They Are Not My Problem: A Content and Framing Analysis of References to the Social Determinants of Health within Canadian News Media, 1993–2014

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ABSTRACT *As public support is essential for implementing policies that act on the underlying social determinants of health (SDOH), it is important to consider how the public is exposed to this issue. This article explores how the SDOH have been represented in Canadian news media articles from 1993 to 2014. Of the 113 articles that explicitly included SDOH, housing (12.9%), income (10.5%), and poverty (9.3%) were most frequently reported. Over time, the reporting of SDOH increased, with peaks of coverage occurring at different times for different determinants (e.g., housing in 2005, income in 2009). A framing analysis revealed that the SDOH are presented in multiple ways: as an actionable issue and responsibility of government, a moral responsibility, and—problematically—as an issue that only affects disadvantaged groups.*

KEYWORDS *Social determinants of health; Content analysis; Frame analysis; Newspapers; Health inequalities*

RÉSUMÉ *L'appui du public est essentiel pour mettre en œuvre des politiques portant sur les déterminants sociaux de la santé (DSS). Il est donc important de tenir compte de la manière dont on informe le public sur cette question. Cet article explore comment des articles parus dans des journaux canadiens ont représenté les DSS de 1993 à 2014. Dans les 113 articles se rapportant explicitement aux DSS, les trois thèmes suivants étaient prédominants : logement (12,9%), revenu (10,5%) et pauvreté (9,3%). Au fil du temps, le nombre d'articles sur les DSS a augmenté, atteignant des sommets à des moments différents pour des thèmes différents (par exemple, logement en 2005, revenu en 2009). Une analyse des cadres a montré que les médias représentent les DSS de manières diverses : en tant que question recevable et responsabilité du gouvernement, en tant que responsabilité morale et—de manière problématique—en tant que problème qui touche seulement les groupes défavorisés.*

MOTS CLÉS *Déterminants sociaux de la santé; Analyse de contenu; Analyse des cadres; Journaux; Inégalités en santé*

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Introduction

The social determinants of health (SDOH) refer to the complex set of political, social, and economic forces (e.g., employment, gender, income) that shape the conditions we are born into, grow, live, work, and age in (Raphael, 2009; World Health Organization [WHO], 2008). These conditions shape the health of individuals, communities, and jurisdictions through the distribution of wealth, power, and resources (Raphael, 2009).

As predictors of health at both the population and individual level, the SDOH are not only a foundational concept to population and public health but also a matter of public importance (O'Hara, 2005; Public Health Agency of Canada, 2011; Raphael, 2009). Despite numerous public policy documents[1] that have drawn attention to the SDOH in Canada over the last 30 years, the general public remains relatively unaware of and uninformed about the SDOH and their importance to health (Raphael, 2009). The findings of geographer John Eyles and colleagues Michael Brimacombe, Paul Chaulk, Greg Stoddart, Tina Pranger, and Olive Moase (2001) from their survey of Prince Edward Island health practitioners and the general public support this claim. The authors (2001) found that respondents from the general public deemed personal health practices and formal health care as the most important factors to health and SDOH (e.g., income and employment) among those least important (Eyles, Brimacombe, Chaulk, Stoddart, Pranger, & Moase, 2001). Similarly, nutrition scholar Judy Paisley and colleagues Corina Midgett, Glenn Brunetti, and Helen Tomasik (2001) found that residents of Hamilton-Wentworth, Ontario, most frequently identified smoking and poor diet as risk factors for cardiovascular disease, despite the strength of the association shown with SDOH, such as income inequality (Paisley, Midgett, Brunetti, & Tomasik, 2001; Raphael, 2002). Findings from the 2003 Canadian Population Health Initiative survey on public views of the SDOH also found that 65 to 80 percent of participants reported personal behaviours (e.g., smoking, eating, exercise) as most influential to health (Canadian Institute for Health Information [CIHI], 2005). Even when prompted about the SDOH, only a third of participants reported the influence of social and economic conditions (CIHI, 2005).

Dennis Raphael (2009), professor of health policy and risk management, has claimed that the general public is "woefully uninformed" (p. 85) about the SDOH, which he attributed in part to the biomedical and lifestyle discourses that pervade mass media. As social geographer Michael Hayes and colleagues Ian Ross, Mike Gasher, Donald Gustein, James Dunn, and Robert Hackett (2007) found in their media analysis of Canadian national newspapers, only about 5 percent of all stories ($n = 4732$) reported broader, social influences of health, despite 65 percent of articles covering health (Hayes, Ross, Gasher, Gustein, Dunn, & Hackett, 2007). Likewise, a 2003 media monitoring study of health coverage in national, provincial, and territorial newspapers (commissioned by the CIHI) found that 30 percent of all articles ($n = 1467$) reported on personal health behaviours, while just 14 percent reported on social determinants [i.e., childhood 7% and employment 7%] (CIHI, 2005). A multimedia analysis of print, television, wire, and radio sources conducted found similar results (Higgins, Naylor, Berry, O'Connor, & McLean, 2006). The authors found that of all health discourses reported from 1999 to 2003, SDOH (e.g., culture, poverty, gender) accounted for just 3.6

percent of media coverage per year (Higgins et al., 2006). An American study similarly found that among news articles reporting on type 2 diabetes ($n = 698$), only 11.6 percent reported on the condition's SDOH (Gollust, Lantz, & Ubel, 2009).

