THE EMERGENCE OF THE SOCIAL DETERMINANTS OF HEALTH ON THE POLICY AGENDA IN BRITAIN: A CASE STUDY 1980 -2003

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DEDICATION

This is dedicated to the future- my nephews, Joseph Jamal Andress and Marcus Elliotte Richard.

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I would like to thank my parents for their support and understanding in the face of what appeared to be a long and relentless quest.

In my endless journey to know myself and where I fit in humankind's efforts to be compassionate and just I believe that my parents represent action in the pursuit of justice and a concern for the well-being of the community.

It is now clear to me that the pursuit of this degree in the field that I have chosen is a continuation of my parent's search for social justice and equality in America's communities.

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THE EMERGENCE OF THE SOCIAL DETERMINANTS OF HEALTH ON THE POLICY AGENDA IN BRITAIN: A CASE STUDY 1980 -2003

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Numerous theories have been advanced in the effort to explain how a given policy issue manages to take root in the public sphere and subsequently move forward on the public legislative agenda - or not. This study examined how the social determinants of health (SDOH) came to be part of the legislative policy agenda in Britain from 1980 to 2003.

The specific objectives of the research were: 1) to conduct a sociopolitical analysis grounded in alternative agenda-setting theories to identify the factors responsible for moving the social determinants health perspective onto the British policy agenda; and 2) to determine which of the theories and related dimensions best accounted for the emergence of this perspective.

A triangulated content and context analysis of British news articles, historical accounts, and research commentaries of the SDOH movement was conducted guided by relevant agenda-setting theories set within a social movement framework to chronicle the emergence of the SDOH as a significant policy issue in Britain.

The most influential social movement and agenda setting elements in the emergence of the SDOH in Britain were issue generation tactics, framing efforts, mobilizing structures, and political opportunities grounded in social movement and agenda setting theories. Policy content or the details of the policy had comparatively little impact on the successful emergence of the SDOH. Despite resistance by the government, from 1980 to 1996 interest groups created a political understanding of the SDOH utilizing a framing package encompassing notions of inequality, fairness, and justice. This frame transmitted a powerful idea connected to a core set of British values and beliefs. After 1996, a shift in political opportunities cemented the institutional arrangements needed to sustain an environment conducive to the development and implementation of SDOH policies and programs.

This research demonstrates that the U.S. emergence of the SDOH on the policy agenda will depend upon: 1) U.S. ideals and values regarding poverty, inequality, race, health, and health care that will determine issue framing; 2) political opportunities that will emerge - or not - to advance the SDOH policy agenda; and 3) the mobilizing structures that support or oppose the issue.

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CHAPTER 1: STATEMENT OF THE PROBLEM

Introduction and Significance

In the history of Western civilization, depending on the time period and prevailing political ideology, various theories were promoted to explain the etiology of disease.[1]

Society's quest for health has resulted in various perspectives on the causes of disease that have captured the attention of governments throughout the centuries by identifying the factors would explain how to either achieve healthy outcomes or eradicate the causes of disease. In this research, the health perspective under study is called the social determinants of health (SDOH), a population health-centered theory that concentrates upon societal factors to explain variations in health status within populations.

With a focus on the emergence of the social determinants of health, this study examines how the SDOH came to be part of the legislative agenda and health policymaking in the United Kingdom.[a] Three different agenda setting models set within a social movement framework are used to examine the question.

The ultimate goal in framing priorities and proposals for the policy process, sometimes referred to as legislative agenda setting, is bringing a problem to the attention of the legislative body and convincing them that they must deal with that issue. However, while winning a place on the legislative agenda may be the summary goal, the term agenda setting itself refers to a multiplicity of methods and agendas (the public, the media, and the legislative system) all of which play interactive roles in advancing the disposition of an issue towards policy action or inaction.

[a] Hereafter referred to as the U.K. or Britain.

Researchers studying legislative agenda setting have advanced several models that seek to answer the question of why some issues or perspectives eventually achieve governmental agenda status and others do not? In the pursuit of an answer to this question, they may study a variety of contributing factors. The possible areas of agenda setting research include an analysis of media influence on other the media, the public, and policymakers; public influence on the public, the media, and policymakers; and policymakers' influence on policy, the media, and the public.[2]

Media-agenda setting studies conceptualize the mass media news agenda as the dependent variable under study.[3] Public agenda setting studies analyze the importance of issues to members of the public as the main dependent variable of the study.[3] Finally, policy agenda setting studies examine the issue agenda of governmental bodies or elected officials as the main dependent variable of the study.[3] In this study, agenda setting is taken to mean policy agenda setting-raising an issue or perspective to the status of a public issue so that it eventually achieves a position on the legislative agenda.

Agenda setting turns on the desire and ability of issue advocates, or policy elites to convince a series of audiences that a condition or issue is a social problem or that one particular method, approach, or scheme is a desirable solution.[4] In the case of this analysis, where the emergence of the SDOH onto the policy agenda is examined, the question is what factors in the agenda setting process influence whether this health perspective modeling casual factors in health and disease becomes a practicable and influential driver of the legislative agenda?

Gaining a spot on the policy agenda is seen as one effective way to convince policymakers to use a new health perspective as the foundation for subsequent health policies and regulations. With sufficient momentum among key interest groups and other audiences policymakers will feel authorized to pursue policies that address the social determinants of health.[5]

The primary purpose of this dissertation is to identify the key factors behind the most successful case of a particular health perspective not only achieving priority on the legislative agenda of a western industrialized government but also shaping policy initiatives in a number of areas and systems. The principal objectives of the research are: 1) to conduct a social and political analysis to uncover the factors responsible for moving the social determinants health perspective onto the public agenda in Britain; and 2) to determine whether these factors can be accounted for with existing agenda-setting models and theories.

Advancement of a policy agenda for the social determinants of health means that interest groups and policy elites that traditionally support health issues will implement strategies and tactics designed to command the attention and action of policymakers. This analysis will provide new information on the factors most important in legislative agenda setting. Further, the study will assess the existence of agenda-setting factors particular to the social determinants of health. Most studies on the social determinants of health seek to ensure the soundness of the theory itself by relying principally on epidemiological evidence.[5] In contrast, this investigation seeks to understand the socio-political factors that account for when and how a SDOH perspective succeeds or fails in shaping national health policy

irrespective of the accumulated evidence of thirty years of valid research and knowledge demonstrating a positive correlation between social determinants and health outcomes.

Purpose and Aim

The overarching study objective as mentioned earlier is to identify the key factors that affect when a social determinants of health perspective assumes a place on the national legislative agenda. This objective is achieved through an analysis that relies upon key concepts in three different agenda setting models organized within a social movement framework. The social movement framework allows each agenda setting model to be analyzed for its ability to detect, scrutinize, and account for: 1) how an issue is generated and propelled (or not) onto the agenda; 2) the openness of a given political system and the influence of political opportunities; 3) the characteristics of the groups that mobilize around an issue; and 4) how society thinks and feels about a given issue including its values and ideologies.

Based on a review and synthesis of the literature on social movements and agenda setting, this analysis begins with the following explicit questions that draw upon concepts and themes from these areas.[6]

1. Does agenda setting for a social determinants perspective depend on the method of issue generation defined either as outside initiative, as mobilization or as inside access?
2. Does agenda setting for a social determinants perspective depend on political opportunities which includes the openness of the political system, the presence of state repression, and the social changes in institutional structures or informal power

relations of a given national political system that make the system more receptive to challenge?

3. Does agenda setting for the SDOH depend on the characteristics of mobilizing structures and on the impact of external opportunities on structures and resources?
4. Does agenda setting for the SDOH depend on framing processes which includes the cultural toolkit[b] of a jurisdiction, framing strategies, frame packages, the structure and role of the media and the goal of the framing tactics?

The elements to be examined from the research questions (political opportunities, mobilizing structures, framing processes) are meant to represent the three broad factors utilized to analyze social movements.[6] Political opportunities will take into account the features of the political context and how they operate as barriers or facilitators. The forms of organizations active in the movement including political parties, advocacy groups, and/or citizens groups will be accounted for with mobilizing structures. The ways in which societies interpret, construct, and attribute collective experiences is considered in the analysis of framing processes. Last, how an issue moves beyond a small cluster of individuals or community of interest is analyzed with the concept of issue generation.

A descriptive content analysis of British news articles, historical accounts, and research commentaries of the SDOH movement was conducted guided by relevant agenda-setting theories set within a social movement framework to chronicle the emergence of the SDOH perspective in Britain. A triangulation of data sources and evidence and a context

[b] The attributes of groups or societies that shape how they classify, evaluate, and assign meaning to understand experiences. These attributes include shared values, codes of manners, dress, language, religion, rituals, norms of behavior, and systems of belief. More generally, the cultural toolkit includes a set of distinctive spiritual, material, intellectual, and emotional features that a society uses to interpret experiences.

analysis of the British sociopolitical environment confirmed the impact of alternative agenda-setting factors in influencing the emergence of SDOH as a significant policy issue in Britain.

An intended product of this dissertation is an account of the social and political factors that acted to constrain or facilitate the emergence of the SDOH in Britain. Subsequently, this detailed explanation will be the basis for the development of a general theory on the major social and political factors that may exert an influence on the emergence of the social determinants health perspective in the United States.

CHAPTER 2: THE GOVERNMENT AND PRINT MEDIA IN BRITAIN

Background

This section reviews political arrangements and systems of the U.K. including an examination of the role of the media, how pressure groups influence policymaking, citizen participation, and the governmental system. An understanding of these systems as they function in the U.K. provides a context for understanding later discussions and explanations of agenda setting tactics for the SDOH in the U.K.

Institutions and Political Arrangements

The traditional political model for the government in the United Kingdom is said to be based upon the Westminster model.[7] However, as will be discussed later, it is believed that methods of governing since the late 1970s lean towards practices which may no longer sustain the Westminster model.[7]

In its most simple version the Westminster model means that all power or sovereignty is concentrated in the Westminster Parliament. There is no written constitution; instead, the relationship between the State and the people relies on statute law, common law and conventions.

The U.K. Parliament makes primary legislation (other than for matters devolved to the Scottish Parliament and the Northern Ireland Assembly) and is the highest authority in the land. It continues to have the supreme authority for government and law making in the U.K. as a whole. The executive comprises the Government (members of the Cabinet and other ministers responsible for policies); government departments and agencies; local authorities; public corporations; independent regulatory bodies; and certain other

organizations subject to ministerial control. The judiciary determines common law and interprets statutes but makes no pronouncements regarding Parliament and its laws and decisions.

The U.K. Parliament is based on a two-chamber system. The House of Lords and the House of Commons sit separately and are constituted on different principles. However, the legislative process involves both Houses. Parliament has three main functions:

- To examine proposals for new laws;
- To scrutinize government policy and administration;
- To debate the major issues of the day.

Constitutionally, any law may be overturned by a majority in Parliament demonstrating that state power is at the center.[7] Theoretically, legitimacy and democracy are maintained because ministers are answerable to Parliament and the House of Commons is elected by the people. Key policy decisions are made by the Cabinet and implemented by what is described normatively as a neutral Civil Service motivated by the public good.[7]

About 20 ministers (the number can vary) chosen by the Prime Minister sit in the Cabinet; these may include both departmental and non-departmental ministers. The Cabinet balances ministers' individual duties with their collective responsibility as members of the Government and takes the final decisions on all government policy.

The Cabinet meets in private and its business is confidential, although after 30 years Cabinet papers usually become available for inspection in the Public Record Office at Kew, Surrey.[8]

Normally the Cabinet meets weekly when Parliament is sitting, and less often when it is not. Cabinet Committees take some of the pressure off the full Cabinet by settling issues among smaller groups of people or at a lower level, or at least by clarifying them and defining points of disagreement. Committees let those ministers most closely concerned make decisions in a way that ensures that the Government as a whole can accept full responsibility for them. This delegated responsibility means that Cabinet Committee decisions have the same formal status as those taken by the full Cabinet.

While the Westminster model provides basic important information about the British system of government Richards and Smith[7(p. 48)] label it a "legitimizing mythology" to justify how the elected official and civil servants view themselves. In this myth, the public does not have necessary information to make informed decisions. Accordingly, a closed, secretive system of governing is welcomed as necessary and justified based upon governmental assurances of honesty and pledges of belief in and adherence to a public service ethos.[7]

For the last thirty years, political scientists have tried to map the changing state of the British government that gives challenge to the Westminster model. Rhodes's[9] differentiated polity model provides an organizing framework with which to capture the changes to the system. The key features of the differentiated polity are governance; intergovernmental relations; a segmented executive based upon functional and institutional specialization; policy networks and fragmentation of policies and politics; power dependence; and a hollowed-out state.[7] The hollowed-out state refers to a period from about the mid 1990s to the early 2000s when the domination of a new deconstructionist philosophy overtook the U.K. public sector based upon beliefs regarding the private sector's superiority over the

public sector. This resulted in the dismantling of large public bureaucracies and their emergence as a number of smaller bodies in contractual and market-type relationships with each other.[10]

Governance in the differentiated polity means governing without the aide of the government or more control over a smaller range of areas.[7] This idea is also displayed in notions of the enabling state where government creates the conditions under which other organizations can prosper as opposed to big government present in all spheres.

Intergovernmental relations is an indicator of the broad range of state and international actors that the British government now has to interact with including public-sector organizations, the European Union, and local governments. Relations are also marked by strong associations between public, voluntary, and private sectors where their interests, and organizations have become intertwined so much so that the state may not be able to demarcate itself.[7]

The segmented executive denotes the extent to which the British system of government has become highly fragmented or compartmentalized with departments forwarding their own interests locked in battle for resources. The challenge has been to achieve cooperation across departments especially with regard to cross-cutting issues.

Policy networks in the differentiated polity model denote the extent to which the British government interacts with civil society, especially interest groups within any given policy area. Organized through a formal mechanism called consultations, according to Peele[11] pressure groups have long been a part of British governmental departments included in policymaking issues and even in some cases executive aspects of government.

The official website for the British government describes consultations as a regular and integral effort to involve the public in the work of government.[12] The expressed goal is to make policies more effective by listening to and taking on-board the views of the public and interested groups. All consultation documents follow the Cabinet Office's code of practice. These guidelines help to ensure that a common standard exists across government for consulting the public.

Jordan et al.[13] indicate that most British departments of government welcome group pressure and identify with a policy community or group of organizations organizing them to support their plans if needed. Consultations with interest groups declined a little after 1979 under Margaret Thatcher but were reinvigorated to a certain degree under the New Labour Party after 1997.

In the differentiated polity model, all parts of the British executive system are dependent on one another, which explains the notion of power dependence. Relations between units are based on a series of exchanges where each unit or actor possesses resources that can help the other.[7] Ministers rely on civil servants for expertise and guidance while civil servants need ministers to act as champions to defend, promote and obtain resources from the Prime Minister, Treasury and/or Cabinet.

Despite the notion of power dependency, there are some trends worth noting regarding a shift in relations between civil servants and ministers. According to Richards et al.[7] ministers seem to have assumed a more proactive policy role perhaps based on the increased complex and fragmented policy arena. Next, the balance of power between ministers and civil servants has shifted giving ministers slightly more power using outside

sources for policy advice.[7] The number of special advisers (political appointments paid for by the taxpayer) has always fluctuated but increased significantly since the Labour government in 1997.[7] It also appears that advisers seem to be either policy types or public relations experts.[7]

The hollowing out of the state is used to describe many of the changes that have taken place and continue to occur in British government.[7] Central government's authority and autonomy have been dispersed and condensed either upwards to the international level, outwards through privatization, or downwards through the creation of quasi-autonomous non-governmental organizations called quangos or non-departmental public bodies (NDPB).[7] This has lead scholars to question the core executives' capacity to control the policy process.

Pressure Groups

According to Grant,[14] interest groups lie at the heart of Britain's political system. Grant[14] lays out a series of claims to characterize these organizations which he labels pressure groups: they are only one, but not the most important means to secure social change; they reflect organized interests; they are distinct from political parties; they seek as one of their goals to influence the formulation and implementation of public policy; and, their purpose may be either singularly political or service oriented with involvement in political action as necessary from time-to-time.

The second half of the twentieth century was the best time for pressure groups in the U.K. As the British government built and expanded the welfare state based upon Keynesian theories, the government welcomed their expert advice and needed their informed consent.[14]

Throughout the 1950s and 1960s an even closer relationship developed between government, business, and the unions.

Of note is the increase in non-traditional pressure groups in the 1970s. The number of environmental groups quadrupled and other new cause groups grew and surpassed in number the established interest groups.[14] Many of these new groups were less respectful of entrenched traditions, preferring direct action tactics over the quiet persuasion that has historically characterized the relationship between Whitehall and interest groups.[14]

Upon the election of Margaret Thatcher as Prime Minister in 1979 the approach to pressure groups shifted to a new set of alliances that did not include the conventional interests that had held sway over government since the 1950s. However, even at this time relationships between groups and the government at the departmental level remained relatively the same.[14] The shift in alliances during Thatcher's government was brought about due to the government's view that the market, and not the state, is responsible for public goods and therefore the advice and consent of rational interest groups was no longer required.[7]

The Thatcher government's express desire was to establish a direct link between individual voters and a sovereign Parliament rather than work through interest groups.[7] The government was suspicious of groups and blamed them for "overload and un-governability".[7(p. 179)]

Traditionally, the relationship between the state and groups in Britain has been said to rest upon corporatism.[7] Defined as a specific type of relationship between groups and government, corporatism occurs where the leaders of high resource pressure groups become

incorporated into the policy process and involved in the development of policy.[7] Further, these functional interest groups and state agencies are involved in a closed process of bargaining over public policy to the exclusion of other interested groups.[7]

Some researchers regard corporatism as an important element in the development of the postwar British state as a result of the need to resolve and contain conflicts between business and labor.[7] Still others have found the notion of policy networks to be a more realistic way to describe the relationship between the state and groups.[7] Under this theory, institutionalized government-group relations are a core feature of the modern British state but the nature of relationships between groups and the government varies between stable, strong and closed relationships and weaker more pluralistic interactions.[7]

With the return of the Labour government under Tony Blair in 1997 the close relationship with big business and to a lesser degree with trade unions was re-established. However, a return to the relationships reminiscent of the 1960s did not occur. According to Grant[14], and as explained by Tony Blair upon his election, the politics of production under corporatism was replaced with collective consumption which distinguished actions and policies that pursued a broader public interest. This was meant to carve out a path between Thatcher neo-liberalism and traditional social democracy.

Grant[14] advances a typology to classify pressure groups based upon strategies called the insider/outsider group division. Insider groups are considered legitimate by the government and are part of the formal consultative process used at the departmental level to obtain advice and counsel on policy issues.[14] Alternatively, outsider groups either do not wish to be legitimized by the state or are unable to gain such recognition.[14]

In order to be an insider group, organizations must operate under certain rules and constraints that outsider groups may find restraining. Insider groups have typically built a reputation of providing reliable and accurate information. These groups can talk the language of the civil servants, and negotiate and accept the outcome of the consultation process.[14]

However, the insider/outsider typology has been challenged. Grant[14] identifies the following criticisms: achieving insider status is not that hard because groups may easily be put on a department's consultative list but have minimal impact on policy formation; groups are more constrained in their choice of strategy than the typology implies due to the interaction between the group's goals, their acceptability to decision-makers and the strategy it pursues; it is possible for groups to pursue both an insider and outsider strategy; and, because of new forms of politics in Britain since the 1990s the typology may no longer be valid as there are more political arenas and direct action by protest movements is seen as more legitimate.[14]

Grant[14] asserts that there is no one route used by groups to exert influence. Evidence bears out extensive contact between the executive braches of government and pressure groups during the development and implementation of policy[14]. The four Cs of insider pressure group politics advanced by Grant[14] are: consultation with recognized interests; consent by the interest groups consulted on the decisions of the government; cooperation by the groups in the implementation process; and, continuity as a shared interest between the government and groups in policymaking. Clearly, this process benefits insider groups while outside groups have alternative paths including the media, the courts or private members' bills in Parliament.[14]

Most insider groups will first pursue their interest in discussions with the executive branch or ministers and civil servants as opposed to Parliament.[14] The formal process of consultation that brings groups inside usually begins with a department sending out a proposal for comment to a range of groups. Lists are maintained for the purposes of circulating documents. The civil service believes it better to over consult than to under consult.[14]

Essentially, the chief way that powerful interests have influenced policy-making in Britain may be characterized as bureaucratically.[15] Grant[14] also stipulates the importance of resources to groups and a relatively large, well-paid staff of at least eight people if the group intends to engage in detailed monitoring of legislation, establish relationships with civil servants, and make attempts to influence the content of legislation through the development of detailed reports.

Another key strategy of interest groups in Britain is sanctioning or the use of political strikes such as one staged by the Ultser Workers' Council in May 1974 which paralyzed Northern Ireland for two weeks.[14] However, the use of strikes by trade unions was severely curbed in 1979 by the Conservative government with very little reaction from the public who had had its fill of the inconvenience.

Secondary routes to influence policy, other than through the media, and the executive branch, include Parliament, the political parties, and the courts.[14] However, Grant[14] warns that that taking the policy making process as a whole Parliament is not a major point of contact and the courts are utilized with much less frequency than in the United States due to stricter rules on legal standing.

Grant[14] acknowledges the importance of public attitudes and opinions to interest groups defining attitudes as deeply held perceptions that structure an individual's responses and change slowly or with crisis situations. Opinions, on the other hand, according to Grant[14] are more superficial and may reflect deeply held beliefs or be spontaneous reactions to the times.

Grant[14] believes that while interest groups will try to influence public opinion, more likely than not, any benefit received from public opinion will occur due to a change in factors external to and not caused by the interest group. Rose[16] is more explicit in his theory on interest group efforts to gain public support presenting six points on a continuum to represent the level of congruence between the group's goals and wider cultural norms: 1) harmony between pressure group demands and general cultural norms; 2) a gradual increase in the acceptability of political values supporting pressure group demands; 3) bargaining with fluctuating support from cultural norms; 4) advocacy in the face of cultural indifference; 5) advocacy in opposition to long-term cultural trends; and 6) conflict between cultural values and pressure group goals.

Citizen Participation

In 1983, Parry et al.[17] began to study British political participation with a view toward examining regular, day-to-day patterns of citizen political activity as opposed to simply voting in general and local elections. The study encompassed a national citizen survey, a community citizen survey in six localities selected to cover a range of typical communities, a series of elite studies across the six localities, and a series of in-depth semi-structured interviews with key members of the elite in each locality.

Parry et al.[17] asserts that the term participation came to the forefront of the British democracy in the 1960s and has remained an important part of the political language of the country.

