M., Kendall-Taylor, N. & Volmert, A. (2016). New narratives: Changing the frame on crime and justice: *A FrameWorks MessageMemo*. Washington, DC: FrameWorks Institute.

[xv] See, for examples, Bunten, A., Simon, A., Volmert, A., & Kendall-Taylor, N. (2014). The value of explanation: Using values and causal explanations to reframe climate change. Washington, DC: FrameWorks Institute.

[xvi] For advice about how to construct effective step-by-step explanations, see, for instance, L'Hôte, Fond & Volmert. (2017).

[17] Glaser, B. & Strauss, A. (1967). *The Discovery of Grounded Theory; Strategies for Qualitative Research*, *Observations*. Chicago, IL: Aldine PubCo; Strauss, A. & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, CA: Sage Publications.

[18] For a discussion of sample size for cultural models analysis, see notably Quinn, N. (2005). Introduction. In N. Quinn (Ed.). *Finding Culture in Talk: A Collection of Methods* (pp. 1-35). New York, NY: Palgrave Macmillan. See also D'Andrade, R. (2005). Some methods for studying cultural cognitive structures. In N. Quinn (Ed.) (2005) (pp. 83-105).

[19] See notably Glaser & Strauss (1967). See also Mason, M. (2010). Sample Size and Saturation in PhD Studies Using Qualitative Interviews. *Forum Qualitative Sozialforschung* [Forum: Qualitative Social Research] 11(3).

[20] Quinn, N. (Ed.). (2005).