Aside from media coverage of the SDOH, media reportage (i.e., the act or process of covering/reporting news) is another area where these conditions may be underrepresented or their importance underappreciated. News geographer and communications scholar Mike Gasher and colleagues (2007) discovered through interviews with Canadian health reporters that they prioritized issues of healthcare, individual-level behaviours, and personal health habits in their work, despite the dedication to the SDOH concept they had conveyed to the interviewer. Gasher et al (2007) related these findings to the work of Lawrence Wallack (1990), a professor who studies how public health is socially valued and framed by the public. Wallack (1990) noted that mass media reinforced individual-level explanations of health and disease, which trivialized the complex and systemic processes that produce health (Wallack, 1990).

While attention has been paid to the coverage of SDOH in news media (Gollust, Lantz, & Ubel, 2009; Hodgetts, 2012; Kim, Kumanyika, Shive, Igweatu, & Kim, 2010; Raphael, 2011) and its framing (Aronowitz, 2008; Koh, Oppenheimer, Massin-Short, Emmons, Geller, & Viswanath, 2010; Niederdeppe, Bu, Borah, Kindig, & Robert, 2008), there remains a need to consider how these operate in various settings over time. The purpose of this article is to explore how the SDOH have been represented in Canadian news media articles from 1993 to 2014. Specific research questions included: (a) when were the SDOH first reported?; (b) which SDOH are most frequently reported?; (c) how has coverage of the SDOH changed over time?; (d) how are messages of the SDOH communicated to the public?; and (e) how are reports of the SDOH framed?

This article contributes to the academic literature an overview of how SDOH-related messages are communicated to the public. This can be used to inform researchers, practitioners, and decision-makers of the extent to which their intended messages are reaching public audiences and identify areas where further attention or improvement is needed. This article comes at a time when those working in population and public health have increasingly identified the need to effectively communicate SDOH-related messages to the general public (e.g., Canadian Council on Social Determinants of Health, 2013; Canadian Medical Association, 2013; Government of Alberta, 2014).

Methods

Content analysis was used to answer research questions (a–d) for qualitative document analysis as follows: 1) document and identify the research problem; 2) develop a protocol and collect data; 3) code and organize data; 4) analyze data; and 5) report findings (Altheide, 1996). The findings from this content analysis (i.e., the codes and categories generated) were used to inform a framing analysis of the SDOH in news media reports, to answer research question (e).

Framing analysis was conducted according to the definition and function of frames identified by Entman (1993):

> to select some aspects of a perceived reality and make them more salient
> in a communicating text, in such a way as to promote a particular problem

> definition, causal interpretation, moral evaluation, and/or treatment rec-
> ommendation for the item described. (p. 52; italics removed)

The frame for this analysis was identified through rereading and constant comparison of articles, and by considering the broad themes that emerged through content analysis relating to the issues reported (e.g., the SDOH require action), the causes diagnosed to them (e.g., government cuts to healthcare spending), the moral judgments they made (e.g., inaction on SDOH is "wrong"), and their proposed solutions (e.g., poverty reduction strategy).

Sampling

Data was collected from the ProQuest Database, Canadian Newsstand Complete, by searching for the terms: "social determinants of health" or "social factors of health" or "social elements of health" or "social determinants" or "social aspect* of health" or "social NEAR/2 health." This search returned 860 results from 100 newspapers within the time period of 1985 to 2014. Before placing any parameters on these results, the five earliest articles were included and analyzed specifically to inform research question (a).

Study results were limited to the 25 most widely circulated English-language Canadian national newspapers; 12[2] of these newspapers returned results. This reduced the sample to 194 articles, including the earliest five previously included. Eleven articles were removed because they did not report on the social determinants of health (four articles) or were not news articles (four book reviews; two event listings; one intro-duction to a series of columns). The remaining 183 articles were coded according to predetermined categories for content analysis (e.g., SDOH identified, year published, newspaper title) and framing analysis (see above). As common elements in the data became apparent, additional codes and themes were constructed to accommodate them (e.g., medicalization). NVivo qualitative analysis software was used to assist with data organization and coding (QSR International Pty Ltd., 2014).