The rise in citizen participation is attributed to a theory on "post- materialist values" which contends that as the material well-being of the citizens of an advanced society increases, people will turn their attention to other types of political issues[17(p. 25)]. They become less concerned with policies for economic advancement and more with problems related to material progress including environmental issues, open government or participation itself.[17] These tendencies are found generally in the affluent and young and fall outside the traditional party platforms thus calling for new forms of participation other than voting.[17]

As in other countries, participation in Britain is revealed to be multi-dimensional. Citizens are not shown to be doing more or less but rather, to the degree that they acted at all, they tended to have taken one type of action-protest march or called a councilor.[17] Moreover the form of participation or extent is not just based on individual or group enterprise. Participation is also affected by structural opportunities and the level of encouragement offered by the political elite.[17]

For about half the British population political activity is limited to voting in elections.[16] Balancing this out is approximately a quarter of the population that is comprised of a body of activists who contribute a significant proportion of the political activities. The most inactive 25% of the population only undertake just over two actions each and their share of the pie is a mere 12.8%, which is half their proportionate size in the adult

population[16]. Alternatively, the active quarter of the population contributes political activities almost double their proportionate share in the pie at 43.4%.[17]

In an examination of agendas and participation Parry et al.[17] asserts that citizens take action in response to issues, their needs, and problems prompted by some dissatisfaction with their circumstances. To derive the outcomes for this part of the study Parry et al.[17] asked respondents in an open-ended question to list the issues, needs or problems which people might consider taking action on. Their aim was to get the respondents to think in terms of issues that might invoke some kind of action in the political or public realm.

The authors begin by visualizing a continuum with spontaneity on one end counterbalanced by mobilization on the other. In the middle of this spectrum is "reactive" participation where the individual's agenda is set by the action of others that may include an organization or political elites such as political leaders and groups[17(p. 242)]. Accordingly, the researchers advance the notion that agenda setting is not a one-way process where citizens influence elite or political agendas, but also a process where elites influence the agendas and actions of citizens.[17]

Another theory of Parry et al.[17] is that the public agenda does not always depend on context. For instance, in 1984 when the research was conducted the British news was dominated by a miner's strike, bitter negotiations, and unemployment levels of over three million. Parry et al.[17] admits that a public survey on pre-dominate issues would pick-up these topics.

However, the claim supported by research indicates that there is another public agenda not tied to context or time operating below the level of the big national issues. This

sub-stratum of issues and problems represents the agenda that is most pressing to ordinary citizens and what that they will take political action on Parry et al.[17] asserts. On the other hand, Parry et. al (1992)[17] says that these issues, while unique to the individual and related to circumstances, engender more limited patterns of action and reaction that do not change frequently.

The most interesting data to come out of the survey to support the lack of continuity between the so-called "national agenda" and the sub-stratum is the disparity between their survey data and the content of opinion polls in newspapers at that time in Britain. In this period the polls reported the most pressing problem facing the country was unemployment, followed by strikes and other economic issues[18(p.94-5)]. However, the data of Parry et al.[17] revealed a broader range of concerns that the citizens felt they might take action on.

There was no one dominate concern and while all economic issues, including unemployment, comprised one quarter of the issues, the agenda ranged in nature from immigration to higher education, housing repairs, health and hospitals, the environment and transportation. Parry et al.[17] concludes that there is a connection between action, the issue and scope of issues so that more personal issues tend to be cited as important and for most action to be taken on these issues. The researchers believe that this may be tied to the public's perception of the difficulty of influencing broader systems of decision-making that involve national or international action[17].

Last, Parry et al.[17] examined whether the public agenda represents the interests of a broad range of citizens or is shaped instead by a few sectors of society. It was the case that the more active persons in the community were also those who raised a high proportion of

the issues. However, Parry et al.[17] found that those issues were representative or did not differ from those of the less active part of the population.

The Media

British mass-circulation papers have historically been politically committed journals of opinion as opposed to objective print sources of record.[19] In most cases, there is very little doubt as to the political or even, in some cases, party-political slant of the newspapers.[19]

On the other hand, British television is committed to balanced and impartial broadcasting.[20] Balance, in practice in Britain, does not mean objectivity but rather treating the major political forces in the country with a degree of equality.[20] The genesis of this equality dates back to the wartime coalition government and a political bargain struck by the parties to avoid a major political fight for the control of broadcasting.[20]

Balance under equality has been redefined many times since then. In 1987 for the first time since the 1950s it was defined as exact equity for each of the three party groups: Conservative, Labour, and Alliance where each party received equal time on Television. The inter-party committee generally recommends the ratios of free advertising time (the PEBS or Party Election Broadcasts) to be offered to each party. News editors, under no legal obligation to accept these rations, apply them to news bulletins and lead stories.[20]

The choice of print news sources in Britain is extensive and varied (see Table 1). That the papers are biased is easier to see from the table set out below which clearly indicates the type of paper, readership characteristics, and the preferred election results based upon political party[20(p. 24)].

Table 1: Print News Sources in Britain

Paper	Type[c]	Readership (Millions)	Preferred election result[d]
Sun	Lowbrow	11.3	Conservative
Star	Lowbrow	4.0	Conservative
Mirror	Middlebrow	9.0	Labour
Mail	Middlebrow	4.5	Conservative
Express	Middlebrow	4.4	Conservative
Today	Middlebrow	1.0	Coalition
Telegraph	Highbrow	2.8	Conservative
Guardian	Highbrow	1.5	Labour
The Times	Highbrow	1.2	Conservative
Independent	Highbrow	0.8	No endorsement
Financial Times	Highbrow	0.7	Conservative

In modern Britain six publishers account for 80 percent of all daily, Sunday, and local newspaper sales.[20] According to Miller[20(p. 203)] the "largest selling newspapers in Britain are owned by swashbuckling businessmen who do not hesitate to interfere with the editorial

[c] The type of paper refers to the content and journalistic style of the newspaper. Highbrow refers to the characteristic of being intellectually superior.[109] A highbrow paper would only deal with subjects deemed serious in an intellectual manner. Alternatively, a lowbrow publication would handle subject matter deemed unsophisticated or trivial and not requiring intellectual effort to be understood or appreciated.

[d] Conservative papers support that British political party and its ideals. In contrast, Labour papers support that party and are considered "left-leaning" publications.

content of their papers and whose personal politics are so well known to all their staff that the proprietors can set the tone of their employees' work with out crude, direct, and explicit interference". However, proprietors do act directly to influence newspaper content.[20]

Unlike the U.S. press, where papers serve geographically defined communities, "the British press operates on a national scale and serves social groups or campaigning proprietors rather than complete communities".[20(p. 211)]

Miller found that very few respondents who found politics uninteresting read a highbrow paper. The more politically interested people were, the more they read highbrow papers and listened to Radio 4[20]. The best predictor of reading a left-or right-wing paper was whether the reader was inclined to the left or right.[20] Education had a smaller and more variable influence, particularly on the choice of a right-wing Sunday paper.[20]

Channel choice was the least predictable aspect of television news viewing according to Miller.[20] Age, interest in politics, strong partisanship, and a desire for guidance all facilitated high levels of news viewing, while education encouraged low levels.[20] There was a consistent but slight tendency for the better educated to prefer BBC Radio 4 news and avoid breakfast, lunchtime, early evening, and regional television news.[20]

Reading highbrow newspapers and listening to highbrow radio news correlated strongly with age, interest in politics, and education.[20] As said earlier, the audience for highbrow television was influenced by age and political interest but not by education. Overall, media use motivations had surprisingly little influence on media choice though guidance seekers watched TV more and read highbrow papers less.[20]

Assessing the state's capacity for censorship of the media Miller[20] says that the modern British government is intellectually committed to limited government and political pluralism. However, because they retain some traditional authoritarian instincts, at times impartiality is not even welcome.[20] In comparison to more authoritarian regimes, the "British government makes relatively little use of suppression and censorship, though they do suppress some information and they do sometimes censor the media, especially on defense and security matters".[20(p. 201)]

More often, as opposed to censorship, the British government will try to influence the media to their advantage by the selective release of carefully timed and adjusted information and by threatening retaliation and intimidating staff.[20] Punishment for nonconformity takes the form of denying access to cabinet members, holding down the BBC licensing fee, appointing people to control both the BBC and commercial broadcasting, or stimulating the public to accuse the broadcasters of bias.[20]

In 1987 Miller[20] found that the strongest allegations of media bias were leveled at television which was according to his research, the most balanced and impartial element of British media. Conservative politicians labeled the BBC as having a left wing bias and academic sociologists alleged anti-trade union and a pro-right wing bias.[20] Research on media bias at that time reported mixed results reflecting the prevailing political sentiments. In fact, the British television news had not achieved its goal of perfect impartiality in absolute terms.[20]

However, in relative terms, Miller[20] asserts that British broadcasting comes closes to the "Public Service Ideal" which favors political access, variety, debate and freedom from

government interference facilitated through specific mechanisms based upon public regulation.

Implications

The history of the SDOH issue in the U.K. is long and extensive. On the other hand, it is not clear whether the amount of time that the SDOH has been studied in the United Kingdom is the single most relevant factor in its advancement onto the public and legislative agenda.

In comparison, there is a quiet underswell in the United States to advance social determinants of health perspective under the guise of a racial health disparities framework. However, these efforts have a long way to go before one can say that a more robust perspective on the SDOH has been integrated into the realm of health policymaking in the U.S.

This case study on the factors that affected the establishment of a legislative agenda for the social determinants issue in the United Kingdom will illustrate the sociopolitical factors that must be considered to advance the issue. The analysis should provide insight as to how the issue might evolve in the United States.

CHAPTER 3: THEORETICAL FRAMEWORK

Agenda Setting and Social Movements

In order to examine the key factors likely to affect whether the social determinants of health issue attains a position on the policymaking agenda of a given political jurisdiction this research utilizes two models of agenda setting that draw upon traditional models of agenda setting plus a single theory on social problems using a social definition approach. All three of these (models and the theory) will be referred to as agenda setting models. The agenda setting models provide a perspective to help examine this question by identifying and explaining crucial variables that affect agenda setting, the tasks they perform, and the sequences in the agenda-setting process required to catapult an issue onto the public agenda.

A dilemma is presented at the outset when trying to analyze crucial variables that affect agenda setting based upon three models. Depending on the orientation and discipline of the researcher, agenda setting models tend to emphasize to a greater extent isolated features of the process. With such a wide variety of agenda setting theories, each emphasizing different elements of the process, it becomes apparent that a framework is needed to examine crosscutting features of each model. After examining the profusion of theoretical and empirical work on social movements from various countries and theoretical traditions from the early 1960s to the present McAdam et al.[6] abstracted several concepts that may be of service in this instance.

Borrowing three crosscutting elements from McAdam et al.,[6] and adding one additional descriptor, the result is a comparative diagnostic framework comprised of four elements that will be used to examine common and unique attributes of the three agenda

setting models. What follows in narrative form and in Table 2 is a brief description of each of the elements that make up the comparative diagnostic framework: 1) primary mechanisms for issue generation, 2) political opportunities, 3) mobilizing structures, and 4) framing processes.

Table 2 below lists the diagnostic elements and related dimensions taken from the social movements concepts advanced by McAdam et al.,[6] and used to analyze the agenda setting models. What follows is a description of each element.

Table 2: Diagnostic Elements and Dimensions

Key Elements	**Primary Mechanisms for Issue Generation**	**Political Opportunities**	**Mobilizing Structures**	**Framing Processes**
Dimensions	Outside initiative; Mobilization; Inside access	Openness of formal political system; Stability of elite alignments; Presence of elite allies; State's capacity for repression	Types of structures; Impact of external opportunities on structures; Key mobilization resources	Cultural toolkits available; Framing strategies employed; Frame packages deployed; Structure / role of the media; and Goal of framing package

Primary Mechanisms for Issue Generation

Of the various activities and venues that might be used to move an issue into the policymaking arena which are emphasized in the agenda setting model? The work on agenda setting that came out of political science research developed several models that may be classified as either 1) outside initiative, 2) mobilization, or 3) inside access.[21] The outside

initiative model of agenda setting focuses upon nongovernmental sources of policymaking and the efforts of individuals or groups to convert their concerns into a larger movement.[21] Mobilization theories, in comparison, examine how public officials initiate a campaign to move to the legislative agenda using public support.[21] Finally, agenda setting models that explain how issues gain access to the legislative agenda, without accessing the public agenda, are called inside access theories.[21]

Political Opportunities

Changes in political opportunity make a difference in the effectiveness of social movements. McAdam et al.[22] identify political opportunities as the social changes in institutional structures or informal power relations of a given national political system that make the system more receptive to challenge.[22] Dimensions of this element measure: the openness of the formal legal and institutional structures of a political system; the stability and presence of informal power structures such as elite groups that form alliances (i.e., teacher's unions and the Democrats in the U.S. context or the media); and the state's capacity for repression.[22] Elements of political opportunity can affect social mobilization by sending consistent, if not formal or permanent, signals to social and political actors that can strengthen or discourage the groups' resolve to marshal resources and take action.[22] Signals of political opportunity include: the opening up of the political process; unstable alignments as represented by electoral instability and by changing support for government; the appearance of influential allies; and conflict within and among elites.[23]

Mobilizing Structures

A thorough examination of mobilizing structures seeks to: specify the various types of mobilizing structures; examine the impact of external opportunities on mobilization structures; and identify the key resources that shape mobilization.[24] The central analytic question is which ecological elements shape the movement's forms and activities. Mobilizing agents, in democratic societies, may be classified into three types. The types are social movements, interest groups, and political parties.[25]

They all serve to promote collective interests in an effort to influence political decision-making and social change. Interest groups and political parties are formal organizations. This is in contrast to social movements that typically lack formal rules defining membership and an internal regulatory process. The ideal form of a social movement is a network of more or less informal groups that are not formally and hierarchically coordinated.[25]

Rucht et al.[25] goes on to analyze the features of each mobilizing group examining the mode of operation, primary resources, and structural features. Social movements and interest groups are said to use either protest actions or representation of members in politics as modes of operation.[25] The main resources for social movement groups are their committed supporters. In contrast, interest groups have as resources expertise, money, access to decision-makers, and the refusal to cooperate.

Framing Processes

McAdam et al.[22] define framing as the conscious strategic efforts by groups to create shared understandings of the world and of themselves that justify and provoke collective

action.[6] Dimensions of importance in framing include an examination of: the ideational themes or cultural toolkits available in a national context; framing strategies employed by groups in different countries; the frame packages deployed by proponents and opponents; the structure and role of the media in mediating framing contests; and the extent to which a framing package has as its goal reshaping public discourse.[6]

Application of the diagnostic framework in Table 2 to the three agenda setting models will reveal the primary mechanisms that dominate in each theory, and the degree to which political opportunities, mobilizing structures and framing processes are a part of each model. The three models are labeled by their authors 1) Cobb/Elder, 2) Baumgartner/Jones, and 3) Spector/Kitsue.

The use of the diagnostic elements and dimensions from Table 2 to compare the key features of the three agenda setting models yields the following analytical outcomes indicating the primary mechanisms that govern each model (see Table 3). The mechanisms revealed to be of principal importance in each agenda setting model are discussed in greater detail below.

Cobb and Elder

The agenda referred to in both Cobb/Elder and Baumgartner/Jones is within the realm of politics so that actors are trying to advance a cause or issue within the political system. Cobb and Elder provide an outside initiative model of agenda setting which refers to nongovernmental initiators of policymaking attempting to convert their concerns into a larger movement.[21, 26]

Table 3: Agenda Setting Models Analyzed with Diagnostic Elements and Dimensions

AGENDA SETTING MODELS	Cobb/Elder	Baumgartner/Jones	Spector/Kitsue
Primary Mechanism(s) for Issue Generation	Outside Initiative	Mobilization, Outside Initiative but primarily Inside Access	Outside Initiative
Political Opportunities	Yes	Yes	No
Mobilizing Structures	Partially	Partially	No
Framing Processes	Yes	Yes	Yes

Cobb/Elder, like Baumgartner/Jones, recognize the idea of dual agendas at operation within the system. Accordingly, the model refers to a systemic and governmental agenda. The systemic agenda contains the issues commonly perceived by the political community as meriting public attention.[26] The issues at this point are abstract, general items that identify a problem.[26]

On the other hand, the governmental agenda or formal agenda entertains specific, concrete items that are up for action and serious consideration by decision makers.[26] In this model the agenda setting process is assumed to be sequential so that groups outside the government first push an issue so that it makes it onto the public or systemic agenda. After finally achieving recognition on the systemic agenda the issue moves to the governmental agenda. It is possible, according to the Cobb/Elder model, to bypass the systemic agenda and move onto the formal governmental agenda. However, the model posits that this is only

possible for issues of "little social import or concern"[26(p. 87)]. According to Cobb and Elder no issue with substantial public consequences will gain admission to the governmental agenda without first gaining status on the systemic agenda.

Analysis of the agenda setting process in Cobb/Elder reveals a linear model that begins with initiators and triggering events to create conflict. Initiators are individuals or groups that have a motive for raising a grievance.[26] Trigger devices are unforeseen events that help shape issues defined by the initiators.[26] Specifically, the model has two major kinds of trigger events: 1) internal events consisting of natural catastrophes, unanticipated human events such as riots, technological changes, imbalances in the distribution of resources, and ecological changes and 2) external events including war or military violence, new weapons technology, international conflict, and changing world alignment.[26]

The trigger alone does not create an issue. An initiator must recognize the triggering event, establish a link and then use the trigger to elevate the problem. The initiator and the triggering mechanism transform the grievance into a public issue. In the Cobb/Elder model the next steps after the initiator and trigger event merge involve transforming the issue into a public agenda item. To do this the model stipulates that interest groups must then: examine the issue itself and the symbols and language used to reach the public; implement a campaign to create a demand for action in different sub-populations of the public; attract media attention; and, depending on the extent to which the issue has been expanded at the public level, select a channel to gain a place on the policymaker's docket.[26]

Issue expansion refers to the specific methods used to move a grievance beyond the interest group to the policymaking agenda. Two of the models, Spector/Kitsue and

Cobb/Elder, set down a specific linear process, so that in Cobb/Elder this means the interest group must first get a defined target group to be aware that the issue is contested.[26] The greater the size of audience to which the issue is enlarged, the greater the likelihood it will to expand to reach the formal agenda.[26]

In contrast to the other two models, Cobb/Elder segments the public into members of a hierarchy that must be ascended to move an issue from the systemic agenda into the governmental realm. Further, the Cobb/Elder model, unlike the other two models, notes that the members of the public hierarchy attracted to an issue will be defined by the subject, vary depending on the nature of the issue, and is thus subject to change composition.[26] Unlike the Baumgartner/Jones model, Cobb/Elder highlights the characteristics of distinct groups as opposed to seeing the public as one monolithic, amorphous group.

Accordingly, Cobb and Elder create boundaries for subgroups within the public that range from most involved to the general public which will be least involved.[26] First are the "specific publics", which would include identification groups and attention groups[26(p. 105)]. Specific publics are those groups who lean towards that interest group's issues associating their interests with those of the group or having sympathy with its interests.[26]

In the category of specific publics, identification groups usually have relatively stable ties and will be the most sensitive segment of the general population, should grievances involving any of its member-groups arise.[26] Identification groups will be the first segment of the population to get involved, should the issue expand beyond those initially involved.[26]

Attention groups are the next level within the category designated as specific publics. People in this category are usually not interested in most issues, but they are informed and

concerned about specific issues. Attention groups are easily mobilized once an issue appears on the radar screen in the sphere of their concern. The primary difference between attention groups and identification groups is that the involvement of the former depends on the issue, whereas the latter gets involved based on group affiliation of the disputants.[26]

Last, the issue can expand to the category of mass publics further broken into the attentive public followed by the general public.[26] The attentive public is that part of the population that comes from "more educated and higher income" groups[26(p. 107)]. Opinion leaders generally come from this group and serve as generators of interest in the less active and interested parts of the population.[26] In the Cobb/Elder model the last segment of the population is the general public, which is less active, interested and informed.[26] This is the last segment of the population to get involved in a dispute that must be generalized and symbolic to attract their notice according to Cobb/Elder.[26]

Generally, the role of language in agenda setting takes on a more instrumental use in the Cobb/Elder model than the other two agenda setting models. Similar to Baumgartner/Jones, the definition assigned to an issue is a key factor in successful agenda setting. Symbols and language can determine if an issue is shaped to achieve exposure.[26]

In the Cobb/Elder model the functionality of language and symbols are highlighted. Effectiveness is measured by whether the symbol is used appropriately for an issue.[26] Other key criteria to judge language and symbols are saturation or over use and too many uses of a given symbol.[26] The model stipulates that the language must be appropriate to the targeted subculture, i.e., a group defined by ethnicity, social class, race, or region.[26]

For Cobb/Elder, language is seen as having the power to convey key factors that will affect issue expansion. The model accounts for the history and credibility of a symbol, noting that it too can determine the effectiveness of language.[26] Similar to Baumgartner/Jones and the Spector/Kitsue model, the emotive appeal of language is recognized as a powerful force in Cobb/Elder shaping the agenda setting process.[26]

In summary, applying the diagnostic framework, the Cobb/Elder model is a linear, outside-initiative model that utilizes initiators external to the policymaking process to explain how conflicts are transformed into public issues and placed on the legislative agenda. The model does not wholly attend to the element of political opportunities as defined in the diagnostic framework. The concept of triggering events in the Cobb/Elder model is meant to focus attention on the impact of social change on agenda setting but fails to consider changes in the political system, institutional structures, or power relations.

The third element of the diagnostic framework contrasts the kinds of mobilizing structures needed to move an issue, resources that influence mobilization, and the impact of external opportunities on mobilizing organizations. Cobb/Elder pays very little attention to mobilizing structures other than to acknowledge that initiators or interest groups must exist to activate the agenda setting process. Initiators are clearly distinguished from the public. Cobb/Elder does attend to resource differentials as influential factors affecting organizations but gives greater weight to cultural constraints and popular sentiment as high-ranking variables, affecting not the organization but the efforts of the organization in the political process.[26]

Finally, application of the diagnostic framework shows the framing process to be central in Cobb/Elder. In this model, framing activities are portrayed as fundamentally necessary and the primary means for understanding and shaping cultural ideology to facilitate agenda setting. On the other hand, the Cobb/Elder model does not position framing processes as a tool to reshape public discourse. Framing is primarily a short-term activity limited to utilization for the duration of an issue campaign.

Baumgartner and Jones

Again, like Cobb/Elder, this model situates agenda setting activities firmly within the realm of the political. Agenda setting in the Baumgartner/Jones model unfolds from an examination of the groups and institutions attached to an issue plus the definition of the issue provided by those institutions.[27]

Beginning with the sociopolitical context to describe how an issue moves from the sphere of the interest group to beyond, Baumgartner/Jones presents two routes that follow a path of either intense enthusiasm or escalating criticism.[27] This is in opposition to the other two models that begin their issue expansion explanations with formulaic descriptions, detailing a series of steps that typically occur in a linear process.

Examining a confluence of factors that interact, merge and flow together over time, the Baumgartner/Jones model depicts issue expansion, not as a series of actions, but as set of variables that interact. The result of the interaction is a form of issue expansion that is dependent upon another set of variables operating at the outer margins to provide parameters or the broad context.

The Baumgartner/Jones process for the advancement of an issue to the legislative arena, unlike Cobb/Elder, is neither sequential nor tightly ordered, providing several alternative routes that may be used to reach policymakers. In fact, a central tenet of the model is the existence of other routes or venues that may be utilized to push an issue onto the legislative agenda. A policy venue is an institution or group in society such as the judicial system or regulatory agencies with authority to make decisions on issues.

The model highlights but integrates two policy subsystems that run parallel to each other. The first system, similar to a public agenda, is referred to as "subsystem politics", which reflects, respectively, individual political behavior and experts in issue-systems. In Baumgartner/Jones this public subsystem functions like that of the public or systemic agenda in Cobb/Elder. This system incorporates the need to attract the support of key public groups in order to elevate the issue to legislative status.

Next, the legislative agenda in this model, called the macropolitical subsystem, is characterized as the actions of the President and Congressional leaders when they "disrupt" activity occurring in subsystems[27(p. 21)].

It is important to note that the public subsystem, running parallel to the macropolitical system, processes issues at the same time as the macropolitical subsystem. The public subsystem track processes multiple issues simultaneously, while the macropolitical system takes issues consecutively. An issue must move from multiple-issue parallel processing in the public subsystem to the realm of serial processing in the macropolitical system to reach policymakers.[27]

However, the model also indicates that it is possible for an issue to by-pass the public subsystem, gaining admission to the legislative arena via other venues such as legislative committees, the judicial system, or regulatory agencies.[27]

Additionally, integration of the agendas can occur because the public subsystem can be disrupted when actions in the macropolitical systems intervene.[27] An example of this occurs when one political party or the President decides to elevate the status of an issue. If the issue gets enough attention it can no longer be part of the public subsystem.

In Baumgartner/Jones the definition of an issue is at the heart of political conflict.[27] This model stresses the notion of the image, which must have certain qualities to attract the attention of policymakers. The image will determine stability of the issue or its vulnerability. The ultimate outcome of agenda setting, according to Baumgartner/Jones, is government action allowing for possession and control of an issue along with the political understandings and institutional arrangements that support the issue.[27] The image must transmit a powerful idea connected to core political values in order to achieve this result.[27]

Two components make up the image in the Baumgartner/Jones model, empirical information and emotive appeal or tone.[27] Tone drives stability or issue-expansion and mobilization.[27] The image may be used to invoke adherence, acceptance and support or indifference to keep others out, uninterested, or uninvolved.[27]

Like the Spector/Kitsue model, the Baumgartner/Jones model specifies the need to identify causality-blame, and the private or public nature of the problem using the image.[27] The model also attends to the social and political environment with features that acknowledge the importance of these variables in agenda setting. Key macro-forces in the

Baumgartner/Jones model include the structure, and organizational rules of political institutions, and the historical context.[27]

In all three models, interest groups function in the same manner. Alternatively, each model varies in how it attends to the breadth and depth of the role of the public. In terms of influence on agenda setting, the Baumgartner/Jones model elevates the importance of the interest group and patterns of mobilization over policy content.[27] The model, similar to the Spector/Kitsue model, focuses upon the activities of the interest group, ignoring the characteristics of the public and interest groups.

Interest groups play a variety of roles in Baumgartner/Jones, helping to create and destroy restricted systems of participation, acting as an avenue for policymakers seeking to expand participation for an issue, configuring the range of options for the public's understanding, and structuring the choices available to policymakers.[27] In summation, according to Baumgartner/Jones interest groups seek either to maintain a policy monopoly, to tear down an existing monopoly, or to construct one.[27]

The public, in Baumgartner/Jones, is an undistinguished monolithic group portrayed as having a limited amount of attention to allocate among issues. In order to gain allies it is the role of interest groups to alter the way in which the public has assigned its attention.[27] Public opinion for Baumgartner/Jones is but one, and perhaps the least significant, of many venues in society that may be accessed in an effort to gain the attention of policymakers.[27] Ultimately, the Baumgartner/Jones model attends more to contextual features to determine how a grievance moves into the governmental arena.

In summary, applying the diagnostic framework of Table 2 the Baumgartner/Jones model does not advance a single mechanism for issue generation. Rather, the model is a composite of outside initiative, mobilization, and inside access theories. However, ultimately, the model's features lean more heavily toward the inside access theory where issues come to the attention of policymakers without the development of a public agenda.

The model is fairly accurate in representing the key element of political opportunities as defined in the diagnostic framework. The structure, organizational rules of political institutions, and the historical context define political opportunities in Baumgartner/Jones.

The third element of the diagnostic framework compares the kinds of mobilizing structures needed to move an issue, the resources that influence mobilization, and the impact of external opportunities on mobilizing organizations. Mobilizing structures are a key factor in the model where the examination of the life-cycle of issues is dependent on the nature of the interest group and on its ability to generate either waves of enthusiasm or criticism to create or undermine policy monopolies. There is very little analysis of resource differentials in the Baumgartner/Jones model.

Finally, application of the diagnostic framework shows the framing process to be central in Baumgartner/Jones where framing activities can determine if any issue will rise to prominence. The model does adopt a long-range view of the framing process and examines the changing image and tone of an issue over many years. It is the image and subsequent discourse that determines if there will be adherence, acceptance or indifference to the establishment or continuation of the policy monopoly.

The Spector/Kitsue Model

The final example of agenda setting emanates from the discipline of sociology and the work that comes out of social problems research. The Spector/Kitsue model advances a theory of how members of a society define a condition alleged to exist as a social problem. Essentially, agenda setting under a social problems model studies the process of definition by examining the activities of those who assert the existence of the condition and take action to define it as a social problem. The point of inquiry is how a collective constructs a definition of a condition that results in the decision to call it an actionable threat.[28]

Unlike the other models, the Spector/Kitsue model does not confine its examination of agenda setting to that of simply interest groups and the government. Actors and sources of data are broadly defined beyond politics in the Spector/Kitsue model. Agenda setting may occur within the realm of a profession such as the instance of one faction of the American Psychiatric Association promoting consideration of how psychiatry was used to control politically active Soviet citizens in the 1970s.[28]

The Spector/Kitsue model, similar to Baumgartner/Jones, is primarily interested in the tactics of groups that attempt to assert a grievance as opposed to the social characteristics of the groups.[28] The model begins its analysis, not with the nature of groups or organizations, but with claims and claims-making activities. Claims are defined as the demands made by one party to another that something be done about a condition.[28]

The variables under study in the Spector/Kitsue model include: how claims-making activities become organized; to what agencies or to whom the claims are directed; the assertions made and the responses; how one party becomes the claimant and one the recipient; how the parties decide where to lodge the claims; how the claimants construct their

notions about the condition; how the recipients respond to the claimants; the available solutions, words, and vocabularies that help shape the definition of a condition; how participants construct and impute motives; and how claimants and respondents justify their support of claims.

In comparison, the Spector/Kitsue model is like Cobb/Elder in laying out a series of steps to follow to gain access to decision makers. However, all of the steps in Cobb/Elder are compressed into a single stage in the four-stage Spector/Kitsue model. This is because the model examines the entire life cycle of an issue, going further to explore what happens to an issue once it achieves governmental agenda status. However, for comparative purposes, the focus in this research will be contained to step one of the Spector/Kitsue model. In step one groups attempt to assert existence of a condition.[28] The group is victorious if they are able to create controversy and private troubles become a public issue.[28]

The Spector/Kitsue model indicates that groups must consider the language and symbols used for pressing claims, and where to lodge their complaint. If they get a response then conflict is generated, which increases the visibility of the debate to facilitate public awareness.[28]

The Spector/Kitsue model attends to interest groups and the public much in the same way as Baumgartner/Jones, and yet differently. Similarly, two separate groups exist and it is the function of one group, the interest group, to act upon another group to achieve wide spread knowledge in an undifferentiated target population which results in expansion of support for the issue.[28]

Interestingly, the concept of a formal public agenda is not recognized in this model. The model only acknowledges the need for publicity to elevate the status of the issue to get a response. In the end, in the Spector/Kitsue model there is no public agenda, just a need to generate exposure, controversy, and a response from a target group that is greater in number than the original claimants.[28]

Like the other models, but to a heightened degree, the Spector/Kitsue models stresses the importance of symbols, and language in the agenda setting process. In the Spector/Kitsue model the use of language is one important factor to investigate in a range of activities utilized to press an issue. Language and symbols are determined to be effective based on the groups' ability to express dissatisfaction, power, blame, and responsibility for the issue.[28]

It is accurate to say that the Spector/Kitsue model of agenda setting is an inner-directed model, turning the focus upon the activities of those who assert the grievance examining what they do, and their strategies, and tactics to push the issue forward. Contextual factors are largely ignored in Spector/Kitsue. Further, objective conditions are irrelevant in the Spector/Kitsue model.[28] The social, cultural and political environments are not considered in the analysis of how a problem becomes a social issue. Further, the factual basis or truth and falsity of the issue are unimportant in comparison to the process of social problems construction. Applying the diagnostic framework to the Spector/Kitsue model reveals that the primary mechanism for issue generation advanced is an outside initiative theory. Like Baumgartner/Jones, the model acknowledges the mobilization theory, where the government may initiate agenda setting activities to attempt to persuade interest groups or the public to accept a policy position. However, the strongest area of inquiry asserted by the

model is an exploration of how groups outside of some institutional system convince a larger population and then decision makers that a condition is in need of attention.

Because the model is an examination of the use of claims and claims-making tactics to advance an issue, there is very little attention given to political opportunities as defined in the diagnostic framework. An analysis of the impact of changes in the institutional system, or power relations seems to be excluded from the Spector/Kitsue model.

The third element of the diagnostic framework examines the kinds of mobilizing structures needed to move an issue, resources that influence mobilization, and the impact of external opportunities on mobilizing organizations. The Spector/Kitsue model examines the strategies of the groups and resources only to the extent that they allow the group to convey its claims with power and to position themselves as influential actors.

Finally, the fourth element of the diagnostic framework, framing processes, is the central feature of the Spector/Kitsue model. This model focuses on variables in the framing process and views institutional discourse as the primary barrier or facilitator that can impact agenda setting activities. Framing, in this case, serves the purpose of altering the prevailing discourse of an institution to achieve systemic change.

The Social Determinants of Health Perspective

Having compared and contrasted three agenda setting models to determine the key variables active in the process of elevating an issue onto the legislative agenda, this section now provides a general overview of the social determinants of health to further aide in the effort to define relevant criteria to detect the presence of a SDOH perspective in the U.K. print media and on the legislative policy agenda.

A universal definition of the SDOH is presented followed by the application of various policy objectives and discourse models to aide in this effort.

A Universal Social Determinants of Health Perspective

Classified as a population health theory, social determinants claims view health as the collective social experiences of a group of people classified together because they share distinguishing features such as racial or social class, residence in a community, or gender.[5]

A population health theory may for example be compared to a biomedical model of health where the discussion is focused upon individual biology and/or personal behavior and choices. In contrast, population health extends beyond the traditional spotlight on the medical, biological, or lifestyle factors that contribute to an individual's health. A population health perspective will consider those traditional factors plus social and economic forces that shape the health of groups.

Population health is a broad and complex field that must explain the systematic, differential distribution of health status by socio-economic position. This enduring tendency holds across a wide variety of health conditions and disease states (from accidents and injuries to mental illness to coronary heart disease) and for a variety of conceptions of socioeconomic position (e.g., social class, minority status, educational attainment), to different degrees at different states of life course and differently for males and females.[29]

One of the fundamental assertions of the social determinants of health as a population health model is that people at the top live longer, whether that is defined as more assets, more income, or a higher-level job.[30] Further, these people (at the higher end of the scale) generally have better health during their longer lives. Social determinants observations rest

upon study after study, in many countries, over many years to confirm the claim that there is a connection between health status and social status.

Generally, when health outcomes are viewed through the social determinants lens a central claim used to press the issue is the assertion that the major factors determining health outcomes are not only medical care but cultural, social, and economic factors. Social determinants claims center upon a series of propositions that link health to a broad array of factors including social stratification, income, wealth, employment, education, social relationships, early childhood development, and even business and banking policies.[5]

It is instructive to reflect on how the social determinants came to be classified as a population health theory. In the 1970s and early 1980s, researchers were disenchanted with health perspectives targeting individuals at risk of disease with medical care as the main driver of people's health.[31] Critics argued for: a population focus; an examination of the societies to which people belonged; a view that looked to factors which help people stay healthy over a perspective that emphasized health care services that assist when people are ill; and, a refocusing on factors upstream-away from individual risk factors for disease to the contextual determinants of health.[31] This call for a new paradigm or approach to the manufacturing of health took root in Canada and the World Health Organization.

In 1974 the Canadian White Paper, *A New Perspective on the Health of Canadians*,[32] proposed that changes in lifestyles or social and physical environments would likely lead to more improvements in health than would be achieved by spending more money on existing health care delivery systems. The Lalonde report was the first government report to recognize factors other than the health care system as influencing population health.[32]

The Canadian report is credited with leading the way in stimulating the World Health Organization (WHO) to adopt a broader set of health indicators in the quest for improved global health.[33] These four categories of indicators included: health policy indicators; social and economic indicators; indicators of the provision of health care; and indicators of health status including quality of life.[33] As the WHO concept of "health for all" was more fully defined a social determinants approach gained widespread acceptance as the appropriate framework for developing and delivering public health policy aimed at improving population health.

Policy Objectives for a Social Determinants Perspective

What then might be considered the policy objectives where a government has decided to invest in the social determinants of health? Hilary Graham[34] presents a continuum of three objectives that governments may choose as policy goals. Policies regarding the social determinants may range in nature from: 1) "improving the health of poor groups; through, 2) closing the gaps between those in the poorest circumstances and better-off groups; to, 3) addressing the association between socioeconomic position and health across the population" (e.g., the gradient)[34(p. 115)].

These three policy objectives have both commonalities and important distinctions that influence "distributional goals, their moral base, and their desired policy outcomes"[34(p. 118)]. The policy goal of remedying health disadvantages for poor groups must be done, says Graham[34], if health gaps between poor and better-off groups are to be closed. Further, the first two objectives are also required to address the health gradient.

The most vivid symbol used to support social determinants claims is the health gradient often depicted using data on mortality in relation to social class.[35,36] Arranging a grouping of individuals according to social class along a continuum best depicts the health gradient. This reveals a clear gradient-the higher up the ascending hill the healthier a person is considered.[36] Additionally, the gap in health outcomes between groups-low, middle, and upper levels-becomes evident once arranged on the gradient.

This gradient is said to be consistent across space and time illustrating that even as medical care has increased and become more sophisticated over time the health gradient has not declined and in some cases grown steeper.[36] Further, the existence of the gradient is used to support claims regarding the dangers of stratified societies wherein there are distinct class and income differences in the population.

That the gradient has never declined reveals that while the causes of death have changed and average life expectancy increased "….on average the 'lower classes' still die sooner, indicating that the sources of the gradient lie, not in the relative incidence or severity of particular diseases, but in underlying patterns of differential vulnerability- or 'host resistance' - by social class"[36(p. 17)].

As an extension of the gradient then the basic claims supporting the social determinants issue are: 1) An individual's health correlates to the degree of inequality in their society; and 2) Individual health is relative to position in the society's income distribution.[36] Accordingly, a social determinants health framework reveals individual variations in health along with social differences linked to more complex structural inequalities.

Drawing out distinctions between the three policy objectives consisting of: 1) improving the health of the poor, 2) closing the gap between rich and poor, or 3) addressing the gradient, i.e., the association between socioeconomic position and health, demonstrates the differences in possible outcomes, solutions, and programming that might occur in an effort to implement a social determinants perspective.

Remedying disadvantage means improvements targeted solely at those groups defined as disadvantaged. This is the most frequently cited social determinants policy objective of governments and organizations. This occurs without improving the health of those groups who are not the worse off but are in a poor condition relative to the next group up on the gradient. Tackling the health inequalities of the poor or least advantaged will leave groups higher up on the gradient out of the process.

Closing the gap is accomplished when health improvements in the lower socioeconomic groups occurs at a faster rate then health improvements in those groups further up on the gradient. Such a policy goal requires action to improve levels of health in poor groups and a rate of improvement that keeps pace with or outstrips health improvements in upper socioeconomic groups.[34]

The last objective, i.e., addressing the gradient, or the association between socioeconomic position and health, is the most difficult concept to visualize and translate into policy solutions and programs. To address the last objective, the gradient, policies have to "be associated with absolute improvements in health for all socioeconomic groups up to the highest socioeconomic group, and with a rate of improvement which increases for the worse off at each step down the socioeconomic ladder"[34(p. 127)].

As indicated, it is possible for everyone on the gradient to have worse health in relation to those higher up on the scale. To address the fact that everyone has a poor health status when seen in relation to the next group higher up on the scale the programs and policies must do two things. First to address the gradient one must get at the underlying determinants that result in unequal health. Next, programs and policies must avoid too narrow a focus on any one group at the risk of making the group higher upon the scale worse out of neglect of their health problems.

Addressing the association between socioeconomic position and health across the population (the gradient) requires policies that speak to the "causes of health inequality, not in the disadvantaged circumstances and health damaging behaviors of the poorest groups, but in the systematic differences in life-chances, living standards, and lifestyles associated with people's unequal positions in the socioeconomic hierarchy"[34(p. 125)].

Discourse Models Used to Talk About A Social Determinants Perspective

Another SDOH feature is the discourse adopted by institutions as they propose models, present the problem, frame solutions, and adopt policies. An examination of the discourse surrounding an issue highlights how the language constructs the social world in various ways. Examining the language of politics, Levitas[37] contends that discourse becomes a road map describing the world and proscribing a way of acting in the world. This in turn sends signals as to what counts and does not count as important or acceptable in relation to a topic. The discourse serves to define, sanction, and veto possibilities, solutions, and actions.

Sandra Carlisle[38] provides a summary of three types of discourse models developed by Levitas[37,39] to examine the various meanings of social exclusion utilized in policy

discussions in Britain after 1996. The three discourse models, each reflecting varying problems, causes and solutions, are useful in analyzing different perspectives on the SDOH.

The three discourse models are: RED (a redistributionist discourse); MUD (a moral underclass discourse related to pathological culture/behavior); and SID (a social integrationist discourse). Levitas[37] says that all of the discourse models have moral underpinnings but differ in what they see as the causal factor and consequently the solution to the problem of social exclusion, or in this case the issue of SDOH. RED focuses upon the lack of money. MUD places primacy on individual behavior and morals. Lastly, SID conjectures that being outside mainstream society, as it is defined, e.g., having a job, home, affiliations, has negative consequences resulting from failure to integrate into the social order.

The redistributionist discourse (RED) is linked to a poverty and deprivation explanatory model for the social determinants. In this case, poverty is thought to lead to social exclusion or deprivation.[39] Deprivation includes the social and material conditions one experiences depending on the level of poverty or lack of income and of the equivalent resources one experiences. Poverty thus takes on the characteristics of deprivation so that under the (RED) redistributive discourse poverty is not subsistence but an individual's ability to participate in the accepted life of a society as it has been defined.[39]

A central feature of the redistributionist discourse model is that it defines the problem as one of wealth and poverty. The role of relative inequality is part of the discourse along with strengthening the welfare state. RED discourse posits that since social exclusion results

from poverty, raising benefits to reduce poverty will reduce exclusion.[39] The lead indicator for RED is low income.

The RED approach starts at the level of the social structure where the concentration of resources in higher socioeconomic groups is to be remedied.[38] The inequitable social distribution of resources is fixed by dealing with poverty through the redistribution of resources using socioeconomic policy.[38] Further, RED entails a reduction in inequalities plaguing society and a redistribution of not only resources but also of power.[37]

The materialist-structural explanations for inequalities, as underpinning RED, are thought by some to be inadequate reasons to explain the health gradient where health inequalities are not relegated to the poor but follow the slope of the social class gradient based upon one's position in society relative to others. Other critics of the RED approach view the redistributionist solution as simplistic in nature founded upon the belief that increases in income will be accompanied by an increase in healthy types of behavior due to greater income.[38]

In the case of the MUD (moral underclass approach) Levitas[37] says the main characteristics are these: the underclass are culturally distinct from the mainstream; a focus upon the behavior of the poor rather than the structure of society; unpaid work such as stay-at-home mothers, is not acknowledged; dependency on the state is a problem but social economic dependency-women and children on men is okay and has a good effect on men and thus society; gendered discourse about idle, criminal men and single mothers; benefits are bad and encourage dependency; and, inequalities among the rest of society are ignored.

Carlisle[38] says the source of the problem for MUD is lower socioeconomic groups who require help developing coping skills. A MUD orientation is founded upon the belief that social and health inequalities are endemic in all societies.[38] MUD defines a link between poverty and social exclusion but sees the causes of poverty as being in cultural and moral self exclusion rather than the other way around with cultural and moral exclusion causing poverty.

Using traditional health promotion or empowerment campaigns, one solution is to teach adaptive skills and a reduction in needs. The result will be an increase in resources at the individual and community level, no attempts to address structural inequalities, and financial output from the government goes unchanged.[38]

The social integrationist discourse (SID) traces the problem to the effects of social polarization and social exclusion among socioeconomic groups.[38] Theories on social capital and social cohesion fit nicely into the SID model. Unlike the RED approach, which is based upon a combination of materialist and structural theories, Carlisle[38] links the SID approach to social determinants models developed around the notion of psychosocial stress. The lead indicator for SID is unemployment or economic inactivity meaning that an individual is outside what has been defined as an acceptable existence that includes work.[39]

Levitas[39] believed that SID discourse supported policies implicitly or explicitly related to a model of inclusion in which attachment to the labor-force is critical (SID) so paid work becomes the sole legitimate means of integrating individuals. SID glosses over the way in which work may fail to reduce social exclusion as in the case of being stressful, alienating, underpaid, or where work hours are long and asocial excluding social participation.

Within a SDOH perspective, the upshot of the criticism against the RED approach and in support of SID, backed by broader literature and studies of hypothesized causal connections using multivariate regression analysis in most cases, is that, at least among citizens of wealthy countries or political jurisdictions, any association between individual income level and health status exist because of the effects of the social context in which people at different levels find themselves.[36] Money cannot buy better health as Robert Evans says.[36]

SID, relying upon evidence that material circumstances are without significant influence after certain threshold levels are passed, rest upon the idea that psychosocial stress effects disease development directly by transmitting experiences through the central nervous system and also indirectly as stress expressed through unhealthy behavior.[38]

In the SID approach adherence to the psychosocial position falls into two camps. First, one looks to physiological effects to occur from what is going on in the mind of the individual including self-esteem, or degree of trust in others.[36] The problem lies in systems that favor stratification resulting in stress and illness because of the oppressive self-awareness of one's position as inferior. Greater inequality means that a person is constantly exposed to notions of inferiority experiencing psychological stress in a constant mental assault that affects health status. Alternatively, mistrust in others increases stress and a sense of vulnerability in every interaction occurring day in and day out resulting in poor health.

Next SID, relying on a psychosocial mechanism, may also mean adherence to the neo-materialist view which contends that in wealthy countries while only a few suffer the effects of sheer material deprivation the entire population confronts minor and serious

challenges and threats to well-being as they live day-to-day.[36] Knowledge of having money and resources at-hand make a person feel stronger, more able to handle day-in and day-out situations. Accordingly, the effects of income or money help to lessen, and avoid these stresses allowing one to call upon resources to cope with the strain.[36] Essentially, "higher income is associated with greater coping ability, or its converse, lesser perceived vulnerability" resulting in good health[36(p. 29)].