Where "clusters" of articles (i.e., three or more unique or similar stories that run in different newspapers within a short time period) appeared, they were considered as individually unique articles. They were treated in this way because an early reading of the data identified that some articles reported relevant differences; specifically, where the article elaborated on the SDOH that were reported in its clustered counter-part (e.g., Laucius, 2013a, 2013b).

Results

When were the SDOH first reported?

Reports of the SDOH first emerged as a cluster of articles ($n = 4$) published May 21 and 22, 1993, which covered a health policy conference put on by McMaster University (Morrison, 1993; Ottawa Citizen, 1993; Vancouver Sun, 1993; Edmonton Journal, 1993). Specifically, the articles reported on a keynote address delivered by Dr. Sol Levine (1922–1996), a medical sociologist and professor of health behaviour at the Harvard School of Public Health. Levine observed that, "health increases with every rung up the social ladder" (Morrison, 1993, p. B3) and used the example of income linked with chronic and degenerative diseases (e.g., cancer, hypertension, and Alzheimer's) to illustrate

his point. In addition to income, the reporters listed social support, stress, family, where we live, and flexibility on the job as examples of SDOH in their articles.

All four of these articles reported on Levine's identification of government accountability and responsibility for improving public health through action on the SDOH. Three articles from this cluster reported this key message verbatim, by writing that: "If we cared about health, we would not blindly accept the social structures in which we live" (Morrison, 1993, p. B3; Vancouver Sun 1993, p. A7; Edmonton Journal, 1993, p. D17).

Which SDOH are most frequently reported?

Of all articles analyzed (n = 183), 113 (63.8%) reported and named specific SDOH. Over the course of 1993 to 2014, SDOH were reported a total 418 times. The determinants most frequently reported were housing (12.9%), income (10.5%), education (10.5%), poverty (9.3%), and food insecurity (5.9%). Less frequently reported SDOH were control over aspects of one's life (1.4%), childcare (1.4%), culture (1%), disability (2.2%), drug or alcohol abuse (1.6%), early childhood (2.6%), ethnicity and race (3.1%), family (2.2%), gender (1.2%), inequity and inequality (2.9%), homelessness (1.4%), health services (1.7%), neighbourhood (2.6%), social support (2.6%), socioeconomic status (2.4%), and welfare (2.2%).

An additional 28 items were reported as SDOH but were reported too broadly (i.e., without specification of how the determinant linked to health) or too infrequently (<2 reports) to represent an SDOH group and were therefore labelled as "other." These included factors such as: risky health behaviours (unspecified); sedentary-promoting commodities (e.g., computer games, automobiles); access to legal assistance; economy or economic aspects (unspecified); language barriers; public policies and politics; public security and safety; self-esteem; sexuality; social aspects (unspecified); stress; transit; school curriculum (e.g., nutrition, sex education); exercise; free time; and, history of emotional, domestic, or sexual abuse. A summary of frequently reported SDOH is shown in Table 1.

Table 1: Distribution of social determinants of health, where reported

	No. of times reported in news media (percent)	Terms included
Childcare	6 (1.4)	Subsidized day care, childhood care
Control	6 (1.4)	Coercion, exclusion from the decision-making process, having control over decisions in your life, lack of human rights, sense of control over life
Culture	4 (1)	Cultural beliefs
Disability	9 (2.2)	Anxiety disorder, being unable to work, mental illness, chronic health conditions
Drug and alcohol abuse	7 (1.6)	Drug addiction, alcohol addiction, alcohol abuse, misuse of cannabis, drug abuse

Table 1 (continued)

	No. of times reported in news media (percent)	Terms included
Early childhood	11 (2.6)	Early childhood education and programs, lack of stimulation before the age of five, suboptimal early childhood experiences, child(hood) poverty, adequate child welfare
Education	44 (10.5)	Access to education, education level, inadequate education, lack of education, poor education, educational funds, literacy, illiteracy, literacy rate
Employment	24 (5.7)	Access to employment, adequacy of employment, low levels of employment, good job, seasonal job security, part-time job security, jobs, flexibility on the job, stress on the job, unfavourable work conditions, unsafe work/working conditions
Environment	18 (4.3)	(Lack of) clean water, sanitation, cleanliness of air and water, environmental aspects, (levels of) pollution
Ethnicity and race	13 (3.1)	Race, racism, privilege of being born in Canada, Aboriginal history of trauma, colonization, and oppression, disenfranchisement
Family	9 (2.2)	Illness to family structure, family support, (poor)/parenting, having parents around, spouse
Food insecurity	25 (5.9)	(Lack of) access to fresh produce/healthy foods, adequate nourishment, (good)/nutrition, (unhealthy)/diet, (lack of)/healthy food, food security, hunger
Gender	5 (1.2)	Gender equity, gender inequity
Healthcare	7 (1.7)	Access to advanced technology, access to doctors, healthcare, access to health services
Homelessness	6 (1.4)	Homeless
Housing	54 (12.9)	Adequate housing, affordable housing, bad housing, good housing, inadequate housing, insecure housing, low-cost housing, poor housing, living conditions (crowded, overcrowded, overcrowding)
Income	44 (10.5)	Income adequacy, adequate income, economic inactivity, economic security, family income, income gradient, income level, personal finances, secure income, income security, wealth, economic insecurity, (lack of) living wage, minimum wage, low income, savings in the bank
Inequity and inequality	12 (2.9)	Economic inequality, health (in)/equity, inequities (unspecified), social injustice, economic inequity, social inequity, social inequality, health inequality
Neighbourhood	11 (2.6)	City design, nearby pollutant-causing firm, nearby chemical factories, geography, nearby industries, remote living, walkability, where people are living, urban polarization

Table 1 (continued)

	No. of times reported in news media (percent)	Terms included
Other	34 (8.1)	Access to legal assistance, automobile, behaviours (unspecified), computer games, domestic abuse, economic aspects (unspecified), economics (unspecified), economy, exercise, free time, history of emotional or sexual abuse, insecurity (unspecified), language, policies (unspecified), politics, public security, related behaviours, safety, school curriculum, self-esteem, sexuality, social aspects (unspecified), social factors (unspecified), stress, success addiction, transit, and violence in relationships
Poverty	39 (9.3)	Poverty
Social support	11 (2.6)	Having people who love you around, supportive friends, community programs, community support programs, job retraining programs, positive friendship network, social isolation, strength of community, social participation, social exclusion, social participation, social isolation
Socioeconomic status	10 (2.4)	Economic status, social class, social status
Welfare and social services	9 (2.2)	Income support, job/employment support, social assistance, social services, adequate welfare support

Where explicitly identified or listed, the SDOH were reported in 209 unique ways, which are provided in a condensed format in the "Terms included" column of Table 1. Reports of SDOH varied widely, from individual-level behaviours such as diet, exercise, or cannabis use, to community-level influences such as community support programs or network of positive friends, to even broader, societal-level influencers such as poor public policy or public security. These vast differences among the different SDOH reported reflect the complex and widespread influence of the SDOH and the many levels at which they influence health (WHO, 2008).

How has coverage of the SDOH changed over time?

Figure 1 illustrates the distribution over time of the five most frequently reported SDOH, among articles that explicitly reported them (n = 113). As shown in the figure, there was increasing news media coverage of these SDOH from 1993 to 2014. For example, where housing was reported, it ranged from its lowest coverage in 1993 (n = 0) to its highest in 2005 (n = 8). As another example, coverage for income ranged from its lowest in 1993 (n = 0) to its highest in 2013 (n = 9).

Figure 2 shows the distribution of all media articles included in this study (n = 183). Articles reporting on the SDOH were least frequent in 2003 (n = 0) and most frequent in 2013 (n = 36). A number of spikes in coverage (shown as a marked increase in Figure 2) occurred in the following years: 1993 (n = 4), 2001 (n = 5), 2004 (n = 5), and

Figure 1: Distribution of main SDOH reported in Canadian news media, 1993 to 2014
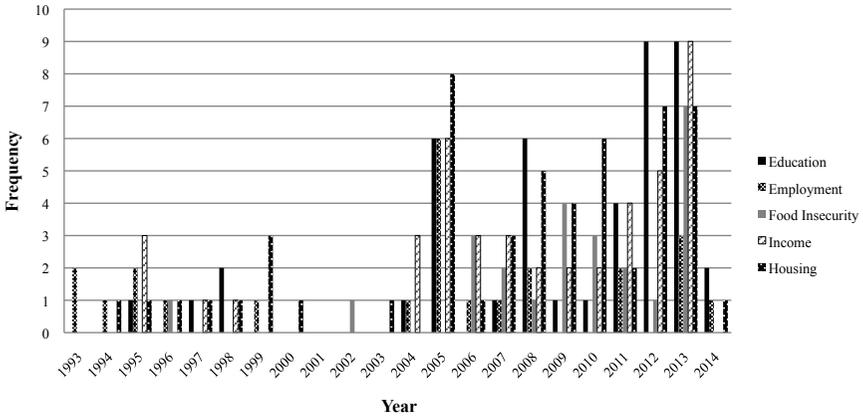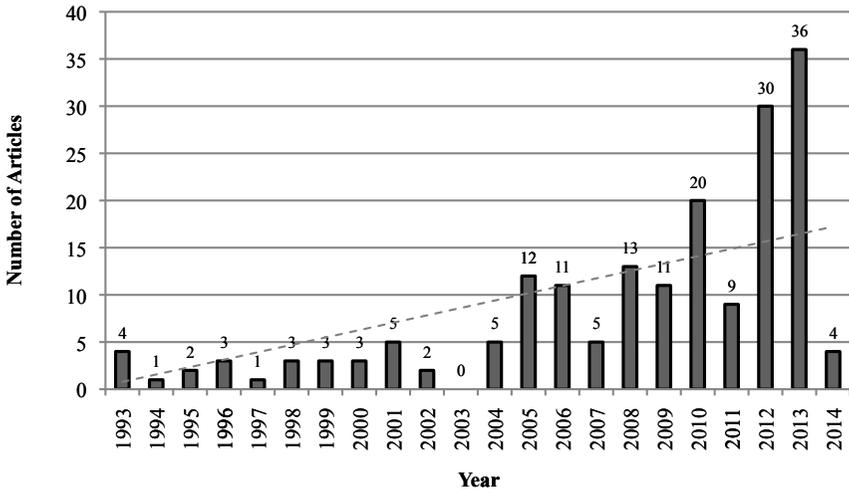