Levitas[37(p. 22)] says that the social integrationist discourse model focuses upon "the integrative function of paid work". The notion of social exclusion becomes synonymous with unemployment. In this case, work is seen as an essential means by which to ensure that individuals are connected to society. Employment is valued not only as a means of income, but primarily because it provides solidarity, and integration for individuals resulting in cohesive members of the community.[37]

Starting at the action level of community, the solutions offered in the SID approach generally focus upon reducing the gap between groups and increasing social integration.[38]

Carlisle[38(p. 274)] developed a table (Table 4) that presents the differences found within the RED, MUD, and SID discourses on the social determinants. In practice social determinants policy may manifest qualities from all three discourses. In the end, all of the approaches, according to Carlisle[38], recognize the impact of broader social inequalities only differing significantly in their orientations to the problem, causal mechanisms, and solutions.

Table 4: Discourse Approaches to the Social Determinants

Discourse Level	Source of Problem	Explanatory level	Causal Mechanism	Solution	Action Level
Redistribution RED	Concentration of resources in higher socioeconomic groups	Social structure	Inequitable social distribution of resources	Relieve poverty by redistributing resources downward	Socioeconomic policy
Social integration SID	Social polarization of socioeconomic groups	Interaction between individual and social structure	Relative inequality and social stress in disadvantaged groups	Reduce gap and increase social integration	Community
Moral underclass MUD	Lower socioeconomic groups	Individual experience and action	Narrow resource margins	Help poor people develop coping strategies	Individual

Recall that a diagnostic framework was employed in the study of three agenda setting models to elucidate the key factors that influence how issues become part of the policymaking agenda. Further, a universal definition of the SDOH has now been presented along with a range of policy objectives and discourse models to help distinguish relevant criteria for detecting the appearance of a SDOH perspective in the print media and on the health policy agenda.

CHAPTER 4: METHODOLOGY

This study utilizes a descriptive content analysis of British news articles, historical accounts, and research commentaries of the SDOH movement guided by key variables from relevant agenda-setting models and a universal definition of the SDOH to chronicle the emergence of the SDOH perspective in Britain. A triangulation of data sources and evidence and a context analysis of the British sociopolitical environment are employed to measure the impact of alternative agenda-setting factors in influencing the emergence of the SDOH as a significant policy issue in Britain.

Recognizing that attainment of certifiable truth, as specified by logical positivism,[e] was unrealistic a new philosophy of science, that of post-positivism, emerged.[40] Post-positivism, defined as the search for "warranted assertability", or rather relative or qualified truth, encourages the use of critical multiplism which advocates for: 1) rational, empirical and social ways to identify the assumptions and biases present in options of methods and theories used to investigate experience; and, 2) the use of several perspectives and methods to conduct research[40(p. 523)].

Consistent with the principles of critical multiplism this study incorporates the use of triangulation calling for the combination of two or more theories, data sources, methods, or investigators in the study of a single phenomena.[41] Ultimately, triangulation is meant to short-circuit the biases of the investigator and overcome deficiencies inherent in a single-investigator, single-method study to increase confidence in the observed findings.[42] In the

[e] Logical positivism, a philosophy developed in the beginning of the 19th century, states that the only authentic knowledge is scientific knowledge. A further postulate of positivism is that a statement is meaningful only if it is empirically verifiable. Logical positivism holds that philosophy should aspire to the rigidity of science that provides strict criteria for judging assertions as true, false, and meaningless (Logical Positivism, 2006).[114]

case of this study, multiple theories, data sources, and methods will be employed to reinforce one another.

Qualitative research values the role of features or items in relation to their function as contributing parts in a system.[43] In this sense, multiple data sources such as documents including news articles, historical accounts, and commentaries are used as important resources for data triangulation to increase certainty in research observations.

The qualitative interpretation of documents may be of two kinds: content analysis where the sources are viewed as independent containers of evidence about the world; or context analysis where sources are analyzed within the social contexts that produce and use them.[43] Context analysis may be further distinguished where documents are researched as commentary or actors.[27] The use of documents as actors views the contents of the document as less important than their production, exchange, operation, or action.[43] One example is the integration, handling, and use of patient records from a healthcare setting to establish or document policies and procedures for handling patient information or seminal events. The records themselves, not the content, provide the information.

On the other hand, a context analysis of documents as commentary accompanies a descriptive orientation where the goal is to isolate organizational and institutional structure and processes in their natural milieu.[43]

Content Analysis

Newspapers in the U.K. are openly biased towards the interest of specific political groups. For this reason the newspaper sample included six newspapers representative of two major political ideologies.[19] The sample (Table 5) made use of two left-leaning publications

and four conservative papers. These papers were selected based upon political ideology, circulation rates, and the availability of archived information accessible for retrieval.

Table 5: Newspaper Sample

Newspaper	Time Period	Ideology
The Financial Times	1982-2003	Conservative
The Guardian	1984-2003	Liberal
The Times	1985-2003	Conservative
Daily Mail	1992 -2003	Conservative
The Mirror	1995-2003	Liberal

The original goal was to obtain articles to cover the time period from 1980 until 2003. These temporal markers coincide with a sequence of sociopolitical events related to changes in political power and ideology that defined and influenced that era. The year 1980 is marked by the publication of the first major inquiry into health inequalities[f] originated at the request of the government. Policies, statements, and actions on the SDOH are traceable from this point forward as the Labour party and other special interest groups spent the next twenty-three years challenging the Conservative Party and subsequently controlling the agenda on health inequalities**.**

[f] Generally referred to as "The Black Report", the document is considered a major report on inequalities in health from a committee chaired by Sir Douglas Black and commissioned by the Labour Government in 1977. Black, D., Morris, J., Smith, C., Townsend, P. *Inequalities in Health: Report of Research Working Group* (London, Department of Health and Social Security, 1980).

It was in 1990 that the first activity of think tanks to set the 1997 Labour Party agenda on inequality and the social determinants became noticeable.[37,39] Subsequently, after 1997 with a Labour victory the government began enacting legislation to address a wide range of social issues. Finally, six years later in 2003, the final year in the study time period, the effects of the 1997 decision to put into place a Labour government are evident and easily traceable.

After consulting with several research librarians and examining a number of commercial online databases (InfoTrac Custom Newspapers, Factiva, and the Business and Resource Company Center) it was determined that LexisNexis Academic had archived the oldest set of articles for each news publication. Only in the case of one newspaper did an alternative source prove to have articles archived at an earlier period than LexisNexis. While articles for the *Daily Telegraph* were available on LexisNexis from 2000 forward, the paper's website archived articles back to 1996.

The use of the six papers was meant to ensure diverse coverage at the earliest point in time within the selected range from 1980 to 2003. Ultimately however, the retrieval of news articles spanning the period from 1980 to 2003 was circumscribed by the limits of archived material available in online databases. Subsequently, after the search for articles, the time period to be studied through the use of news articles was narrowed to 1985 to 2003. Neither electronic access or print indexes for articles before 1985 were accessible. To maintain the original time frame from 1980 until 2003 this limitation was overcome with secondary data sources such as reports documenting events and written, eyewitness accounts of events.

A “full text” search in LexisNexis for each news publication used the following key terms: inequality, inequity, inequality and health, poverty and health, social exclusion, and social disadvantage. Prominent individuals instrumental and active in the SDOH movement in the UK were used as search terms. The specific names of government publications were also added to the search terms. Articles having any of these words in the body at least two times were incorporated into the sample of news articles.

Newspaper articles that covered individual health risk factors and health care were included in some cases if they mentioned any of the key terms. Otherwise, these articles were excluded. News stories, opinion pieces, editorials, and letters to the editor were included.

On the first reading a total of 225 news articles appeared to meet the inclusion criteria for the descriptive content analysis. After reading through the articles a second time eighty-eight were eliminated because they were duplicates or utilized the search terms in relation to non-SDOH issues, e.g., equity and small business loans. In the end, a total of 134 articles met the inclusion criteria.

Coding

A measurement instrument was developed for coding detailing major categories (see Appendix A). These categories were based upon the variables and factors that influence agenda setting and social movements. The coding assessed the elements of a social movement as set out in Table 2 including mechanisms for issue generation, political opportunities or the openness of the political system, mobilizing structures, and the presence and characteristics of framing tactics. To operationalize these social movement elements news articles were coded for: title of article, newspaper, location in newspaper by page

number, author, year published, length of article, issue generation method, type of organizations, type of actors, names of organizations and actors, frames, types of evidence used, and the discourse model.

It should be noted that the coding for issue generation varied from the three theoretical categories. Because the sampling unit in this study was newspapers "inside access" (gaining entry onto the legislative agenda by circumventing a public communications process) was excluded from the coding. Accordingly, the rule was as follows. If the article originated in relation to a statement, report, activity, or program initiated by the government it was coded as a mobilization effort. In contrast, all other articles were coded as an outside initiative where the newspaper, a special interest group, an individual, or a non-governmental entity initiated or was the subject for the news article.

To determine whether the news article was favorable or unfavorable to the SDOH a code was created and labeled "Controversy". Two questions were asked: (1) Overall does the reader sense that the problem with poor health outcomes is based on social inequality?; and (2) Overall does the reader sense that solutions include population level policies aimed at reducing inequality or individual health solutions?

An article favorable to the social determinants of health, on the whole, indicated that health outcomes were dependent on social and economic factors so that a clear correlation was demonstrated between social status and health. An anti-SDOH article defined and referred to health solely in terms of individual behavior, lifestyle, and responsibility.

A "yes" response to both questions meant that the article was non-controversial because it was consistent with a SDOH perspective. Controversial articles, were found to be unfavorable because they elicited a "no" response to both questions.

To assess the expression of national ideational and cultural themes in news articles the study adapted a framing[g] matrix presented by Charlotte Ryan in her book *Prime Time Activism*.[44] Ryan's matrix was used to analyze the frames employed by the print media in framing Central American issues in El Salvador, Guatemala, and Nicaragua.

For coding purposes this study adopted six frame characteristics from the Ryan et al.[44] framing matrix: 1) a core position of the article; 2) metaphors expressed; 3) repeated catch phrases; 4) visual images that the article calls to mind; 5) the implied solution to the problem; and 6) the appeal to a principle or value that holds wide appeal for the public.[44] Each of the elements was coded independently in a news article. In contrast, Ryan coded each article with a single frame illustrative of and tied to representative concepts for each element (image, metaphor, catch phrases, etc.).

The type of discourse in each article was identified using Levitas'[37] discourse typology that included: RED (a redistributionist discourse); MUD (a moral underclass discourse related to pathological culture/behavior); and SID (a social integrationist discourse). The coding of news articles for the type of discourse was largely temporal. Generally, most articles appearing before 1997 were reflective of a moral underclass

[g] Framing is both a verb and a noun. McAdam et al.,[22] defines framing as purposeful strategic efforts by groups to create societal understandings of the world and of themselves that validate and rouse reaction and action. As a noun Schon and Rein[115](p. xiii) define frames as "the broadly shared beliefs, values, and perspectives familiar to the members of a societal culture and likely to endure in that culture over long periods of time, on which individuals and institutions draw in order to give meaning, sense, and normative direction to their thinking and action in policy matters."

discourse as they echoed the government's anti-SDOH position where those with poor health were thought to be irresponsible or lazy. Articles after 1997 were generally reflective of a redistributive discourse mixed with social integration.

Discourse designations based on time period were also confirmed by reading the articles for key words and phrases. MUD was most often accompanied by words and phrases indicating individual responsibility, behavior, and lifestyle. Frequently phrases related to "community" or the phrase "we are all in this together" were found in SID articles. Last, RED articles contained comments from the finance advisor or Chancellor of the Exchequer, Gordon Brown. These articles also referenced or discussed redistributive policies and goals.

Finally, secondary data sources consisting of published texts of historical accounts from public health researchers and other eyewitnesses were used in two ways. First, these data sources ameliorated the lack of news articles from 1980 to 1984. References to activities during this period could be found in articles dating from 1985. With the aid of secondary data sources and the references to the past in the sample of articles, the analysis was able to proceed with an examination of the original period from 1980 to 2003.

Second, the process of triangulation was made possible with the secondary data sources. Findings from the analysis of the news articles were checked, confirmed, clarified, and in some cases enhanced in the process of comparing multiple accounts of sociopolitical activities and events.

The analysis of the news articles, utilizing content analysis, facilitated an examination of the extent to which different agenda setting factors and models helped to illuminate the key factors in the emergence of the SDOH in Britain. From these findings an array of data

tables were constructed to respond to the principle study objectives. The data tables display the major agenda setting factors found to be of significance in the emergence of a SDOH perspective in Britain.

Historical and institutional facts were integrated through the context analysis of Britain during the period from 1980 to 2003 to elucidate the details of the political system, mobilizing structures, and framing packages including the values and ideologies that were major agenda setting factors during that era. Findings from the context analysis indicating the existence of two significantly different periods, 1980 to 1996 and 1997 to 2003, were employed in an analysis of how the agenda setting factors interacted.

From the analysis, inferences are drawn about how the SDOH assumed a place on the policymaking agenda in the U.K. The inferential utility of these findings is then employed to construct a theory about how the SDOH might become part of the health policymaking agenda in the U.S.

CHAPTER 5: RESULTS AND ANALYSIS

This section examines the four research questions.

1. Does agenda setting for a social determinants perspective depend on the method of issue generation defined either as outside initiative, as mobilization, or as inside access?
2. Does agenda setting for a social determinants perspective depend on political opportunities which includes the openness of the political system, the presence of state repression, and the social changes in institutional structures or informal power relations of a given national political system that make the system more receptive to challenge?
3. Does agenda setting for the SDOH depend on the characteristics of mobilizing structures and on the impact of external opportunities on structures and resources?
4. Does agenda setting for the SDOH depend on framing processes which includes the cultural toolkit[h] of a jurisdiction, framing strategies, frame packages, the structure and role of the media and the goal of the framing tactics?

The following two sections, presented before the analysis of research questions, are additional background information and will assist in understanding the analysis and results that follow.

[h] The attributes of groups or societies that shape how they classify, evaluate, and assign meaning to understand experiences. These attributes include shared values, codes of manners, dress, language, religion, rituals, norms of behavior, and systems of belief. More generally, the cultural toolkit includes a set of distinctive spiritual, material, intellectual, and emotional features that a society uses to interpret experiences.

General Background

The descriptive content analysis of British newspaper articles and historical accounts from 1980 to 2003 demonstrates the presence of critical elements that characterize agenda setting activities, mechanisms for issue generation and expansion, political opportunities, mobilization structures, and the presence of framing tactics and cultural toolkits, i.e., cognitive maps, ideology, and values upon which to frame the issue.

Unexpectedly, the examination of historical narratives and the news articles revealed the presence of two distinct eras within the single timeframe selected for examination in this study. These two eras were 1980 to 1996 and 1997 to 2003. The primary reason for the two eras, as revealed by the analysis, was a shift in the sociopolitical landscape including the economy and politics. Arrangement of the 1980-2003 period into two discrete political eras makes clearer the relationship between the elements of a social movement and the sociopolitical context as stressed in the Baumgartner/Jones model of agenda setting.

Recall that agenda setting in the Baumgartner/Jones model does not unfold in a linear fashion. Rather this agenda setting model examines a confluence of factors that interact, merge and flow together over time. Issue generation and expansion[i] are not seen as a series of actions, but a set of variables that interact to result in issue expansion dependent upon another set of variables operating at the outer margins to provide parameters or the broad context.

[i] Issue expansion refers to the specific methods used to move a grievance beyond the interest group to the policymaking agenda. In comparison, issue generation focuses upon the sources that propel an issue out into the public realm including an outside initiative by nongovernmental groups, mobilization efforts initiated by the government, or inside access where issues come onto the agenda bypassing public venues.

The bifurcation of the time frame (1980 to 2003) into two political eras portrays the emergence of the SDOH perspective on the legislative agenda as a call and response. From 1980 to 1996, interest groups were the initiator with the government as respondent. Alternatively, from 1996 to 2003 the government became the leader with interest groups playing the part of the respondent. Evidence from this analysis indicates that the newspapers played a key role serving as the medium through which the interchange took place between interest groups and policymakers both between and within news articles.

This is consistent with the Baumgartner/Jones characterization of the media in agenda setting. Rather than serving as a reflection of public attitudes, the media is one of several conduits used to transmit a dialogue that conveys warring policy images and frames.

Support for this idea comes from this analysis which indicates that while the media conveyed a dialogue between interest groups and the government on the SDOH perspective as an issue of equality, other research on lay perceptions of class, identity, and health confirm that general attitudes on health were not connected to the "equality-inequality" frame highlighted in the news articles.[45,46] The media, in this case, served as a transmitter of the interest group- government dialogue on equality rather than a reflection of public attitudes on individual health.

Studies by Blaxter et al. and Macintyre et al.[45,46] confirm that the existence of inequalities in health reproduced in countless epidemiological studies and related news articles in the UK offer very little explanation for the way in which individuals conceptualize their health status or reconcile class issues. The clearest findings in several studies are that

individuals tend not to consider structural causes of health and rarely talk about inequalities in health unless directed to based on the design of the study and prompting.[47]

Macintyre,[46] in a quantitative study using data from a community-wide postal survey in Scotland, asked the respondents: "Who do you think is more likely to have the following experiences (health, disease, being fit, cancer, mental illness, accidents/injuries, living longer): rich people, poor people or both about the same?" Across all health categories the outcomes indicated that those in lower social classes or from poorer neighborhoods were equally or less likely than more socially advantaged counterparts to say the poor had worse health.[46] Controlling for sex, age, class, and locality those in lower social classes and in the poorer areas were significantly less likely to say that richer people live longer. Macintyre[46] concluded that those most at risk for poor health were less likely to acknowledge the social gradient in health.

Bolam[48(p. 1355)] explained the lack of association between health and class on "two competing argumentative positions" around which individuals work to negotiate class, identity, and health. The first position denies the significance of class for identity and individual health substituting mythical stereotypical narratives of "heroic and stoic" working class identities[48(p. 1355)]. In the second position associations between the realities of class relations and their implications for health and identify are made only within the context of a broader discussion on health as a social or political phenomenon.

Blaxter[45] offers several possible explanations for the lack of findings that lay people associate health with inequalities. First, the widespread, long-term effects of health promotion education have influenced the way in which individuals conceptualize health.

This conceptualization is a narrow version of health determinants excluding socioeconomic factors and dependent upon lifestyle, behavior, and/or the effects of health care Second, Blaxter[45] says that acknowledgement of inequality would be to admit an inferior moral status for oneself or one's peers.

Finally, a study by Davidson et al.,[47(p. 2173)] found that individuals will discuss the effects of socio-economic deprivation on well-being but only after being "explicitly prompted to talk about inequalities in health with the introduction of images and headlines from the reporting of government consultative and policy documents"….and newspaper pictures and headlines on deprivation and health inequalities between the rich and poor.

In conclusion, while one might believe that conducting a dialogue based upon competing policy frames and images via newspapers would serve to both reflect and increase public awareness of the relationship between structural factors and health such was not the case based upon this analysis as supported by other research on lay perceptions regarding health.

The most likely explanation, again, is that the media is a venue or transmitter of a framing dialogue that occurs among interest groups in an effort to place an issue on the policymaking agenda. The cultural, ideational frame of equality was the chosen message which had national resonance. However, as the message and frame were focused upon equality delivered as a dialogue among interest groups via the print media competing notions regarding individual health as lifestyle/behavior were never impacted.

What follows next is a brief explanation and description of the two eras. The first phase is from 1980 to 1996, followed by the period from 1997 to 2003.

Two Eras

The Conservative[j] government that came into power in 1980 was committed to and elected on a platform of reducing public expenditures, lessening dependence on government, moving towards a free market economy, dismantling trade union power, and an increased focus on law, order, and national defense.[49]

During this era, particularly in the 1980s, the Conservative government was vociferously accused of suppressing both data and reports that highlighted inequalities and structural and social causes of health over individual and lifestyle factors. As a result, the 1980s and early 1990s are generally characterized as a bleak period for the SDOH and the issue of inequalities.[50] In fact, many of the news articles from this time reflected the government's use of a moral underclass discourse (MUD) featuring references to individual behavior and responsibility for health.

The traditional rival to the Conservative regime is the Labour Party.[k] While out of office (serving as the Opposition party) from the 1980s until the 1990s the Labour party continued its historical commitment to increase equality and the living standards of the poor and including health outcomes in that commitment.

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[j] The Conservative Party is the largest political party on the right-of-center in the United Kingdom. The Party is descended from the Tory Party, one of the two ruling parties of 18th and 19th Century British Politics, and its members are still commonly referred to as *Tories*. Though the Conservatives were considered to be the dominant governing party in the United Kingdom for much of the 19th and 20th Centuries, since losing the 1997 election to the Labour Party under Tony Blair, they have been in 'opposition' in Parliament. The last Conservative Prime Minister was John Major.

[k] Created in 1900 though a coalition of working people, trade unionists and socialists, united by the goal of changing the British Parliament to a more egalitarian representative body**,** the political ideology of the Labour Party was grounded in Socialism. The Party, labeling itself a democratic socialist party, has historically stood for social justice, common endeavor, and an equal society. [111]

The 1997 general election, held in May, heralded the first change in the U.K. Government for 16 years. The Labour Party under Tony Blair defeated the Conservative Party by a huge margin causing a major change in the political landscape of the United Kingdom. From this point forward it is said that "inequalities came fully out of the closet".[50(p. 1)]

In 1997, the Labour Party had run on a platform characterized as the "'New Center and center- left politics". The defeats suffered by the Party over a sixteen -year period of time had convinced it of the need for reform. Hence, the Labour government's new political ideology was referred to as "New Labour". This ideology was characterized as the Labour Government's attempt to persuade the public that the party was in tune middle England[l] and shared their existing values.[51]

One key concept that exemplified the New Labour ideology was the "Stakeholder Society".[52] The key themes of the Stakeholder concept were equal opportunities for all citizens, reform of the welfare system, prioritizing of training and cooperation between business and Government.

This marked a departure from the Labour Party of the 1980s by emphasizing equality for all, but through opportunity as opposed to the redistribution of wealth. The Stakeholder concept pointed to a trend in New Labour to conceptualize the welfare state in a manner similar to the American welfare system that included the imposition of duties and conditions on the recipients of welfare. Further, income redistribution, as an explicit Party manifesto,

[l] Similar to America's middle class, in this case, the phrase "middle England" refers to middle-income citizens.

was greatly downplayed in the 1990s as well as leading up to and after the election of the Labour Party.

Subsequently, over the period from 1997 to 2003 the Labour Government had a paradoxical effect on Britain. While changing the express ideology of the Party helped them acquire the support of those who typically were further right than many traditional Labour supporters, it also helped persuade those who already backed the party to shift their views to the right.[51]

On the other hand, policymaking by the Labour government from 1997 to 2001 has been characterized as "one of the most active, radical and thoroughgoing reform programs in public policy of any U.K. government".[53(p. 1)]

Further, successive budgets under the Labour Government consistently redistributed income in favor of lower income groups so that the net effect of fiscal reforms starting in 1997 was to "increase the incomes of the poorest two-tenths by over 10 percent and to reduce that of the richest two-tenths by around four percent".[54(p. 1)]

Other reforms included: a shift in the provision of the largest single area of state spending so that pensions came to be supported by private enterprise at a level of 60 percent in comparison to 60 percent public support as in the past; the largest expansion of education from pre-schools to further and higher education; reinforcing the incomes of those who worked by introducing Britain's first ever minimum wage; introducing a system of negative income tax administered via tax credits available to families with children and since 2003 to all working people subject to eligibility; and, the expansion of government activity in the area of childcare for working parents.[54]

Later, this analysis will reveal the Labour government's discourse to be largely social integrationist (SID) while explicitly disavowing a redistributive (RED) ethos. This tendency under the Party after 1997 represented Tony Blair's efforts to relate to the middle-class, alter the Party's "tax and spend" image, and keep down panic among the voting population regarding redistributive policies. Alternatively, at the same time, evidence such as that cited above now indicates an active effort by the government to enact RED policies.