Figure 2: Distribution of articles reporting on the SDOH, by year, 1993 to 2014

2005 (n = 12). After 2005, the average number of articles reporting on SDOH grew substantially, with an average of 16 articles reported per year between 2006 and 2014. As shown by the increasing trend line in Figure 2, and the more frequent spikes in coverage (i.e., 2008, n = 13; 2010, n = 20; 2012, n = 30; 2013, n = 36) media coverage of the SDOH is shown to have risen fairly steadily since 1993.

Four notable clusters occurred around articles covering SDOH. The earliest, as described previously, reported on a lecture given by Dr. Sol Levine in 1993 (n = 4). The second cluster appeared in March 2005 (n = 5) and marked the first spike in coverage as shown in Figure 2. This second cluster of articles reported on the selection of former Minister of Health and Welfare (1977–1979) and current academic, Monique Bégin, and former politician and current HIV/AIDS activist, Stephen Lewis, to serve on the World

Health Organization's (WHO) Commission on the Social Determinants of Health—a prestigious, three-year panel and study that investigated the SDOH internationally.

Finally, the third and fourth clusters of articles reporting on the SDOH appeared in 2012 ($n = 6$) and 2013 ($n = 13$) due mainly to the activities of Dr. Anna Reid. As the 2012–2013 president of the Canadian Medical Association (CMA), Reid took an advocacy stance for the SDOH and called fellow CMA members do the same. In her first news statement given prior to commencing her term in August 2012, Reid expressed her view that the federal government had "withdrawn some of its responsibility to take true leadership on the health care portfolio," and identified the "top-down, thisiswhat'sgoing-to-happen [*sic*]" (Kirkey, 2012a, p. A9; 2012b, p. A10; 2012c, p. B6; 2012d, p. A3) approach as the cause of problems experienced by the Canadian public (e.g., suicide, addiction, mental health issues). Reid also drew attention to the "cracks and chasms" in the Canadian healthcare system, and the need for government to act on the SDOH (Kirkey, 2012a, p. A9; 2012b, p. A10; 2012c, p. B6; 2012d, p. A3; 2012e, p. A6; see also Picard, 2012c).

Reid was again the subject of another cluster of articles ($n = 13$) in 2013 when she held CMA town halls across Canada to seek public input on the SDOH, spoke to the federal Anti-Poverty All-Party Caucus, and published a CMA report on her findings. The report, *Health Care in Canada: What Makes Us Sick?* drew attention to income, housing, nutrition, and food security, and also recommended that action to be taken on them (CMA, 2013). The abovementioned clusters of Reid and others illustrate how coverage of SDOH in Canadian news media has often focused on key figures and leaders who advocate action on the SDOH.

How are messages of the SDOH communicated to the public?

Print media reporters communicate messages about the SDOH to their readers by writing about them in a carefully organized article. In this study, messages about the SDOH varied in where reporters first made mention of this topic in their article. To determine "position" of SDOH reporting within a data source, news articles were considered as stories with the literary devices of beginning, middle, and end. Article text was searched to determine whether the SDOH was positioned in the first (beginning), second (middle), or third (end) portion of the news report.

Among the 183 articles included, 19.5 percent ($n = 36$) reported SDOH at the beginning of the article, 40.5 percent ($n = 75$) at the middle, and 40 percent ($n = 74$) at the end of the article. Depending on how authors structured their news report, the intended message on SDOH may be interpreted in different ways. To help understand positioning in news reports, the St. Petersburg College Libraries (SPCL) identifies five common formats for structuring news articles: the inverted pyramid, hourglass, nut graph, narrative, and five boxes story (SPCL, 2014). While each of these formats differ in how they develop a story and report on its details, each supports presenting the "lede"—that is, a short sentence and/or headline that conveys the main topic and captures the reader's attention—at the beginning of the article. If we consider this to be representative of Canadian news media reportage, we see that the SDOH are considered the main topic or most important and interesting component of an article approximately one-fifth of the time.

The following 2010 *Edmonton Journal* article illustrates how SDOH might appear when positioned as the lede of a story:

> Suppose I told you I was writing a column on the social determinants of health and the impact of substandard primary health care on acute care wait times? Unless you were a health-policy wonk of the most earnest kind, your eyes would glaze over. Perhaps they have already.
>
> So let me put this in blunt terms.
>
> Children and babies are dying needless deaths, at Third-World rates, right in the heart of our city. (Simons, 2010, p. B1)

This example shows how readers are immediately introduced to the SDOH, followed by the reassurance their eyes will not "glaze over" with boredom. This article instead frames the SDOH as an important issue that is relevant to the general public/reader (e.g., "So let me put this in blunt terms") (Simons, 2010, p. B1).

In comparing the above example—where the SDOH are reported in the beginning—with the following 2012 *Globe and Mail* article, one can see how the SDOH message might be lost in the middle portion of an article:

> Seven and a half more years.
>
> That's how much longer adult Ontarians would live, on average, if they could collectively overcome five unhealthy habits: smoking, excess alcohol consumption, poor diet, sedentary behaviour and stressing out.
>
> That is the conclusion of a new report from the Institute for Clinical Evaluative Sciences and Public Health Ontario. [5 paragraphs removed]
>
> Of course, lifestyle choices are just part of the equation. There is ample evidence that the social determinants of health – income, education, employment, stable housing, physical environment – have a tremendous impact on health and life expectancy. [5 paragraphs removed]
>
> The new ICES/PHO data, on the other hand, are more positive. They show that small changes can have a big payoff in life expectancy and quality of life. That should be motivating individually and inspiring collectively. (Picard, 2012a, p. A6)

As shown in this example, the message of the SDOH is not highlighted in any way to draw the reader's attention to it. In fact, the SDOH are only mentioned after the lede of the article suggests Ontarians "overcome five unhealthy habits." By promoting small lifestyle changes that "can have a big payoff" and glossing over the role of the SDOH, this article detracts from the complex nature of the SDOH regarding how different factors interact to influence health and how even "small changes" may be out of reach for many. On the one hand, this article speaks to the collective of "Ontarians"; however, it is framed to motivate individual behaviours as a means of improving population health. This article exemplifies how article position can influence a reader's understanding of the message. In this case, the SDOH may be misunderstood by readers who gloss over its minimal coverage somewhat buried in the article. Most likely, readers may adopt

the main message of this article's frame (contrary to the SDOH) regarding the straight-forward link between personal health behaviours and population health.

As a final example of positioning, consider the following brief 2010 *Globe and Mail* story that positions the SDOH message at the end:

> It actually makes sense to try and measure population well-being and happiness (H Is for Happiness – Focus, Dec. 4). Such measurement is a variant on the dual continuum model of mental health that measures whether people thrive or languish due to their social or health conditions. Researchers have found that 60 per cent of the population can move between thriving or languishing over a 10-year period.

> Measuring the effects of social and health conditions on well-being is good public policy and should lead to an increased focus on the social determinants of health. (Lurie, 2010, p. A14)

As exemplified in the article above, positioning the SDOH at the end of the article resonates more with the top-to-bottom reader than the middle position, because it may contain the "kicker" to the story. Similar to the lede, the kicker may be an important quote, comment, or conclusion about the topic (St. Petersburg College Libraries, 2014). In consideration of this, the 40 percent of the SDOH messages that appear in the end portion of articles may indicate that they are communicated with the intention of conveying the importance of this issue. On the other hand, presenting the most key message about the SDOH to readers at the close of an article may not adequately convey its importance, as readers may be "simply … not willing to read beyond the first paragraph (and even sentence) of a story unless it grabs their interest" (Arnold, Cook, Koyama, Angeli, & Paiz, 2013, p. n.p.), or reporters may lack space to explain this complex concept.

However, given the shift toward electronic-format news (PewResearch, 2012), this raises a separate concern relating to the different ways that individuals read electronic media. Eye-tracking studies conducted in 2008 found that Web users read an average of just 28 percent of words per page (Weinreich, Obendorf, Herder, & Mayer, 2008), in an "F-shape" pattern, by reading top sections horizontally before scanning the left margins of the article (Nielson, 2008). This may mean that where newspapers provide their readers with the option of reading print content in electronic format, their messages may not be read the same way as the conventional left-right, top-down approach. To exemplify the meaning of this using the results of this study, this means that readers could miss up to 80.5 percent of the messages regarding the SDOH should they decide to read the 183 articles of this study electronically. Consequently, reporters wishing to convey specific messages on the SDOH should carefully consider the format and structure of their stories.