In effect, the original period under examination became, upon close inspection, two distinct eras with unique sociopolitical characteristics. The consequence of having these two unique political eras highlights more plainly, within an analysis of the research questions, the relationship between social movement elements and the social, economic and political context.

Research Questions

Does agenda setting for social determinants perspective depend on the method of issue generation defined as either outside initiative, mobilization or inside access?

From the 1980s to 2003, agenda setting activities for a SDOH perspective in the U.K. were tied to a specific method of issue generation. Specific issue generation approaches that may have been utilized to get the SDOH onto the public agenda include: 1) the outside initiative model of agenda setting which focuses upon nongovernmental sources of policymaking such as the efforts of individuals or groups to convert their concerns into a larger movement; and 2) mobilization efforts where public officials initiate a campaign to move to the legislative agenda using public support.[21]

At issue is what factors shaped issue generation. In the end, the analysis will demonstrate that issue generation for the SDOH was affected by the two time periods (1980 - 1996 and 1997- 2003) and three factors (political opportunities, the cultural toolkit, and societal familiarity with the SDOH) that either interacted or did not interact with the time periods to influence the specific method of issue generation. These factors and their interaction are displayed in Table 6.

Table 6: Issue Generation and Political Time Periods

	Political Opportunities	**Framing Process: Cultural Toolkit**	**Framing Process: Societal familiarity with SDOH**
Period 1 1980- 1996 Issue generation method	Yes: Outside Initiative	No, method remained fixed	No, method remained fixed
Period 2 1997-2003 Issue generation method	Yes: Mobilization effort	No, method remained fixed	No, method remained fixed

One factor affecting issue generation was the concept of political opportunities examined in research question two. Political opportunities shifted during the two distinct time periods. As Table 6 demonstrates there was interaction between the method of issue generation and the two eras based upon the time period.

Following a temporal alignment, the political agenda of the prevailing government in power at the time was a major influence on the method of issue generation. Accordingly, with an anti-SDOH regime in power from 1980 to 1996 issue generation was primarily an

outside initiative. After that period, when a political party with a pro-social equality agenda came into ascendancy, the method of issue generation shifted to become a mobilization effort.

Of the 134 articles analyzed from 1980 to 2003, a total number of sixty-nine and sixty-five were labeled as an outside initiative or mobilization effort, respectively. However, from 1980 to 1996 sixty-three percent of the articles were produced based upon an outside initiative where SDOH interest groups sought to capture the public's attention as a means to reach policymakers.

In comparison, from 1997 forward, issue generation was predominated by mobilization efforts fifty-seven percent of the time. In this case this finding is consistent with the reign of a government that hoped to influence public opinion to achieve a positive reception to its policies and programs.

In the end, because of political opportunities played out by the presence of two socio-politically distinctive time periods, the specific method of issue generation for the SDOH is temporal and shifts over time, exhibiting at intervals, the efforts of interest groups to shape the agenda or the government to sway public opinion.

Alternatively, while the framing process facilitated issue generation it did not alter the method of issue generation within the two time periods. In this case the framing process is conceptualized as the cultural toolkit[m] of the citizens based upon a national, ideational theme of equality and the nation's familiarity with the SDOH as seen throughout history.

[m] See Note b

Accordingly, operational across the single time period from 1980 to 2003, the framing process facilitated the success of issue generation tactics irrespective of the time period in which the interest group or government operated. The interest groups, most vocal in the first time period, and the government in the second were still dealing with the same cultural factors in both eras. As will be demonstrated, the framing process was a canvass that allowed different groups to craft a message that might or might not resonate with the citizens. In the end the framing process determined the success of issue generation tactics but did not alter or affect the method used irrespective of the time period in which the interest groups or government operated.

Table 6 displays the three factors and their positive or negative relationship to the political eras and the method of issue generation.

What follows next is an examination of how the framing process (national, cultural toolkit, societal familiarity with the SDOH), and the political climate shaped the methods of issue generation and expansion for the SDOH.

Does agenda setting for the SDOH depend on the framing process which includes the cultural toolkit of a jurisdiction, framing strategies, frame packages, the structure and role of the media and the goal of the framing tactics?

Framing is an intentional strategic effort to create shared understandings that have the potential to authenticate and rouse reaction and action.[6]

The cultural toolkit of any society is composed of frames that are the broadly shared beliefs, values, and perspectives familiar to the members of a collective culture. These frames

usually endure over long periods of time and assist individuals and institutions in assigning meaning, sense, and normative direction to their thinking and action.

SDOH interest groups constructed issue generation and expansion tactics by promoting a connection between poor health and a nationally shared notion of inequality or rather an inequality frame. A societal conception of inequality has a long history in the U.K. The "British Social Attitudes Survey", which began in 1983, demonstrates that attitudes towards income inequality over the years have consistently found it to be unacceptable.[49]

Further, it has been documented that attitudes towards the government playing a role in reducing income differences has consistently received support from British citizens. Between 1985 and 2000 there has always been majority (ranging from 51 to 65 percent) in favor of the idea that the government should be responsible for reducing income differences.[49] In fact, of the 59 different solutions identified in news articles in this analysis 21 listed the government as the party responsible for taking action. Solutions calling for government action represented 40% of the total possible solutions coded in articles.

In the Baumgartner/Jones model of agenda setting the definition of an issue is at the heart of an effort to build public awareness and/or government support for action. The image associated with the issue must transmit a powerful idea connected to core political values in order to achieve this result.[27] Of additional importance is the empirical evidence and tone utilized to drive issue expansion and mobilization. Last, the Baumgartner/Jones model specifies the need to identify causality-blame, and the private or public nature of the problem using the image.[27]

Employing the British society's interest in and concern for equality, SDOH interest groups from 1980 to 1996 and the Government from 1996 to 2003 utilized an inequalities frame package and discourse to encase the issue of poor health. The inequalities frame package included easily identifiable symbols, metaphors, catch phrases, and visual images that resonated with the public, the media, and policymakers. A list of these elements resulting from the analysis of the news articles is recorded in Appendix B. By connecting health to inequality SDOH interest groups[n] were successful in achieving their objective to have policymakers take-up the issue.

While empirical epidemiological evidence was produced and published to support poor health and a relationship between inequality, it was the tone, image or inequalities frame that helped to propel the SDOH.[o] During the 1980s and early 1990s, while the Government sought to make poor health an issue of personal responsibility, news articles indicate that SDOH interest groups managed to make it a public problem of inequality accompanied by a message affixing blame on the Government.

> ……..England is split in two by a 'death line', a Labour MP claimed yesterday….Mr. Milburn, member for Darlington, accused Ministers of sweeping regional health inequalities under the carpet….Mr. Milburn said: 'The Conservatives' market-driven approach in the NHS has diverted funding away from areas of greatest need.' His attack came as Health

[n] See table 7

[o] Again, as depicted in Table 6, the framing process and the inequality frame helped to propel the SDOH but did not affect the method of issue generation used by either the interest groups or the government from 1980 to 2003.

> Secretary Virginia Bottomley claimed progress in cutting deaths from preventable illnesses.[55]
>
> Critics of Mrs. Edwin Currie's claims of a North and South health divide were proved largely wrong in a statistical survey disclosed yesterday…Northerners, as the junior health minister said, are more overweight than southerners, eat too many crisps and drink too much…The Henley Centre, a leading forecasting organization which questioned 18,000 people, claims, however, that she missed out the income and employment links which disadvantage the North…Dr. Colin Wayne, chairman of the clinical research Division of the Royal College of Practitioners, said yesterday that Mrs. Currie had failed to understand that a northern diet is based on a tradition of low wage levels and heavy manual work.[56]

Twenty out of the forty-eight frames identified in the sample of news articles were related to inequality and a health, social, income, or class gap. These twenty frames are listed in Appendix C. The twenty inequality frames were documented in one-hundred news articles. The most frequently identified inequality frame was "the issue of government allocation of resources to address poverty and social inequality".

The most frequently used catch phrases related to inequality were: "division between rich and poor"; "gap between the rich and poor and/or reduce the income gap between the rich and poor; "health inequalities and/or health and inequalities". Twenty-eight of the one-hundred forty eight catch phrases were variations on the idea of inequality (Appendix D).

These twenty-eight catch phrases were cited one-hundred eighty one times in 88 news articles.

The most frequently evoked image associated with inequality was that of the "rich and poor divide". This image was recognizable eighty-one times in news articles. In comparison, the only other more frequently invoked image was that of "links to poverty and health" identified twenty-two times in articles.

The presence of strong attitudes towards notions of inequality indicates the existence of a societal cognitive frame available for interest groups or the government to utilize in building awareness and support for an issue. From 1980 to 1996 this societal frame made it expedient for SDOH interest groups to mount an outside initiative strategy to influence public discourse in an effort to reach a government that was not easily persuaded by arguments regarding societal inequality. Later, in the second era, the availability of the inequality frame facilitated the use of an outside initiative by the government to push their policy and program initiatives into the public domain.

The second non-temporal element affecting issue generation and fueling efforts to address health and inequality is the Nation's long-time familiarity with poverty, equality, and inequality through extensive lay and scientific publications.

Following closely upon the heels of and in relation to the inequalities frame is England's almost 200-year fascination with the existence of distinctions and differences created because of socioeconomic inequalities among groups.[34,57] The distinction being made here is between the presence of a cultural cognitive frame for the notion of "equality-

inequality" versus distinct and specific actions taken by individuals and groups to highlight and address factual, evidence-based inequalities.

Beginning in the late 1700s British researchers began to examine and expose the connection between health and poverty. At that time, Thomas Clarkson wrote a treatise against slavery using arguments over poverty and health to support abolition. From that point forward in history a strong collection of work spanning more than two centuries and comprising many different kinds of evidence from individual anecdote, to structured research, to statistical analysis has been brought to bear in Britain to demonstrate links between poverty, inequality, and poor health.

This history of advocacy for health linked to inequality in Britain is most notable for the incorporation of scholarly works that became popular and popular writings that influenced scholarship.[34,57] Efforts by special interest groups (SPIGS) to expand and generate interest in the SDOH continued into the 20th century and beyond. In the case of this study, 95% of the news articles in the sample discussed, analyzed the results of, or invoked popular writings or scholarly reports to support a discussion on the SDOH.

Groups, organizations, and policymakers interested in expanding the SDOH beyond the interest group level towards the policymaking agenda had a naturally existing social context upon which to build to expand the SDOH. These groups were fortunate to have in existence a national cognitive frame on inequality and societal familiarity with the SDOH through centuries of scientific and lay publications on research on social inequalities and health. This meant that the use of familiar images, symbols, language, and ideas to shape the SDOH to achieve exposure and escalate the topic in the public sphere via the print media

could be used to gain the attention of policymakers or, conversely, shape public opinion for particular policies.

Does agenda setting for social determinants perspective depend on political opportunities defined as the openness of the political system, the social changes in institutional structures or informal power relations of a given national political system that make the system more receptive to challenge and the presence of state repression?

The social context, contemporaneous events, and the ideology and policy agenda of the prevailing government in power at the time were major influencers in the selection of a method of issue generation and the strategies of the SDOH social movement. Accordingly, as said earlier, with the Conservative Party in power from 1980 to 1996, issue generation was primarily an outside initiative mounted by pro-SDOH groups. After that period, when a political party with a commitment to equality came into ascendancy, the method of issue generation shifted slightly to become a mobilization effort on the part of the Government. What follows next is an examination of how the political opportunities of the period affected issue expansion and the goal of attaining the legislative agenda.

An appreciation of how political opportunities played a central role in shaping the SDOH social movement will be examined by reviewing three topics: 1) Publication of the Black Report in 1980; 2) Abolition of the Health Education Council in 1985; and 3) SDOH policies, government publications, and programs after 1996.

Publication of the Black Report

As noted previously from 1980 to 1996 the Conservative Party prevailed. During their 16-year reign over the Government, they maintained a steadfast denial of inequalities in

general and any relationship they might have had to poor health. Thus it may seem strange that the "match that lit the fuse" and subsequent high-water mark for SDOH policymaking in the U.K., was the 1980 publication of the "Black Report".[p] However, at the outset, in 1980, the Black Report heralded in the bleakest period in British history for the SDOH social movement. To understand the Conservative government's reaction to the Black Report we start in the late 70s with an examination of how the Black Report came to be commissioned.

The late 1960s and all of the 1970s are characterized as a tumultuous time in the U.K. First, with the exception of four years between 1970 and 1974, the Labour Party was the ruling regime holding the office of Prime Minister and control of Parliament during the 1970s. During this phase there was a delayed but growing sense of public frustration over data from the 1960s indicating a failure to distribute health resources on a rational and fair basis resulting in a regional, disproportionate allocation of services.[58] The result was a concentrated focus on research examining inequalities in access. Consequently, between 1968 and 1975 a substantial body of research and literature targeting different audiences built up exposing the wide extent of geographical and social class disparities with respect largely to the distribution of services under the welfare state including health and social services.[58]

A global economic crisis, high inflation, industrial unrest, and a slow down in the long period of Welfare State activity owing to a crisis precipitated by oil price increases in 1973 meant that under the 1974-79 Labour administration the leading political issues were unemployment, recession, poverty and inequality.[58]

[p] A major report on inequalities in health from a committee chaired by sir Douglas Black and commissioned by the Labour Government in 1977. The Report discussed the inequalities in health and in income that existed at the time and made a series of policy recommendations.

Thus, under pressure from stagnant economic growth, and inundated with data, studies, and publications demonstrating an increase in inequalities in health services the Labour administration called for an investigation into health inequalities in 1977 to be chaired by Sir Douglas Black.[q] It is reported that for the first time a government accepted that it was necessary to sanction an investigation into health inequalities.[58]

The authorization of the health inequalities investigation under Sir Black, which began under a Labour administration, went awry as the party lost control of Parliament to a Conservative government in 1979. Subsequently, starting in 1980, the reigning Conservative administration began to be publicly accused of systematically suppressing documents and information that supported the SDOH and the relationship between poverty and health. It was at this point in 1980 that the work of the Committee, appointed by the previous Labour government, presented its findings to the new Conservative regime.

The completion of the Black Report, at a time contemporaneous with the newly elected Conservative government's agenda to reduce welfare state expenditures, was viewed as a failure in tactics by the SDOH interest groups and a political nightmare to be hidden away by the new government. When submitted to the Conservative Government's Department of Health and Social Services (DHSS), and Lord Patrick Jenkin, Secretary of State for Social Services, the Black Report was met with criticism and labeled a "mixture of semi-digested data and proposals for massive public expenditure".[59]

The Government's labeling of the Black Report as a call for immense public expenditures was echoed through-out all of the news articles that referenced the report. The

[q] Sir Douglas Black, Chief scientist, Department of Health and Social security (DHSS), 1973-77; President, Royal College of Physicians, 1977-83.

most frequently coded image in the sample of news articles was discarded and discredited. Subsequent news articles that referenced the report for as long as three to four years after its publication still framed the Black Report in this manner. Finally, as the regime in power and the media began to put a price tag on the report's recommendations a key principle that came to be associated with the report in news articles was that of "fiscal responsibility". Calls for budgetary restraint were frequent lasting well beyond the report's publication date.

News articles and historical accounts spanning 1980 to 1996 depict the stalling of the SDOH social movement due to the non-responsiveness of the Conservative government. The Government was accused of suppressing both data and reports that highlighted inequalities and structural and social causes of health over individual and lifestyle factors.

These sentiments led to the widespread belief that the government systematically suppressed, hid, and denied the assertions and recommendations of the Black Report along with any other subsequent data on the SDOH and inequality.

Historical accounts of the Black Report detail how a single reporter for a publication titled the "New Society" persuaded Sir Black and the research authors to go around the Government and call a press conference to release the document.[60] The reporter, Jill Turner, received an advance copy of the report from one of the authors a few weeks before the August Bank Holiday. Upon calling the Department of Health she discovered that the Government considered it to be on "only a working party report" and had no plans to release the report[60(p. 154)].

Turner informed the authors of the Report that it was "absolutely obvious that every attempt was being made to sweep the report under the carpet".[60(p. 154)] Sir Black, the authors

and the reporter than agreed to call a press conference to release the Black Report on the Tuesday immediately after the Bank Holiday.

> In 1980 the ground-breaking Black report was published. It put health inequalities on the agenda around the world, and made recommendations remarkably similar to yesterdays from Sir Donald Acheson. But it produced specific proposals: a big increase in child benefit, a quadrupling of the maternity grant, free school meals for all…The Tory government costed them at around (5 billion pounds) in today's money and panicked. Patrick Jenkin, then health secretary, wrote a dismissive introduction, cyclostyled[r] off a mere 260 purple-covered copies (now collector's items) and released it late on the eve of an August bank holiday. He refused a government press conference to Sir Douglas Black, the former chief scientist commissioned by the previous Labour government to produce it. Sir Douglas had to retreat to the Royal College of Physicians to hold his own show.[61]

In one news article, coming more than ten years after the official release of the Black Report, allegations of a cover-up, echoed in countless other articles, still lingered.

> The links between poverty and ill-health have been banned territory since *Inequalities In Health* by Sir Douglas Black, a former Chief Scientist at the Department of Health and then President of the Royal College of Physicians, was published in 1980. The Government was

[r] A device for producing copies.

> aghast at its conclusions that the lower occupational classes suffered increasingly poorer health than the upper classes because of social and economic factors, and its 37 recommendations to redress the balance. The then Health Secretary, Patrick Jenkin, dismissed it out of hand, saying all this would cost far too much, and the report was not properly printed or published.[62]

Still other news articles reported on acts of censorship under the Government during this period to include the abolition of the Royal Commission that once reported regularly on the distribution of income and wealth; the curtailment of the scope of the General Household Survey; the abolition of the Supplementary Benefits Commission, with its regularly published dispatches; the many changes in the presentation of the unemployment figures; the removal from Social Trends of the table revealing the link between unemployment and ill health; and, the huge reduction in the analysis of Census data on death and social class.[11]

Suppression frames coded in the sample of news articles included: "Concealment", found in four articles; "Freedom of Speech", in three articles; the "Government ignoring data connecting poverty to health", in one article; and, the "Government ignoring how economic and social factors influence health", in three articles. News articles featuring suppression frames were all dated before the 1997 Labour Government. Coded metaphors for suppression in the news stories included: government as suppressor; government as bully; and, government as evasive. Again, these metaphors all appeared in articles generated before 1997. Two primary solutions for the Government's suppression were coded more frequently in the news articles: "Stop censorship and allow negative information on inequalities to be

printed"; and "The government should pay attention to data, facts, and reports on health and the health divide".

Health Education Council

Another example of how political events and sociopolitical context influenced the SDOH social movement was the elimination of the Health Education Council (HEC) in 1987. The idea to replace the HEC was announced by the Conservative Government in November of 1986. The official date for elimination of the HEC was to be March 31, 1987. In its place, the Conservative Government called for the creation of the Health Education Authority (HEA). Differences in the two organizations are related to their function and authority. The original HEC had a broader mandate and less accountability to Parliament.

Historical accounts indicate that decisions to disband the HEC, and cancel the release of a SDOH report were contemporaneous with rumors of the possibility of an early election and thus a fight for the Conservative Government to maintain control of Parliament. Because of the outspoken criticism of the Government's relationships with the tobacco, alcohol, and food industries, the Conservative Government felt it might be less work to win the election without such claims being pressed by the HEC.[60]

Further evidence of how political events shaped the SDOH social movement are accounts of the termination of an HEC press event. News articles of March 25 -26, 1987 provide an account of the cancellation of the press conference even as reporters were arriving for the affair. The order for the cancellation concerned the release of a report titled the "The Health Divide- an update of the Black Report" by Margaret Whitehead. The HEC report detailed the connection between poverty and illness.[63]

While the actual order to cancel the event was given by the HEC Chairman, news articles implicated the Conservative Government. Accounts of how the Labour Party in Opposition made accusations against the Conservative Government were detailed in early articles. As time passed, two to five years out, any references to the HEC report would always include a long list of repressive actions taken by the Conservative Government to dodge the SDOH and inequalities claims.

In the end, members of the research group that wrote the HEC report are said to have marched down the street to another location, reporters in tow, on the day of the cancelled press event to launch the "Health Divide" report independently of and outside the HEC office the week before the abolition of the Council.

> …A Health Education Council report accusing the Government of allowing the health gap between rich and poor to widen was at the centre of an extraordinary row yesterday…Dr Player[s] was ordered to cancel a press conference on the report. Arriving journalists and a panel of exports invited to discuss it were told they had to leave the council's London headquarters…The order came from Sir Brian Bailey, the HEC chairman, who has also been named chairman of the new authority, 45 minutes before the conference was due to begin….Mr Michael Meacher, Labour's chief spokesman on health and social security, said last night: 'The Government has clearly leaned on its new, so-called independent chairman, Sir Brian

[s] British news articles omit the punctuation after Dr. and Mr.

Bailey, in an attempt to suppress information which contradicts the Tories rosy pre-election scenario…'.[63]

With the election of the Labour Party in May 1997, the flood gates opened up for the SDOH movement. In this second phase from 1997 to 2003 the effects of political opportunities and the socipolitical landscape on the SDOH movement may be measured by the variety and quantity of programs, policies and government publications.

SDOH policies, government publications, and programs after 1996

First and foremost, the new Labour Government appointed the first minister of public health in 1997, Tessa Jowell. From that point forward, the Labour Government displayed a strong commitment to the SDOH and the issue of inequalities. In fact, one year after her appointment as Britain took over the European presidency and Jowell chaired the first meeting of EU health ministers she was able to discuss Britain's new public health agenda of recognizing and tackling health inequalities across the whole range of Government responsibilities.[64]

Another decisive event renowned for inaugurating the "New" Labour Government's commitment to the SDOH was the authorization of an inquiry into inequalities and health. Two weeks after the election of the Labour Government in May 1997 Tessa Jowell announced the new mission to tackle inequalities. Recognition of this objective was commemorated by the commissioning of an inquiry to be lead by Sir Donald Acheson, the former Chief Medical Officer for England (1983 – 91). The inquiry began in July 1997 and published a report 16 months later hereafter known as the *Acheson Report* in November 1998.

The *Acheson Report* exemplifies how the Labour Government worked to frame its version of the SDOH. Vowing to tackle inequalities, the Government had also been elected on a promise of a "new" Labour philosophy antithetical to a tax-and-spend, expansion of the welfare state. Part of Blair's appeal, despite his Labour party label, was his promise to reign in or at least not increase spending.

Accordingly, while the Acheson team had been commissioned to make recommendations to remedy health inequalities, they were also constrained by directives to make recommendations within the broad framework of the government's financial strategy of cost containment. They could not cost out recommendations or set targets.