Framing analysis and discussion

Frame 1: Social determinants are an urgent, actionable issue and government responsibility

One way that news media articles framed the SDOH was as an urgent and actionable issue that involved multiple actors, but was a responsibility of government. Action

on the SDOH was conveyed in a number of ways, through calls for more research to initiatives such as healthcare reforms, affordable housing programs, labour policies, investment in social supports, redistributive taxation measures, or raising the minimum wage (e.g., Gandhi, 2006; Lemstra, 2012; Picard, 2006, 2008; Rothman, 2013a). As well, many actors were considered as having a role to play in acting on the SDOH, although articles predominantly focused on those working within the healthcare system—namely nurses (e.g., "one of the key things nurses do is assess social determinants of health" [Naud, 2012, p. F4]), doctors (e.g., "If doctors begin to talk about the determinants of health, it is possible that governments will begin to act" [Lemstra, 2013a, p. A13]), health-related organizations (e.g., "Drawing attention to the role poverty plays in health outcomes is part of the role of the CMA" [Laucius, 2013d, p. B1]), and institutions (e.g., "hospitals and medical schools are grasping the need for a workforce with the inclination and skills to care for the global village within Canada" [Tam, 2009, p. A1]). Other actors, such as citizens, businesses, consumer groups, and patients, were also identified but their roles were discussed to a much lesser extent, if at all (e.g., Pedwell, 2013; Picard, 2012b).

While multiple actors were identified as having a role to play in acting on the SDOH, news media reports predominantly assigned blame for inaction to governments. One reason for this may be the perceived lack of responsibility among Canadian governments for the health of its people that was reported. For instance, one article identified the federal government as having "no clear goals and a dearth of leadership" (Picard, 2012b, p. A19) regarding the sustainability of healthcare, while another identified the need for "[a] government that's really accountable for its people's health" (Edmonton Journal, 1993, p. D17). Related to this, other articles reported a lack of accountability for the SDOH in government and reported that "no one in government is talking much about this" (Campbell, 2006, p. A14) and critiqued "the pervasive Not-In-My-Backyard attitude and the denial … from civic leaders" (Todd, 2007, p. B1) and misguided priorities of governments that detracted from creating a healthy society (Watkinson, 2010).

Finally, many articles pointed to the action and lack thereof that government had taken against the interest of the SDOH. Some articles pointed to the Harper Government's "gnawing away at the country's social safety net" (Kirkey, 2012e, p. A6) or the recognition that the Progressive Conservatives had been "particularly savage on the province's poorest" during their time in power in Ontario (Campbell, 2006, p. A14). Others spoke to the need for "the federal government to build on their commitments to reduce and eventually eradicate poverty," (Rothman, 2013a, p. A16), yet understood that social policies that improve health, such as those supported by the New Democratic Party (e.g., minimum wage, employment standards, women's equality scales), were likely to "'run into heavy political opposition'" (Ross, 1995, p. A1) with recognition that "[r]eform is only going to happen if the political environment changes" (Picard, 2012b, p. A19). In this frame, the problems of health inequalities were diagnosed as the result of government inaction, unaccountability, and disinvestment.

Outside of the news media, the call for government action on the SDOH has repeatedly been resounded by those working in population and public health (Braveman,

Egerter, Woolf, & Marks, 2011; Gore & Kothari, 2012; O'Hara, 2005; Raphael, 2008; Reutter & Kushner, 2010; Sparkes, 2009). Of particular importance, in June 2009 the Senate Subcommittee on Population Health declared in its final report that, "governments have a moral obligation to foster the social, economic, cultural and environmental conditions that empower individuals, communities and societies to create and maintain good health for all citizens" (Keon & Pépin, 2009, p. 16). This helped to solidify the view in Canada that action on the SDOH is a responsibility of government. Despite this, however, attention has been drawn to the Canadian government's failure to act on the SDOH. At the federal level, Toba Bryant and colleagues Dennis Raphael, Ted Schrecker, and Ronald Labonté (2011) have pointed to the mid-1990s reduction of federal transfers to provinces for funding social and health services in Canada, which increased their privatization and created an "inability of governments to influence the provision and quality of these services," thus limiting their capacity to act on the SDOH (Bryant, Raphael, Schrecker, & Labonté, 2011, p. 54). Ted Schrecker and Vanessa Taler (2013) have suggested that governments have failed to act on the SDOH because they lack the coordination of departments, ministries, and agencies to achieve the "whole-of-government" approach that is necessary to address such complex issues. At the municipal level, the National Collaborating Centre on the Determinants of Health (NCCDH) found that public health units did not see the relevance of their work to the SDOH, which limited their attempts at taking action (NCCDH, 2010). This speaks to the epistemological barriers to action on the SDOH that Dennis Raphael, Ann Curry-Stevens, and Toba Bryant (2008) identified for population and public health professionals, the government, and the general public. The authors found that in North America, the responsibility of one's health status is placed on individuals (and their motivations and behaviours) and not on the ways that society distributes and organizes the resources that create opportunities for health (i.e., power, wealth, resources) (Raphael et al., 2008).