> A radical, uncosted plan to close the health gap between the rich and poor by eliminating poverty has been put forward by an independent inquiry set up 16 months ago by the Government…..The inquiry team, chaired by the former Chief Medical Officer, Sir Donald Acheson, makes no recommendations about how the reforms are to be funded but insists that its entire plan of 39 major recommendations and 35 minor ones must be carried out if it is to stand any chance of success.[65]
>
> ..The report was warmly received by Frank Dobson, the health secretary, who said the government had already started on Sir Donald's agenda. But with the recommendations implying a shift of billions of pounds to the less well-off, Mr Dobson was careful not to endorse any specific recommendations…There are no costings for the 74 proposals. Sir Donald said affordability was a matter for politicians, not scientists.[66]

The *Acheson Report* was a foundational statement for the SDOH movement after 1996 in many ways. First, it set the principles that would guide the new Labour Government's discussion about the SDOH. The message would be one of agreement on the severity of the problem, decisive action, partnerships between the government, individuals, and communities, and cost containment.

> ……It is the social injustice of ill health that has spurred the Government into action in producing one of the most socially-concerned documents ever published. It has, at last, changed the debate about the causes of ill-health- putting inequality at the centre of its planned public health strategy…For the first time a Minister of Health has admitted that being poor can seriously damage your health…That is why the Government has launched its Contract for Health. It is not simply another health promotion message that we have all heard so often before….It will involve local authorities, schools, workplaces, local organizations and individuals….But just as individuals can't succeed alone, neither can the Government. It must be a joint project.[67]
>
> ….Mr Blair and Mr Brown are determined to face down their critics. They argue that implementing the cuts, which will cost lone parents up to 11 (pounds) a week and save 200 million (pounds) a year, are crucial if the Government is to prove it will keep to the spending limits inherited from the outgoing administration.[68]

Next, the *Acheson Report* heralded in an age of open and willing government communication on inequalities in general and as it related to health. As observed, during this period from 1997 forward the Labour Government very actively promoted its SDOH agenda. It has already been noted how issue generation and expansion tactics at this point began to be initiated less by interest groups and more by Governmental efforts to increase public support.

In fact, after 1996 this analysis identified in the sample of news articles at least ten Labour Government reports (including the *Acheson Report*) highlighting inequalities and promoting new SDOH policies and programs. In contrast, between 1980 and 1996 the Conservative Government released one major publication[t] and five minor publications that either failed to discuss inequalities, discussed health strategies in relation to individual lifestyle, published the data so it went unnoticed, or disputed the existence of inequalities by reinterpreting the data to indicate positive gains for the less well-off despite the widening gap.

> Health workers will be told to act immediately on targets set in the Government's health promotion white paper, published yesterday, to improve England's record in heart disease and strokes, cancers, mental illness, sexual health and accidents. But the paper has been criticized for ignoring social inequality and failing to accept the case for a ban on tobacco advertising...Critics said the strategy ducked the single most important step that could be taken, a ban on tobacco advertising; evaded the issue of poverty and inequality, which underpinned much ill health; and

[t] "The Health of the Nation" released by the Conservative Government in July 1992. The report is known for a failure to acknowledge the role of social inequality in health.[116]

failed to come up with funding for investment in services to help reach the targets.[69]

Fifty-six thousand babies and children under the age of 16 died in England and Wales in the four years around the 1981 census. These deaths have now been analyzed in a long-awaited report which was published very quietly just before the Parliamentary recess in July. As a result it received much less public attention than its contents deserved.[70]

……Mr Simon Hughes (Dem. Southwark and Bermondsey) said that between 1976 and 1987 the gap between the average earnings of the top and the bottom 10 percent in London had increased by 50 percent…Mr. Scott (Health and Social Security Minister for Conservative Government) quoting the Family Expenditure Survey, said living standards of people in all income groups had risen substantially. Claims that the poor were getting poorer did not stand examination.....A government amendment, claiming its policies helped to boost Londoner's incomes, was carried without a vote.[71]

In comparison, during its reign news articles consistently and constantly portrayed the Labour Government's role in fighting inequality and poor health. Often, articles describing Labour SDOH initiatives compared and contrasted them with the previous Conservative Government.

Tessa Jowell is determined to eliminate the divide between the "health-rich" and the "health-poor". The idea that inequality can make us

> ill was consistently shunned by the Tory Government. The Health of the Nation strategy launched in 1992 was firmly based on the belief that simply encouraging people to change their behaviour was the best way to meet health targets. Its 27 unrealistic and unachievable targets were based on wishful thinking, with no hope of being reached. But the new Green Paper[u] does not apportion blame. It realizes that good health is about opportunity, education, and responsibility. And on geography, wealth and class.[67]
>
> ……. In the 1970s and particularly the 1980s under Mrs Thatcher, we saw the growth of individualism, victim blaming and finger-wagging. And, if you were ill, it was do with your unhealthy lifestyle and, by implication, you were to blame. ..We believe there is a need for a new approach to public health for the late 1990s and the Millennium which includes a contract for better health, she (Tessa Jowell) said.[72]

News articles confirmed the existence of many new SDOH policy and program initiatives under the Labour Government.

> Tony Blair has ordered the establishment of a Government unit to tackle poverty and reintegrate the "underclass" into society. The Prime

[u] A Green Paper is a consultation document issued by the government which contains policy proposals for debate before a final decision is made on the best policy option. A Green Paper will often contain several alternative policy options. Following this consultation, the government will normally publish firmer recommendations in a White Paper. Green Papers and White Papers may be the subject of statements or debates in the House of Commons. In February 1998 the Labour Government published a Green paper on public health, called " Our Healthier Nation". This was followed by the Acheson Report in November 1998. Next, in July 1999 the corresponding White paper "Saving lives: Our Healthier Nation" was issued by the Government.

Minster will personally over see the new Social Exclusion Unit, which will draw up an inter-departmental strategy for solving problems relating to homelessness, crime and public health.[73]

...Mr Blair also defended the Government's plans to introduce a national minimum wage at a level that would offer basic standards of decency while not damaging the economy or employment prospects. The Prime Minster said: "I want to make sure the minimum wage makes a real difference to the pole currently struggling on levels of pay that no Member of Parliament would consider fit…." He said the "minimum wage is good economics" and that it would help people to get of welfare, cut state subsidies to the low-paid, bring families to the workplace and boost training and productivity.[74]

The Chancellor (Gordon Brown) promised to spend an extra 285 million (pounds) on extending the Government's welfare to work programme not only to older unemployed people but also the partners of those out of work, 95 percent of whom are women. Improvements to the "new deal", which is scheduled to come on stream nationally in April, will also see a further emphasis on finding jobs for lone parents, the young homeless and residents of the most disadvantaged housing estates.[74]

The country's first action zones aimed at tackling the underlying causes of illness and cutting through red tape were announced by the Government yesterday. Frank Dobson, the Health secretary, named the first

11 areas to be targeted with extra Government funding to improve medical care. The Government received 41 applications for "health action zones" and plans to extend the scheme in the future. Health authorities, social services, charities and businesses will join forces to provide inter-departmental patient care in the priority zones, which are meant to reduce inequality across Britain.[75]

Having less money than most other people does not make you poor, the Government said yesterday as it set targets to judge whether Tony Blair would achieve his ambition of abolishing child poverty within 20 years. Instead of measuring hardship through household income only, the Department of Social Security announced that it would in future monitor 38 different indicators of deprivation to assess the new poor of the 21st Century…Alistair Darling, the Social Security Secretary, hailed the 168-page report, "Opportunity for All" as a landmark in the campaign against poverty. Mr. Darling launched the initiative at a community centre in east London by unveiling a video highlighting some of the schemes across the country attempting to eradicate social exclusion.[76]

The Health Education Authority is to be closed and half its staff made redundant or moved as part of a shake-up in the way ministers inform the nation on how to lead healthier lives…The HEA is expected to be formally abolished next week and replaced with a streamlined Health Development Agency. This will focus more on research into improving

> public health and correcting inequalities, including the providing of fresh fruit and vegetables in shops around the country.[77]

In the case of political opportunities in a social movement, the objective is the identification of ecological, contextual factors that shape a social movement's tactics and activities. Conditions external to the movement may either restrict or facilitate the agenda setting strategies. From 1980 to 1996 political power was concentrated in such a manner as to restrict and block the efforts of SDOH interest groups. However, as with social movements, the potential to be strong during times of inopportune political restrictions can be realized through the clever leveraging of other opportunities and factors.[25]

SDOH groups, during the period from 1980 to 1996 made use of societal, ideational themes that included framing health as an issue of equality and drawing upon the Nation's historical familiarity with issues of poverty, health, and equality. After 1996, with the election of a political party concerned about equity and justice, conflict between the agendas of the SDOH interest groups and that of the power structure decreased. Advancements were made in the creation and implementation of policies reflective of the SDOH perspective.

It is interesting to note the SDOH policy objective expressed most frequently by the Government after 1996. Graham[34] distinguished between three SDOH policy objectives consisting of: 1) improving the health of the poor meaning improvements only in those groups defined as disadvantaged; 2) closing the gap between rich and poor which means improving levels of health in poor groups at a rate that keeps pace with or outstrips health improvements in upper socioeconomic groups, or 3) addressing the gradient where "absolute improvements in health for all socioeconomic groups up to the highest socioeconomic group,

and with a rate of improvement which increases for the worse off at each step down the socioeconomic ladder".[34(p. 127)]

Using national policy documents Graham concludes that the U.K. effort to address SDOH rest upon "multiple and shifting" objectives as defined by her continuum.[34] Some documents evidenced a tilt towards the third goal of addressing the health gradient.[34] However, on the whole, Graham[34(p. 126)] resolves that the Government leans more towards the concept of reducing the health gap, which ultimately turns the socioeconomic hierarchy of health into a social or health divide.

In comparison, the examination of the news articles verified a SDOH policy objective of closing the gap with an emphasis on helping those most disadvantaged. This is demonstrated after 1996 when a new Government shifted to a pro-SDOH agenda.

Only two articles explicitly referred to the gradient while three were coded as having a core position reflecting the health gradient. In contrast, of the total sample of news articles, fifty-seven percent used the following phrases reflecting the policy objective of closing the gap.

- Division between rich and poor
- Social class discrepancies
- Widening of class divisions
- Socially divided Britain
- Gap between the rich and poor
- Reduce the income gap between rich and poor
- Split into two nations

- Health divide or gap
- Widening gap in the health of the people
- Health class divide
- Close the gap or narrow the widening gap
- North-South divide
- Narrow the gap between upper and lower classes
- Eliminate the divide

That the policy objective of the U.K. leaned toward assisting the poor in an effort to close the gap as opposed to narrowing the health differences among all groups along the gradient is seen most clearly in the news articles quoting government officials.

> Frank Dobson, health secretary, emphasized the hope of closing the gap saying: 'Poor people are ill more often and die sooner. And the greatest inequality of them all though is inequality between the living and the dead'.[78]

> Tony Blair yesterday proposed his own solution to the north-south divide by promising to 'set-up the pace' of his 'fight against poverty' the Prime Minster said he was impatient for change and determined to do more to narrow the gap between 'the haves and have-nots'.[79]

Does agenda setting for the SDOH depend on mobilizing structures including the type of structure, and the impact of external opportunities on structures, and resources?

What were the key mobilizing structures in the SDOH movement between 1980 and 2003? In the Baumgartner/Jones agenda setting model interest groups play a variety of roles

helping to create and destroy closed systems of participation, acting as a conduit for policymakers seeking to expand participation for an issue, in defining the range of options for the public's understanding, and in structuring the choices available to policymakers.[27] Mobilizing structures are a key factor in the model where the examination of the life-cycle of issues is dependent on the nature of the interest group and its ability to generate either waves of enthusiasm or criticism to create or undermine policy monopolies.

Recall that Rucht[25] identified three elementary types of mobilizing groups in modern democratic societies: social movement groups, interest groups, and political parties. In this case the analysis did not yield one single, monolithic group backing and/or opposing the SDOH. Accordingly, it might be more accurate to characterize the conglomeration of mobilizing agents for the SDOH as a social movement group lacking formal structure and rules and regulations. However, in this study, the term "interest group" is used to refer to the collection of organizations that were depicted in news articles including both proponents and opponents of the SDOH. It is more appropriate to label these agents as interest groups, excluding the government and political parties, because of their mode of operation and resources

Entities found to be most frequently engaged in the SDOH social movement between 1980 and 2003 are identified in Table 7. These groups were mentioned and/or quoted recurrently in news articles.

Table 7: Organizations Cited Most Frequently in News Articles on the SDOH Social Movement

Group	Frequency
Political Parties	11%
Academic Institutions	9%
Government-Parliament, Downing Street, Administrative branch- Whitehall	28%
Advocacy groups-Think tanks, Not-for-profits representing poor or low-income	9%

Those groups found in news stories to be most frequently in support of the SDOH were academic institutions, think tanks, the left-leaning political parties, and non-profit organizations delivering services or engaged in advocacy. Opponents of the SDOH identified in the news articles were most often policymakers and the government in the period from 1980 to 1996, and right-wing political parties. In the time-period from 1997 forward the Government, as indicated, became a strong proponent of the SDOH.

While the organizations functioned independently of one another they each had the characteristics of interest groups and political parties listed by Rucht[25] including an internal formal structure, expertise, financial resources, access to decision makers, and voters/constituents.

Summary

Using three agenda setting models organized around the elements of a social movement framework as the analytical tool, this analysis has revealed how the SDOH emerged onto the policymaking agenda in the U.K. between 1980 and 2003. The social movement and agenda setting elements most influential in the emergence of the social determinants of health in the U.K. were issue generation tactics, framing efforts, mobilizing structures, and political opportunities.

Overall, the analysis revealed linear agenda setting models, like the Cobb/Elder and Spector/Kitsue models, to be the least accurate portrayal of the process. Similar to the Baumgartner/Jones model, the study reveals that it is a confluence of factors merging, receding, and interacting over time that influence agenda setting. Ultimately, similar to the Baumgartner/Jones model, this analysis attended more to contextual features to determine how the SDOH moved into the governmental arena.

The Baumgartner/Jones model emphasizes key macro-forces such as the structure and organizational rules of political institutions, and the historical context.[27] These factors or macro-forces were revealed to be key influencers in the SDOH social movement in the U.K.

Of significance is that the analysis did side with each of the three agenda setting models in demonstrating that it is not the policy content but the framing package, images, words, and symbols used to portray the policy issue that is of utmost importance.

Consistent with the Baumgartner/Jones model, findings from the study demonstrate a strong relationship between successful agenda setting and a framing package. Issue expansion and gaining government and public support for an issue is strongly associated with

the use of a frame and images that coincide with societal ideals and values. In this case, a societal core value of equality was linked to health to create strong images and frames that resonated with policymakers. Further, communal, long-term social and political awareness of inequalities in health dating back to the mid-1800s facilitated the framing efforts of SDOH interest groups.

Of additional importance in framing as an element of social movements is the empirical evidence and tone utilized to drive issue expansion and the need to identify causality-blame, and the private or public nature of the problem using the image.[27] In this case, SDOH interest groups made use of both popular and scientific writings to maintain a steady flow of information and generate interest in and awareness of the SDOH. Finally, evidence of a collective conviction on the part of interest groups, citizens, and most of the left-leaning media that government had a responsibility to create solutions to problems linked to social inequality was amply documented by both nationwide annual surveys dating back to the 1980s and the news articles.

One research question explored in the study asked whether agenda setting for the SDOH depended on the method of issue generation defined as either outside initiative, mobilization or inside access. As it turns out issue generation tactics are independent of the issue and result more from an arrangement of socio-political factors or macro-forces as Baumgartner/Jones might say. In this instance, there was no relationship between the issue as the SDOH and the issue generation method.

On the other hand, the study did reveal a temporal relationship between the method of issue generation and sociopolitical factors. As described, the importance of political

opportunities becomes clearer once the presence of two distinctive eras is integrated into the analysis. In the end, the single period under study transformed into two distinct eras each manifesting a dissimilar issue generation method and type of discourse. When an anti-SDOH regime was in power, the issue generation method was an outside initiative with news stories most frequently reporting on the efforts of SDOH interest groups. In response, the discourse from the government was primarily MUD or a focus on individual responsibility and health behavior for the "moral underclass".

In contrast, after 1996, the issue generation method shifted to reflect governmental efforts to capture the issue and bring public and interest group sentiments in line with their views, ideology, and policy initiatives. In fact, at this time the discourse was social integrationist (SID) in nature with an effort on the part of SDOH interest groups to move the government toward a RED (redistributive) discourse.

Interestingly, the Baumgartner/Jones agenda setting model cares very little about the preferences and characteristics of the public instead focusing most of its attention upon the activities of interest groups. The Baumgartner/Jones model explains the tactics of groups as they seek either to maintain a policy monopoly, tear down an existing monopoly, or construct one.[27]

In comparison, social movement research examines the characteristics of movement groups as a means of understanding the potential for the groups to take action. Alternatively, this study did not find the characteristics, structure and function of interest groups to be of major import. This outcome is perhaps the result of the study design where a major source of information was news articles. While the news stories revealed the names of groups and their

ideology, other organizational features and the length and breadth of historical involvement in the SDOH were not characterized.

Based upon the study methodology and subsequent analysis, findings revealed several key groups to have been involved in the SDOH social movement between 1980 and 2003. These groups were comprised of political parties, academic institutions, policymakers, and advocacy groups including think tanks and not-for-profits. The organizational characteristics, specific tactics, funding resources, and levels of power for these groups may only be inferred but not confirmed based on this study.

Despite resistance by the government, from 1980 to 1996 interest groups in the U.K. were successful in creating a political understanding of the SDOH based upon a framing package that utilized notions of inequality, fairness, and justice. This constituted an achievement because such a frame transmitted a powerful idea connected to a core set of values and beliefs in the U.K. After 1996 when the political environment shifted interest groups achieved the institutional arrangements needed to sustain an environment conducive to the development and implementation of policies and programs to support their issue.

Study Limitations

There are several limitations to the study. First was the lack of multiple coders where judgment was necessary to assign latent content. In this case most content coded was manifest so that error was limited to coder fatigue. However, some content coded was latent and subject to bias. Multiple coders would have protected the results against errors in judgment.

In cases such as this, “noncontent analysis data” may be integrated into the study with other content analysis data to increase study reliability and verify the consistency of the coding measures.[81(p. 160)] Here the noncontent analysis data utilized to verify the consistency of the coding included published historical accounts and written reports. These data supported the judgments for latent content (see Appendix A) related to the frames, rhetorical devices, and government discourse models. In this way the threat to the reliability of the study findings is decreased.

The next limitation resulted from electronic databases that did not archive news articles further back than 1985, and, in some cases, 1983. As explained, maintaining the study’s original timeframe from 1980 to 2003 required the use of secondary data sources including eyewitness reports and scholarly writings analyzing the sociopolitical events of the time.

The newspaper articles provided a multi-level perspective of events by offering multiple views in one source. A single article might include a diverse range of views from differing groups (physicians, researchers, citizens) and institutions (think tanks, the government, newspaper outlets). Alternatively, the secondary sources reflected the single viewpoint of the author.

However, ultimately, the range of sources including articles, published accounts and reports served to fill in gaps for news articles missing for the early 1980s, and augment the validity of the research as each source of information operated to reinforce and enhance the other source.

Baumgartner et al.[27] emphasize the importance of longitudinal agenda setting studies to fully gauge the effects of social and political factors on an issue. The researchers argue that every issue goes through cycles where the enthusiasm for an issue is low, high, or stable. The factors that determine the characteristics of a cycle may only be seen over long periods of time.

This study examined a twenty-three year period of time. This is, admittedly, longer than most agenda setting studies that typically cover an election period or four to eight weeks in an issues history. However, upon reading political historical accounts it becomes clear that agenda setting studies cannot explain what exist without examining what has gone before. The optimal length of time for an agenda setting study is perhaps best determined by a painstaking effort to trace the evolution of the issue from its inception. A regression further back than 1980 may have revealed waves of enthusiasm, recession, and stability for the SDOH in the U.K.

There is a lack of detailed information regarding interest groups involved in the movement and listed or quoted in the news articles. Unlike U.S. news articles, news stories from British papers, in many cases, used only a group's acronyms and omitted information specifying the purpose or mission of the organization. To overcome this limitation the study triangulated sources and attempted to identify the organizations through other sources.

However, without more detailed information on the groups mentioned in the news articles it is difficult to determine whether or to what extent the nature of the groups (resources membership, structure) influenced or might have played a role in the emergence of the SDOH.

CHAPTER 6: CONCLUSION: IMPLICATIONS FOR THE UNITED STATES

The ultimate outcome of agenda setting, according to Baumgartner et al.,[27] is government action and institutional arrangements that permit and integrate possession and control of the issue by interest groups incorporating their political understandings of the issue.[27] Further, as highlighted by this study, an image used to cultivate a framing package for an issue must convey a gripping idea connected to fundamental societal values in order to achieve this result.

Placing the social determinants perspective on the U.S. policymaking agenda will depend upon: 1) U.S. ideals and values regarding poverty, inequality, race, health, and health care that will either facilitate or impede the creation of frames, images and symbols to communicate the issue; 2) political opportunities such as the openness or reticence of the political system to take on the issue; and 3) the mobilizing structures that support or oppose the issue including the type of structure, and level of resources.

U.S. Ideals, Values and Frames

The beliefs, values, and ideals in the United States regarding several specific issues will be significant in shaping the level, manner, and mode of support for a SDOH perspective. Unlike the U.K., the cultural toolkit of the U.S. appears to be comprised of a set of ideals, values, and frames that may serve as a barrier to a SDOH perspective founded upon notions of social inequality.

A 2005 announcement from the University of North Carolina Law School declared that former U.S. Senator and vice presidential candidate John Edwards would be taking up the issue of poverty and the "gap between the haves and have-nots in America".[82]

On yet another occasion, almost one year later, when asked about the popularity of the issue in a television appearance, Edwards proclaimed, “I think you have to convince the country that it's (the) moral and just thing to do," he said. But he acknowledged, "I don't think (Americans are) completely there. I think that in their conscience inside they're there, but they haven't had any leadership. No one has ever made them think about it".[83]

The fact is that ancient questions and values-based conflicts lie at the heart of the U.S. dialogue about poverty. Exactly what to do about the poor has always been controversial. In the United States the ideology on poverty is underscored by several images, frames, and metaphors. Up until the 1960s, the idea of welfare symbolized a broad and progressive program backed by great public support for “universal economic security and protection from the consequences of life’s commonplace hazards”.[84(p. 1)] After that time the stigma attached to the welfare state was supported by images of public assistance given primarily to unmarried, young women of color.

Katz[84] says that the major questions driving America’s historical debate on poverty and the welfare system are not subject to empirical resolutions and do not have definitive answers. Their resolution is instead subject to political and moral ideology.

- Who merits help?
- How will this help impact personality, families and the labor market?
- How long should the help go on?
- Who should provide the help?

In the case of the question of who should receive help America constantly debates notions of the deserving and undeserving poor. The undeserving poor are either charlatans

seeking to perpetrate a fraud in return for free benefits or those who are dependent because of some personal failing, irresponsibility, illicit behavior or moral turpitude.[84]

A fear of undermining the incentive to work pervades the issue of poverty relief. The impact of welfare on families by inducing unmarried women to have children or remain unmarried underlines the fears of the religious right regarding welfare[84]. Ultimately, Katz et al.[84(p. 359)] says this of the connection between American conceptualizations of poverty and welfare policy: "The welfare state is about a collection of specific benefits; but it is also about how we define America and what it means to be an American- and how we would like those questions answered……"

Several American myths also act as barriers to a SDOH perspective. These are the "bootstrap" theory and the idea of the United States as the "land of opportunity" for those who are not lazy, irresponsible, or unethical. The bootstrap theory is said to have originated from a German legend about Baron Munchhausen who allegedly lifted himself out of a swamp by pulling himself up by his own hair. Subsequent versions of the legend modified the story so that he was using his own boot straps to pull himself out of the sea, which gave rise to the term bootstrapping.[85]

In the world of computer technology, bootstrapping refers to any process where a simple system activates a more complicated system. The notion of bootstrapping implies the capacity to start a relatively low-level, simple system where there is minimal functionality. Eventually, it is thought, a complex system materializes bit by bit building more complex capabilities on top of the simpler competencies that came before.[85]

The view that individuals are not constrained by their circumstances but, like the legend of the German Baron, can rise, based upon their self-will and good character, from humble circumstances to reach great levels of achievement is a deeply ingrained belief in the American psyche. A central tenet underlying this idea is that of self-sufficiency, freedom and self-determination.

However, the idea that individuals or communities may not be free to advance and develop, particularly when starting from nothing, is supported when one begins to closely examine "general economic, political and social connections"[86(p. 297)]. Many social institutions including those instrumental in the operation of markets, administrations, legislatures, political parties, the judiciary, the media, and the community in general contribute to the process of growth and development by interacting with individual efforts. These external societal arrangements and institutions can alter human efforts by impeding, augmenting, or supporting freedom for community and individual autonomy and initiative.[86]

The reality is that the individual freedom thought to occur in lifting one's self up by the bootstraps can only transpire within an integrated investigation and understanding of the roles of different institutions, their interactions and the interrelatedness of this system.[86] Ultimately, if the ability to use one's bootstraps to make progress in the land of opportunity is to be more than a myth it must involve not only considerations of the characteristics of individuals and processes but of substantive external barriers and opportunities as well.

Unlike Britain with its low tolerance for inequalities, it seems that inequality of almost every kind is acceptable and endemic to American society. The "Economist" makes

the case that European feelings regarding class are completely the opposite of American sentiments.

> They (Europeans) deplore the idea that people may remain mired in poverty, and they have large welfare programmes to help them move up. They also resent the sight of rich families staying at the top for generations and so impose high taxes to redistribute wealth. …..compared with Americans, Europeans cling to a somewhat static view of society…Polls show that, compared with Americans, Europeans are more likely to dislike unfettered market competition and to believe that success is outside their own control.[87(p. 52)]

In America, a failure to feel a sense of injustice over societal inequalities is buttressed by a conviction that life is simply unfair but that with hard work, there exist the potential for upward mobility.

However, there is empirical research challenging the great American myth of the self-made man in the land of opportunity. Bratsberg, et al.[88,89] make the case that if one compares the incomes of children to their parents, Nordic countries emerge as possessing far more mobility than America. Britain, in comparison exhibits less social mobility than the Nordic societies but more than America.

> Around three-quarters of sons born into the poorest fifth of the population in Nordic countries in the late 1950s had moved out of that category by the time they were in their early 40s. In contrast, only just over half of American men born at the bottom later moved up. This is another

> respect in which Britain is more like the Nordics than America: some 70% of its poorest sons escaped from poverty within a generation.[87(p. 52)]

In 2004, the *New York Times Book Review* evaluated the works of two British researchers in an article titled "Keeping Up with the Joneses".[90] In a dismissive and cynical tone, the author conveyed a skeptical view of the idea that social status may cause illness.[90] One book evaluated in the review was by Sir Michael Marmot, an epidemiologist at University College London and leading expert on the SDOH.

Marmot is best known for his decades long research on Whitehall, the British civil service. Within this system, exist rigidly defined categories of workers based upon pay scales and employment grades. Examining this stratified system Marmot has been able to demonstrate the harmful effects of status on health.

Making the argument that social status in America is not the evil that it is perceived to be in British society, the reviewer advanced the idea that Americans are not victims of a social order because we, unlike the British, have options that allow us to transform our identities. Eakin[90] says that even having autonomy, dignity, or worth in our work environment are of no consequence in America where we all have the opportunity to "wield influence" in some other sector.

> The mistake Marmot, in his seriousness…make(s) is positing a single social order in which we are all assigned a place and of which a vast majority of us are victims. Once upon a time, this may have been the case. And in the author's native Britain, it still may be true. But in America, at least, status today is a complex phenomenon. To the credit of our evolving

> democracy, it is increasingly unclear who has it and who doesn't. Given the many subcultures each of us inhabits, it's entirely possible to wield influence in one sphere will hardly registering in another. And who can say which defines a person more: working for minimum wage in the mailroom or being hugely popular on Friendster?[90(p. 16)] [v]

In America the bedrock of identity and citizenship is the work one does. As political scientist, Judith Shklar observed: "the individual American citizen is …a member of two interlocking public orders, one egalitarian, the other entirely unequal. To be a recognized and active citizen one must be an equal member of the polity, a voter, but he must also be independent, which has all along meant that he must be an 'earner, a free remunerated worker…".[91(p. 62)] As a result only Americans with real jobs are citizens.

The refusal to recognize the influence of social status and inequalities flies in the face of an American ideology founded upon self-worth and identity as tied to work. This then makes it that much more difficult to grasp the significance of SDOH research that posits a relationship between identity, status, work, and health.

Placing the social determinants perspective on the U.S. policymaking agenda will also depend upon U.S. ideals and values regarding race and class.[92,93] A large hurdle that will have to be surmounted in the U.S. is the intense focus upon racial differences to the exclusion of socioeconomic status and its effect on the nation's health. What is more, to further refine the American SDOH perspective, consider that the attention given to racial and ethnic

[v] Friendster is an online community that connects people through networks of friends for dating or making new friends.

differences in health are often examined as disparities in health care treatment and access almost to the exclusion of health and socioeconomic outcomes.

America's SDOH perspective, founded largely on differences in racial groups as opposed to socioeconomic groups, is based on historical efforts to deal with racism and a market perspective for the SDOH as opposed to a psychosocial model.[w] In this case the market perspective that supports this single-minded focus on racial health inequities posits that access to social benefits including good health are related to actual assets, wealth, and income.

The next step in the chain of reasoning rests on a common American pattern of wealth and resource distribution historically and disproportionately benefiting non-minorities while disfavoring racial and ethnic groups. Accordingly, it is apropos in the U.S. to focus upon differences in health based on race, as this is how wealth, income, and resources are distributed in America.[94]

Interestingly, while the U.S. collects far fewer data on class than on race, the data that exists demonstrates a consistent inverse and gradient-like relationship between class and premature death.[92] Yet, differences in health between social groups are largely overlooked in the U.S. in favor of race-based research, policies, public health practice, and data collection.

The restricted focus upon racial disparities in health has significant implications. In this case, a limited focus on racial disparities is much like having a SDOH policy goal of

[w] In this case, a market-perspective argues that health inequities tend to emerge from the presence or absence of wealth, assets, and resources. Alternatively, a psychosocial model may also look at the absolute effects of wealth on health but would also consider the physiological effects of a person's socioeconomic status in relation to others. Here, the lack of material resources still leads to the inability to purchase what is required but it is the low social status relative to others that adds extra pressure via a biological or psychological mechanism producing increased stress on the human system and susceptibility to illness.

helping the poor for two reasons. The first reason, that will be discussed later, is that the health community may neglect important opportunities to eradicate health inequalities.

The next reason is that it is not politically expedient in two ways. In a time when the American majority is denying present day racial discrimination, efforts to set aside resources and create policies and programs to address racial disparities in health may encounter strong criticism, barriers, and defeat.[95] Such a singular focus on African Americans is likely to face mounting criticism, denials of systemic responsibility for the problems, and rejections of requests for additional expenditures to deal with a problem that some will say only requires greater self-responsibility on the part of the ethnic or racial group.

One example of this is a denial by the American Enterprise Institute (AEI) that racism could be responsible for health inequalities.[96x] Weighing in with a publication titled *The Health Disparities Myth: Diagnosing the Treatment Gap* by Sally Satel and Jonathan Klick, the position of the Institute is that health disparities may very well exist but, to date, there is not ample evidence to absolutely state that these disparities are due to racism in America's health care system.[97] Instead, the authors argue that other factors such as socioeconomic position or geography, might account for the health inequalities between racial and ethic groups.

First and foremost, consistent with America's historical struggle with racial issues, the Institute is attempting to erase or dismiss the present day existence and effects of racism

[x] The American Enterprise Institute for Public Policy Research, founded in 1943, is a private, nonpartisan, not-for-profit institution dedicated to research and education on issues of government, politics, economics, and social welfare. Public policy experts assist the Institute in its efforts to sponsor research, conferences and the publication of books, monographs, and periodicals. The AEI is considered a conservative think tank.[97]

in the U.S. However, cleverly, while dismissing race, the AEI is staking out a position that resonates with research on the SDOH and a political frame based on inequality.

As has been pointed out, the use of race as the cornerstone for health inequities in the United Sates leaves the advancement of a SDOH perspective vulnerable. The majority of American's are rejecting discussions on discrimination dismissing it as a past mistake that is no longer relevant. Moreover, epidemiological data also supports other determinants of health inequities, including socioeconomic status that in many cases provides a stronger quantitative and sociopolitical basis for health inequities. The AEI is wrong to divert attention away from race in keeping with the U.S. tradition, but they may be correct in expanding the SDOH perspective in American to include socioeconomic determinants of inequalities.

The next factor that makes it politically inconvenient to have a restricted focus upon racial disparities in health is political. Again, the reality is that U.S. views and values with regard to the welfare state and the marginalized will hinder any progress to create programs to benefit racial groups to the exclusion of the socioeconomic problems facing the middle class and other groups of low economic status. Kawachi et al.[93] trace this phenomenon back to historical policies that separated and left unchallenged the advantages whites had over blacks and other minority groups.

For instance, federal housing policy contributed to the maintenance of residential segregation and played a part in the housing patterns we see today.[93] The Servicemen's Readjustment Act, commonly known as the GI Bill was signed into law in 1944 under President Franklin D. Roosevelt to help returning veterans readjust to civilian life through the

provision of low interest loans to attend college and purchase homes. However, the low interest loans were more available to white than to African American veterans.[93] This discriminatory practice helped to cement segregated housing patterns and perpetuate disparities in home ownership and college education for African Americans.

Another example is civil rights legislation from the 1960s, which had the effect of causing many whites to turn against government programs, including social welfare programs, to help blacks and minorities.[y] The separation of whites from blacks and other minority groups has eroded opportunities for class solidarity thus weakening chances for a broad coalition to support "more redistributive policies and a more generous social welfare provision".[93(p. 348)]

Further, because of the dominant focus on racial health disparities, the health community may overlook important opportunities to eliminate health inequalities. For example, "low-income black Americans have more in common as far as their risk of heart disease is concerned- with low-income white Americans than with middle class or affluent black Americans".[93(p. 346)].

Last, much of the research on the SDOH has examined the influence of socioeconomic position (SEP) on health.[93] The major indicators through which SEP operates to directly or indirectly to affect health include income, education, occupation,

[y] The author of this study is not encouraging opposition to historical civil rights legislation that eliminated discriminatory acts and expanded rights for African Americans. However, legal remedies are a blunt tool. An example is desegregation of school systems where the courts remedy was bussing which did not improve school conditions in minority communities. It in fact served to increase racial hostilities that exist to this day with regard to forced integration. A more ideal judicial and policy approach is to craft remedies across ethnic and racial lines when the practice or determinant affects more than one group that has as its principal common denominator social status or income level. This is particularly true in the area of health where groups of low socioeconomic status experience disparities across racial and ethnic lines.

discrimination, and social relationships.[93] A full determination of how SEP affects health must consider all of the major indicators through which SEP operates.

This is not meant to make the case that class should be used in the place of race. Kawachi et al[93(p. 346)] argue for research and analysis that "accounts for the independent and interactive effects of both class and race in producing health disparities….so that racial disparities are not analyzed without simultaneously considering the contribution of class disparities".

As a final point on racial differences in health, recent advances in genetic research may also serve to inhibit advancement of the SDOH. A focus on racial genetics seems destined to set more firmly in place the American fixation with racial differences ultimately giving greater validity to race as a basis for health interventions.[98]

Genetics has traditionally pitted the notion of biology against contextual, environmental factors in shaping the individual. More specifically, racial genetics is thought to be a barrier in the ongoing battle to define race as a social invention and prevent the fusing together of cultural behavior and biological variations.[98] The goal, as stated by critics of race-based genetics research, is to ensure the understanding that race has no biological significance and is not genetically determined.

However, most recently geneticists have been delving into biological differences in health based on race. These investigations have examined whether racial differences might influence drug response and disease susceptibility.[98] Critics worry that increased research emphasizing the genetic differences among racial groups opens the door to misinterpretation and abuse. "Already there are fears that the biological measures of racial differences might

lead to pronouncements about inherent differences in ...complex traits (such) as intelligence, athletic ability, aggressiveness", and even explanations for health disparities.[98(p. 51)]

One example is hypertension, which affects black Americans at a higher rate than white Americans. Geneticists attempt to explain this phenomenon by genes. In contrast, those who see race as a cultural marker largely dependent on social context, would say that the tendency for blacks to have higher blood pressure is based upon a combination of factors that may be partially behavioral (such as eating the wrong foods and getting less exercise) and largely contextual where low socioeconomic status, and/or the stressful lives of dark skinned people experienced on a daily basis contrive to increase blood pressure.[98]

Self-determination is a deeply held societal belief invoking the idea that individuals are capable of conceiving a vision of how they want to be and of achieving that objective. Racial genetics stands in opposition to self-determination. It may in fact engender a deterministic view where biological markers decide who and what we are invoking a sense of finality to the exclusion of other sociological and environmental factors that may act to shape an individual. Ultimately, genetic research on racial differences must be pursued with caution in light of a SDOH perspective.

How Americans think about health and health care will affect a U.S. social movement on the SDOH. First, U.S. beliefs about healthcare area founded largely on a biomedical model encompassing an incessant obsession with the healthcare system to the exclusion of contextual and structural determinants of health.[98] Second, similar to research results in the U.K. described earlier, lifestyle and behavioral factors plus notions of individual

responsibility or irresponsibility shape the realities of lay and public health perceptions on the production of health.

Public health stands accused of limited vision in the construction and implementation of practices that reach beyond the scope of the individual and behavioral outcomes.[99] Based upon its foundation in the human sciences, health promotion and education have resulted in practices that have shaped and fashioned a limited image of subjectivity where individuals are seen as lacking in self-control and rationality.

The deeply rooted beliefs instilled in public health practice from the behavioral sciences have strongly endorsed the position that the marginalized and unhealthy suffer from lack of self or social control resulting in the inability to restrain destructive urges[99,100] . In this case unhealthy people are the result of a condition of personal maladjustment characterized by the correctness of the person's private volitions, strength of personal responsibility, and ability to function as a normalized citizen.[100]

This is in contrast to alternative characterizations that might see the individual as part of a larger system impacted by institutions, policies and regulations but capable of acting as a political agent exerting individual and collective autonomy to shape not only themselves but the system itself.[100] Ultimately, to characterize the ill and the poor as abnormal, having bad habits, and lacking self-control, and rationality invokes a different set of policies and subsequent interventions to address the problem.[37,39,101,102]

Faced with a portrayal of health as predicated on the habits and actions of individual responsibility public health actors have appeared capable only of interventions built upon the

personal identities and behavior of individuals to the exclusion of socio-structural factors outside the body that might act to determine health outcomes.[100,102]

The result is the development of limited policies and interventions incapable of delivering the multi-level, complex strategies required to address the SDOH in addition to the other major factors said to influence health.[5,99]

The American healthcare system along with principles of social justice is subject to the market system. Disgruntled citizens appear incapable of producing the political will to devise a viable solution and demand changes in the provision of healthcare. Instead, simultaneously satisfied with their own personal healthcare experience yet uneasy over the entire health system, American citizens remain locked in a never-ending, circular discussion believing that the government must do something to fix the problem but not trusting them to do the job correctly.[103]

Research into the way Arizona, California and New Hampshire citizens think about health care, health insurance, and the uninsured, reveals a principal frame that seems to dominate public thinking about the lack of access to healthcare services.[104,105] Titled the "Consumer Product Frame" this way of thinking is meant to explain why citizens engage in uncertain reasoning when they try to think through the complexities of the health care system.[104,105(p. 27)]

> The Consumer Stance (Consumer Product Frame) largely preempts a moral perspective on the problem of the uninsured. From the perspective of a consumer, the fact that some people do not have health insurance loses much of its moral force. Not everyone has access to a given consumer

> good, for a variety of reasons, prominently including *Individual Choice and Responsibility* (another 'frame') – if you really want to buy something, you do what it takes (saving, working hard) to buy it. And by the logic of the Consumer Stance, if you don't have a particular good, it's either because it wasn't a priority for you, or it was a luxury beyond your means.

The perspective of the Consumer Stance is that insurance is an individual relationship between insured and provider, rather than a collective relationship that allows people to pool resources and spread risk.[104]

The Consumer Stance, used by the health industry, also has deep ties to American consumer culture, individualism, and conservative values. The frame is easily triggered and interferes with the public's thinking about health coverage in a number of ways.[104]

- It triggers a narrow emphasis on quality and choice.
- An emphasis on costs and benefits acts as a barrier to a moral perspective on the problem of the uninsured closing off altruistic thinking.
- It sublimates thoughts of the uninsured, in favor of the individual relationship between provider and insured.
- It obscures "big picture" considerations of health coverage as a helpful *system*

It easily evokes images and ideas of another negative concept for Americans- "Socialized Medicine."

Researchers believe that the power of the Consumer Stance make ineffective any appeals on the basis of "doing the right thing" for the uninsured. Invoking a moral concept on

the issue of the uninsured, while effective to a degree, also evokes thinking about individual choices, responsibility, and fate.[104] It has been shown that stories about the needy are of limited use and can have undesirable effects - such as underscoring the difference or separation between those who have coverage and those who do not.[104]

Finally, when forced into a choice between the Consumer Stance or Health Care as a Rights Stance, research indicates that most people will often unconsciously default to the Consumer Stance. This was a tendency that was effectively exploited to derail the 1994 efforts of Bill and Hillary Clinton to alter the health system.

Until the U.S. has dealt with the design and arrangements of its health care system, as have other countries, it will be difficult to capture the attention of the public and policymakers to consider the other social determinants of health. Alas, the U.S. seems poised to spend many more years and resources fixing its health care system even in the face of research demonstrating a limited relationship between medical care and health. This passion to pour resources into our current health system stands in the face of evidence that state-level variations in health achievement are explained to a greater extent by economic structure, and state and local government spending on Medicaid and public health than individual medical care.[106,107]

Political Opportunities and Mobilizing Structures

Political opportunities, the social changes in institutional structures that make the system more receptive to challenge, are a key linchpin in social movements and the agenda setting process.[6] Signals of political opportunity include: the opening up of the political process; electoral instability; changing support for the governmental regime; the appearance

of influential allies; and conflict within and among elites.[23] Equally important is how an issue is lodged or framed including the words symbols, images, and metaphors used to describe the issue. Finally, we have discussed the important role of mobilizing structures in the agenda setting process.

In 1994 the U.S. undertook a major health policy initiative lead by Hillary and President Bill Clinton. The proposed effort was focused on the U.S. health care system. This example serves two purposes in this analysis. First, it is representative of most U.S. efforts to engage in health policymaking. Note that it is about health care. Next, the Clinton effort, in this context, exemplifies the interrelatedness of key agenda setting factors such as political opportunities and mobilizing structures. Along the issue generation continuum this particular example is a case of mobilization where the government attempts to push an issue out into the public realm in order to gain support and approval from interest groups or the electorate.

Boldly, the Clintons asserted that nothing short of universal coverage would solve America's healthcare problems. With that, the Clintons proposed a vast overhaul of the health care system based upon the idea of "managed competition".[108] Eventually the 1,342-page plan from the Democratic President died in a Democratic Congress under a mass of withering fire from an array of interest groups representing the private sector health and insurance industry.

The failure of the Clinton administration stands out as one of the most disheartening efforts of the 20th century to advance health care reform in the United States. It also serves as an excellent example of the role of agenda setting factors. Two primary reasons are posited as the basis for the Clinton disappointment during a time when the political opportunity for

such a policy change should have been positive: 1) the lack of success in building a broad base of support for the plan beyond elite policy specialists;[109-111] and 2) the failure to create a message frame that resonated with the public in the face of oppositional positioning of the plan as anti-middle class, bureaucratic, and very complicated.[109,112]

This episode in American healthcare reform demonstrates four important lessons. First, political opportunity is important. However, as seen in the Clinton health care reform effort, even with an alignment of both the Executive branch and Congress the endeavor was defeated. Accordingly, a supportive political opportunity alone is not enough to succeed in agenda setting. Recall that in the case of the SDOH in the U.K. after the 1997 election when political opportunities expanded in the form of a sympathetic government supportive interest groups also existed.

Next, the defeat was helped along by a lack of breadth in the support of the plan by Republican policy makers, Congressional committees, citizen's groups, and voluntary organizations such as nonprofit and public interest groups.[109-111] Additionally, and of note, is that the kind of support for an effort may be found offensive. In the case of the Clinton health care plan, the sole use of the policy elite to develop the plan resulted in harsh criticism and distracted from efforts to mobilize support. Activists are said to have turned against the effort because they were approached for support much later after the plan was designed.[109]

Last, the plan's demise was hastened with an effective framing of the plan by conservatives as against the interests of the middle class and heavily mired in government control.[112] The significant image of the campaign came to be the "Harry and Louise" ads in which a middle-class couple despaired over the plan that proposed a government managed

system with restrictive choices. The Clinton health care reform movement did not have a message frame to counteract the opposition's framing of the plan.

In summary, two final points remain. America has several significant societal, values-based and cultural issues that act as barriers to an agenda setting effort to launch a full SDOH perspective that moves beyond race-based disparities. A complete examination of these obstacles might begin by looking more closely at how citizens think and feel about issues such as equality, social class, and the production of health. Such an analysis should present options for framing a uniquely American SDOH perspective based on racial inequalities plus socioeconomic position and the structural factors that affect health.

Another issue to consider in advancing a SDOH perspective onto the policymaking agenda in the U.S. is that of venue. A central tenet of the Baumgartner/Jones[27] model is the existence of other routes or venues that may be utilized to push an issue onto the legislative agenda. A policy venue is an institution in society such as the judicial system or regulatory agencies with authority to make decisions on issues.

The policy venues in the U.S. currently addressing the SDOH from a health disparities view appear to be regulatory bodies at the federal and state level including state public health departments and sub-agencies of the Federal Department of Health and Human Services.

Data shedding light on the efforts of local governments to address the SDOH indicates a growing movement. The *2005 National Profile of Local Health Departments*[113(p. 71)z] assessed local health department[aa] efforts to address "health inequities" from a SDOH

[z] The survey had an 80% response rate representing 2,300 local health units.

perspective. Figure 1 presents a characterization of the efforts within the local departments to address "health inequities". Finally, the categories of activities that respondents reported pursuing are listed in Figure 2.[113(p. 72)]

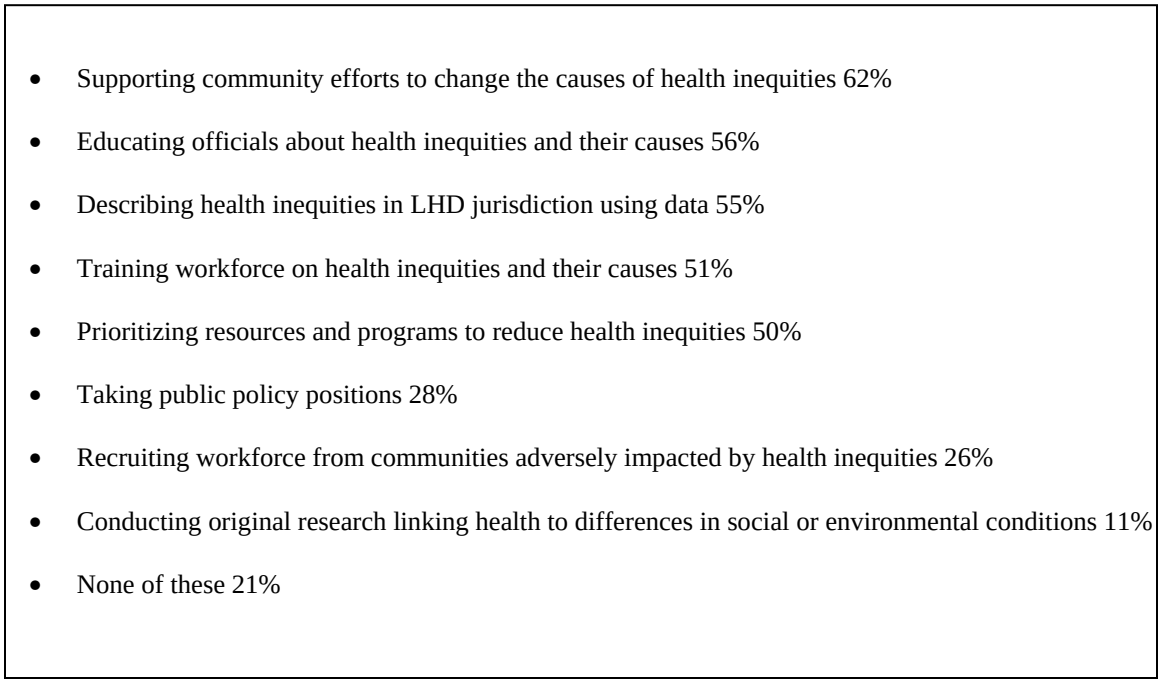
Figure 1: Characterization of local health department activity to address health inequities

- Staff have at least some tools and resources necessary to address health inequities 63%
- Health inequity efforts are integrated into the work of many programs 60%
- Most staff understand the causes and consequences of health inequities 56%
- Dedicated staff focus on health inequity efforts in our LHD 33%
- LHD applied for/received grants to reduce health inequities 32%
- Administration believes that work on health inequities is beyond our agency mandate 7%
- None of the above 15%

The results from the national profile of local health departments are noteworthy in that they paint a picture of governmental efforts at the regulatory level including local and state agencies to integrate a SDOH perspective into public health. It is relevant to this research to note however the absence of little or no effort emanating from the White House to form a coherent national strategy on the SDOH similar to that of Tony Blair's upon his election as Prime Minister in 1997.

[aa] A local health department under the National Association of County and City Health Officials is an administrative unit of local or state government with some accountability for the health of a jurisdiction smaller than a state.

Figure 2: Actions taken by local departments to address health inequities in the last three years



An analysis of the origins of the SDOH activities in these local and state venues will yield descriptive information on the nature of the U.S. efforts, the degree to which they have been successful and why. Isolating whether the agenda setting efforts in the U.S. have largely been an outside initiative launched by groups external to the government or an initiative of the government itself will provide a starting point to begin analysis of the agenda setting tactics for the SDOH in the U.S. The upshot of this effort should assist in characterizing the social movement features that have been successful in placing the SDOH on the U.S. agenda at the regulatory level as opposed to the policymaking agenda as in the U.K.

Last, agenda setting is not a linear process, nor are the elements of that process capable of being ordered in a hierarchical manner to demonstrate which supersedes another

in importance. Instead, the elements of agenda setting are interdependent, each of equal importance in its own right. The existence of a positive political context may not be conducive to agenda setting, where there is an absence of a compelling societal frame. Alternatively, a persuasive framing package may languish without a supportive political regime. Finally, a forceful frame will fail to flourish in the presence of mobilization groups with inadequate skills and resources. This study has added to efforts to determine the conditions under which agenda setting occurs and the factors that influence its success and failure.

APPENDICES

Appendix A: Coding Scheme

1. PARTICIPANTS
    1.1. Organization type
    1.2. Organization name
    1.3. Type of actor
    1.4. Actor name
2. EVIDENCE TYPE
    2.1. Spoken word
    2.2. Written words-reports, documents
3. FRAMES
    3.1. The frame
    3.2. Core position
    3.3. Implied solutions
    3.4. Principle
4. RHETORICAL DEVICES
    4.1. Metaphors
    4.2. Images
    4.3. Catch phrases
5. GOVERNMENT. DISCOURSE MODEL
    5.1. RED
    5.2. SID
    5.3. MUD

6. CONTROVERSY

Overall, does the reader sense that the problem with poor health outcomes is based on social inequality? Overall, does the reader sense that the solutions include population level policies aimed at reducing inequality and not individual health strategies?

6.1. Yes

6.2. No

7. ISSUE GENERATION

7.1. Outside initiative- nongovernmental sources

7.2. Mobilization- government source

7.3. Inside access- bypass public and go to legislative process

Appendix B1: Frames and Rhetorical Devices

1. Government as cover-up/suppressor
2. Government as bully
3. Government as evasive
4. Cold-hearted society
5. Divided society
6. Government as uncaring cynical
7. Poor is unhealthy
8. Future is children we take our measure by our children
9. Government doesn't care about children
10. Big business corporations in bed with Government
11. Don't just throw money at the problem
12. Government as complacent
13. Government as endless research investigation same-old-same-old
14. Government as liberal tax & spend
15. Warring data that cancels each other out
16. Tradition
17. Health as complex – poverty lifestyle requiring multiple interventions
18. Parent as child's caretaker
19. Poor health as holistic community based issue
20. Poor health as family problem
21. Government as wealth creator

22. Free market as just and fair
23. Government as busybody
24. Well being as deprivation index
25. Society as a shiny apple rotten at core –wormy
26. Poverty as social exclusion
27. Goodness as control, hard work sacrifices
28. Welfare state as a give away
29. Community as the panacea
30. Government as fair arbiter of policy, science, data
31. Inequalities as debatable or contestable
32. Government as responsible actor
33. Health as individual behavior
34. Health as social conditions
35. Individual as autonomous
36. Society as lazy over indulgent
37. Health as lifestyle
38. Health as social and economic status
39. Health as gradient
40. Low social status as unhealthy
41. Poverty as roots on a tree
42. Poverty as a trap
43. Government spending on poor children as long term investment

44. Government as huge bureaucracy

Appendix B2: Images

1. Babies children dying
2. Rich and poor divide
3. Big organization squashes smaller; David and Goliath
4. Health for all
5. Headless chicken
6. Foreign country of alienated undesirables
7. Poor not receiving services/aid
8. Britain losing the health race
9. Health minister on a bicycle
10. See no evil hear no evil…
11. Dying parents and children grieving
12. Linkages between poverty and health
13. Decaying neighborhoods
14. Deserving and undeserving poor
15. Child poverty poor hungry children
16. Broken family
17. Conspiracy
18. An earlier report discredited
19. Scientist and data at war 2 sides of the coin
20. Poor people better off to day
21. Our health

22. Children on playground
23. Lazy parents and children stuffing their faces – fast food
24. Entrepreneurial spirit
25. A business lunch with sparkling water
26. Treadmill – stationary bike
27. Nanny state - interfering busybodies
28. Oppression state
29. Low wage jobs
30. Drug infested communities
31. Struggling families
32. Government tackling problems
33. Bloated welfare state
34. Sprawling costly welfare state
35. Welfare state as helpful but under resourced
36. In humanity
37. Everything is okay – no problem
38. Responsible strong individuals and families
39. Irresponsible vs. Responsible
40. Throwing down the gauntlet
41. Britain on the move- improving
42. Incline/gradient
43. Poor as mentally ill person

44. Poverty as deeply rooted tree

45. A binding contract or partnership

46. Muddled up Government policy

47. Big Government

48. Excluded groups outside the circle

Appendix B3: Catch Phrases

1. Shift resources to poor
2. Inequality and health or health inequalities
3. Division between rich and poor
4. Destruction of HEC
5. Degree of freedom
6. Part of the same ugly pattern
7. Systematic intimidation or destruction
8. Political dynamite
9. Links between poverty and illness
10. Social class discrepancies
11. Headless chicken
12. An underclass has emerged
13. Widening of class divisions
14. Official statistics maneuvered manipulated
15. Pre Gorbachev Soviet censorship
16. People living below poverty line
17. Socially divided Britain
18. Class ridden society
19. Gap between rich and poor- reduce the income gap between rich and poor
20. Unemployment and illness people out of work are sicker
21. Protect newborns from poverty

22. Encourage people to take care of themselves
23. Health hype
24. Split into two nations
25. Poverty and health
26. Social inequality
27. Social exclusion
28. Tax policy
29. Tackle deprivation
30. Health divide or gap
31. Antipoverty crusade
32. Disadvantage or old hat [ab]
33. Children without fathers
34. Lifestyle
35. Poor people are better off
36. Widening gap in health of people
37. Health class divide
38. Health not just social deprivation
39. Wealth is key to health
40. Remove children from poverty
41. Child illness; day-to-day; playground bugs
42. Close the gap; narrow the widening gap

[ab] Coding mistake: used this number twice to represent disadvantages

43. Holistic view of health care
44. Areas of deprivation
45. Parental fecklessness, apathy, ignorance
46. Has nothing to do with money
47. Intervention of old left
48. Businesses create jobs and wealth
49. Prevention is the cure or preventable or prevention
50. Monstrous engine of oppression
51. Busybody
52. Tackle the inequalities - commitment to reduce inequalities
53. North- South divide
54. Middle ground position
55. Decent quality of life
56. Social inclusion
57. Gargantuan welfare state
58. Welfare state lean and honest
59. Napoleon HNS
60. Underclass dependency culture
61. Disastrous legacy
62. Involve the public
63. Working with residents
64. Poor are getting sicker

65. High taxation high government spending higher taxes
66. Union power
67. Reversal of shift of taxation in favor of rich
68. Britain's poor record of health
69. Government's vindictive attacks
70. To meet the needs of all
71. Social divisions that give rise to ill health- connection between ill health and inequality
72. To prevent poverty
73. Means test
74. Deprivation
75. Too costly to implement-quite unrealistic
76. Link between deprived areas and poor health – care or services
77. Social deprivation
78. A matter of some dispute
79. Disparities in health
80. xxxxxx [ac]
81. Material deprivation
82. Political machinations
83. Scientific facts or evidence
84. Faddish hobby horses

[ac] Coding mistake, an empty variable was left blank

85. Radicals

86. Propaganda

87. Inner city health or inner city

88. Revitalize inner cities

89. Strengthening health services - improving health provision

90. Improvement in social conditions or social conditions

91. Radical government action- radical

92. Limits to free speech

93. In the hands of individuals – individual factors individuals help themselves

94. Sick man of Europe

95. Too expensive unrealistically expensive

96. Narrowing the gap between upper and lower classes

97. Improve living conditions of poorer people

98. Causes of health inequalities complex not completely understood

99. Economic and social policies

100. Promotion of healthy lifestyles health promotions

101. Social and economic inequalities

102. Class based inequality

103. Race based inequality

104. Across government or cross cutting interdepartmental

105. Culturally sensitive health services

106. Inequalities in health care - inequalities in access to health care

107. Social and economic status, social and economic differences
108. Complex – questions
109. Narrower inequalities – income distributions
110. A gradient
111. Targets - targeting
112. Gyms for the poor
113. Healthier lifestyles
114. Health education campaign
115. Social inequalities social status
116. Preventive health strategy - disease prevention
117. Health promotion
118. Social model of health
119. Link between Psychology and Immune System
120. Biological pathways through psychological factors or psychological risk factors
121. Deprived groups
122. Redistribution of wealth – resources
123. Income inequality
124. Choices we all make
125. Impact of behavior
126. Stress levels
127. Relative inequality
128. Middle class flight

129. Unequal societies
130. Roots of poverty
131. Wage war on poverty
132. Eliminate the divide
133. Public health strategy
134. Social injustice of ill health or social justice
135. A joint project
136. Contract for health
137. Socialism
138. Poverty trap
139. Child poverty
140. Injustice
141. New deal
142. Inner city deprivation
143. Increasing bureaucracy
144. Welfare dependency
145. Streamlining
146. Underclass
147. Crusade against poverty
148. Inequality for all
149. Egalitarian

Appendix C: Inequalities Frames Identified

1. The issue is how to force the Government to do more in its agencies on inequality and health
2. The issue is the socially divided Britain is damaging the health of the poor-"material inequality"
3. The issue is reducing social inequalities in health and health care to achieve a classless society
4. The issue is the provision of resources to poor to decrease inequalities in health
5. The issue is how to bridge gap between rich and poor to stem continuation of growing inequalities
6. The issue is Government allocation of resources to address poverty and social inequality
7. The issue is the existence of a huge gap in prosperity-the rich poor divide
8. The issue is whether the class divide in Britain is a fantasy
9. The issue is whether there is an association between ill health and poverty – class status that the Government should investigate or consider
10. Tackling health inequalities at the neighborhood level in deprived areas
11. Inequalities cause poor health for U.K. and rest of the world
12. Health gap fact or fiction?
13. Issue is government ignoring how economic and social factors influence health.
14. Government can fix health inequalities between rich and poor using health promotion targets or contracts for health

15. The issue is health inequalities widening over time but not clear why
16. Bottom part of social ladder is sicker but they also don’t practice prevention
17. The issue is government policies to address regional economic and social differences
18. The issue is social class status and the relationship to health inequalities
19. The issue is inequality and its relationship to quality of life
20. Health inequalities linked to distribution of resources or prosperity

Appendix D: Most Frequently Cited Catch Phrases

1. Inequality and health or health inequalities
2. Division between rich and poor
3. Social class discrepancies
4. Widening of class divisions
5. Socially divided Britain
6. Class ridden society
7. Gap between rich and poor- reduce the income gap between rich and poor
8. Split into two nations
9. Social inequality
10. Health divide or gap
11. Widening gap in health of people
12. Health class divide
13. Close the gap narrow the widening gap
14. Tackle the inequalities - commitment to reduce inequalities
15. North - South divide
16. Social divisions that give rise to ill health - connection between ill health and inequality
17. Narrowing the gap between upper and lower classes
18. Social and economic inequalities
19. Class based inequality
20. Race based inequality

21. Inequalities in health care - inequalities in access to health care
22. Social and economic status, social and economic differences
23. Narrower inequalities – income distributions
24. Social inequalities social status
25. Income inequality
26. Unequal societies
27. Eliminate the divide
28. Inequality for all

Appendix E: Report, Articles, Books from News Articles

1. Decennial supplement on occupational mortality
2. Black report inequalities and health
3. Health divide report by HEC
4. Update 1988 Black report inequalities in health
5. Study of 8 council housing districts in Gateshead
6. Beyond Acheson
7. Acheson report
8. Losing out by field
9. General household survey
10. Census data
11. 1990 article in BMJ by Davey Smith
12. Economic indicators
13. Social trends
14. Swedish national report HS90
15. British white paper prevention & health everybody's business
16. Report from Association of London
17. Government data on heart disease or life expectancy
18. Health and lifestyle survey – health promotion trust
19. Article editorial BMJ or BMJ 2002 food desserts not likely
20. Report from Bethesda Dr. Baumon unemployment & disease
21. Occupational mortality childhood Supplement 1988

22. Henley Center survey on eating habits 1988
23. Statistics data on infant mortality
24. Health of the nation 1991
25. National Children Home (NCH) report on poverty and diet 1991
26. Lancet report on 2nd Whitehall study 1991
27. Health education authority report suppressed by Health Department
28. 1991 final Annual Report by Chief Medical Officer 1991
29. Acheson state of P.H. 1990
30. Family expenditure survey
31. Report Oxford Social Disadvantage Research Center
32. NHS Scotland's health & well being profiles
33. One City Edinburgh Social Exclusion Report
34. Civitas Legacy Of Single Parent Report
35. Smith Institute Map On Inequality 2000 teenage motherhood & poverty
36. Government Data on deaths by region
37. British heart foundation report
38. Boots a survey by
39. Scottish think tank report 1988 health gap Dr. Mccleod
40. Our Healthier Nation White and Green paper 1998 Labout February 5
41. Norwich Union Health care 500 parent survey
42. Oxford University Study of Poverty Financial Times 2000 Index of Deprivation
43. Beveridge report 1942 social insurance and allied services

44. Parliamentary Acts

45. Labor Party Manifesto 1945

46. NHS National Plan 2000

47. East Riding Health Authority Action Plan 1998

48. Charter for Health Labor Party 1986

49. The State of the Labor Party Today 1986

50. 1986 Townsend Review of Studies inequalities in Health

51. 1986 Le Grand & Illsey Study on length of life in Britain

52. 1987 Cambridge University Clinical School survey

53. 1987 Low Pay Unit study on poverty

54. 1987 National Children's Bureau Report

55. 1978 WHO declaration health for all

56. 1987 House of Commons social services committee report on NHS

57. Townsend 1988 health and deprivation in specific regions

58. Cleveland County council study comparing death rates and mortality 1988

59. Combined health divide [Whitehead] & Black report edited by Townsend Inequalities in Health 88

60. The Nation's Health by King Edward's Hospital Fund 1988

61. 1988 Government Report survey of > 10,000 on average height A. Carr Hill University Of York

62. Growing Up in Britain 1999 BMA report

63. Saving lives 1999 British White paper

64. English Longitudinal study on Ageing 2003 Marmot

65. Health of Britain's Ethnic Minorities 1997

66. Joseph Rowntree Foundation Report 1997, 2000 on widening health inequalities 1999 Monitoring poverty and social exclusion

67. Office of National Statistics health inequalities report 1997

68. 1997 Office of National Statistics Regional Trends

69. 1991 Health and Wealth: Association of Community Health Councils for England and Wales

70. 1991 assessing efficiency in the New National Health Center University Of York Center For Health Economics

71. 1991 IPPR paper on reorganizing NHS purchasing

72. British Thoracic Society 1992 Liverpool study – TB & poverty link

73. Divided London 1993 by University Of North London

74. Mental health foundation 1993 study admission rates to psychiatric hospitals in deprived areas

75. City and east London family health services authority 1993 3 of London's deprived areas on greatest risks to health

76. Health and inequality the northern region 1981-1991 Newcastle University Department Of Social Policy 1994

77. Whitehall study

78. Health of young people 1998 Department Of Health

79. Office Of National Statistics Health Statistics Quarterly 2002

80. 1999 first official party audit opportunity for all tackling poverty and social exclusion
81. 1999 British Heart Foundation study on social inequalities and heart disease
82. 1999 Report On State Of Health in Wales by County Medical officer published since 1992
83. 2000 Rowntree Foundation report on pensioners and pay raises redistribution of wealth
84. 2003 combat poverty study health and low income families
85. 1996 Lancet British regional study & nourishment childhood and social class affects on heart disease
86. 1996 BMJ report on mend in High status jobs and death rate
87. 2001 Lancet a study on breast feeding and blood pressure
88. 1986 WHO figures on under weight babies
89. 1998 United Nations Human Development Index
90. 1999 The Widening Gap Heath inequalities and policy in Britain Gordon, Dorling Shaw & Smith
91. 1999 Sharing the Nation's Prosperity [Blair]
92. 1997 study by Peter Lilley former social security secretary indicating that incomes of lowest earners were rising faster than any others
93. 1997 Rowntree Foundation Death in Britain how local mortality rates have changed 1950s – 1990s
94. 1999 A Scotland where everyone matters

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VITA

Lauri Andress serves as the Director of the Center for Health Equity, Louisville Metro Health Department. The Center is the first of its kind at the local level in the United States.

Ms Andress attended college and graduate school on an academic scholarship. She graduated from Bethune-Cookman College with a B.S. in Biology and from the University of Texas School of Public Health with a master's degree in public health concentrating in public health policy and health services organization. She obtained her J. D. from South Texas College of Law. During her time in law school she received the Vinson & Elkins Public Interest Fellowship and graduated in the top one-third of her class.

Serving as an adjunct instructor and lecturer since 2000, Ms Andress lectures on the public policy process, public health laws and policies, social determinants of health, policy framing, and community organizing. Her research interests have included: the study of state-level policies on the organization of health services; the effects of power on marginalized communities; a comparison and analysis of social capital and community building as levers for improved population health; framing public health policies; agenda setting; and the social determinants of health in the United States and Britain.

From 2001 until 2004 Ms Andress worked for the Texas Program for Society and Health at the Baker Institute for Public Policy, Rice University. The Program focused upon research and policy initiatives related to the social determinants of health. Beginning as a health policy analyst, Ms Andress became the Director of Operations & Strategic Political Action. She was responsible for a collaboration with a state-wide coalition and the

development of a political advocacy plan and a set of state-level early childhood development policies.

For more than twenty years Lauri Andress has provided community, media, and government relations to various non-profit organizations, government agencies and elected officials. Her areas of expertise include evaluation, program implementation, needs assessment, community organizing, project planning and implementation, and message framing.

In the past Ms Andress coordinated a pilot urban litter and blight study monitored by the U.S. Conference of Mayors, Keep America Beautiful, and the City of Houston. From 1994 -1996 her accomplishments were on behalf of community development organizations (CDCs). She provided technical assistance to several small non-profits and community development groups that served Houston's inner-city communities.

Lauri has served as public affairs and public information officer at Houston's Department of Health and Human Services; a legislative aide and press secretary in the United States House of Representatives (Texas 18th Congressional District); special projects coordinator for State District 25, Texas House of Representatives; and, Chief of Staff in Houston's City Council (At-Large, Position One). In 1997 she served as executive director for a non-profit community-based organization whose mission was to raise awareness about and advocate for the needs of a marginalized community in Galveston, Texas.

Ms Andress was the first community liaison on the Galveston newspaper's editorial board where she won support for and wrote about issues that served as the basis for the

board's news editorials. In 2000 she worked as a reporter for The Houston Chronicle's weekly neighborhood newspaper, "This Week".

This dissertation was typed by Lauri A. Andress.