The above studies help to explain the framing of government actors as staying aloof from acting on or bringing attention to SDOH issues. If the public, healthcare professionals, and individuals working in governments internalize health as a personal responsibility to uphold and protect, as suggested by critical health scholars (Hunt, 2003; Lupton, 1993; Raphael, 2008), it is understandable that this view will permeate the approach that decision-makers take to health and social policy. In light of this, there is work currently underway that attempts to bring the need for health and social policy reform into the mindset of the general public, even where health is conceptualized at the individual level. The FrameWorks Institute, for example, has been working on ways of framing the SDOH to Albertans in ways that garner public support, by choosing productive values (e.g., human potential) and emphasizing solutions that widen the context within which people think about health (FrameWorks Institute, 2016).

*Frame 2: Action on social determinants saves money
and is the right thing to do*
In reporting the importance of acting on the SDOH, two reasons dominated the narrative. First, the issue was framed in the context of rising and unsustainable healthcare costs. Readers were presented with arguments of where their tax dollars went alongside calls for action on the SDOH. One article spoke of the Ontario Ministry of Health Promotion's

purpose "which seeks to keep people healthy so they don't soak up health dollars" (Campbell, 2006, p. A14), with another advising that, "It's time to put our tax dollars into the social determinants of health for families and children" (Balmer, 2008, p. A7). Dr. Anna Reid, former president of the CMA, was cited by a cluster of articles (see above) speaking to the high cost of poverty to the healthcare system (e.g., "an estimated one in every five dollars spent on health is directly attributable to the social determinants of health" [Picard, 2013, p. A4]; "20 per cent of health care spending goes to care for diseases that can be attributed to low income and poor housing" [Rothman, 2013b, p. A9]). In some cases, articles spoke to the cost of not investing in upstream health initiatives. These included statements such as, "The cost of inaction is higher than acting" (Laucius, 2013c, p. A8), the warning that we either "pay now with decent social programs or pay later with increased health costs" (Gandhi, 2006, p. A13), and the reminder of poverty's "cost to government, cost effects on health care …" (Palmer, 2011, p. A3).

Second, action was framed as important on the basis of moral claims. Based on the concepts presented in public health ethics (e.g., that governments are stewards for the public's health and that we share responsibility for health in political society), the moral claim of addressing SDOH simply because it is the right thing to do seems appropriate in the context of the government's role in protecting public health (Coggon, 2012). One report bluntly quoted the Canada Research Chair in Globalization and Health Equity, Ronald Labonté, on government inaction by stating that, "A failure to act now is a moral failure" (Picard, 2008, p. A9). This statement is consistent with the social justice claims carried throughout the WHO's Commission on the SDOH, which included the claim that "Social injustice is killing people on a grand scale" (WHO, 2008, p. 26). Many reports that occurred during the proceedings of the commission also adopted this tone. Two articles quoted Michael Marmot—chair of the abovementioned commission—in stating that action on the SDOH was needed "because it's the right thing" (Picard, 2009, p. A7), and that, "We have the knowledge and we have the money—what we don't have is the will" (Fidelman, 2009, p. A9). Similarly, Dr. Anna Reid was quoted in her town hall meetings with the statement that "Poverty kills" (Pedwell, 2013, p. L6). Finally, there were some articles that posed moral questions to its readers. For example, one asked whether "we really prefer to fix damaged children rather than create the environment for them to thrive …?" (Steinmetz, 1998, p. A8). Another article from Saskatchewan simply discussed issues of inequality (e.g., rising food bank users, income inequality, increased mental disorders, and infant mortality) in contrast with building a proposed domed stadium (a $431 million project) (Watkinson, 2010). As it was worded:

> When we have fulfilled our promise to eliminate poverty, perhaps then we can talk about building a new Roughrider stadium since we will then have substantially reduced the health and social costs arising from poverty. (p. A10)

Alongside moral claims were also statements that elicited a sense of urgency. Some examples included reports that: "Now is the time … to call on the federal government" (Rothman, 2013a, p. A16), "we must … invest in the smart family policy parents require now" (Kershaw, 2010, p. A23), or that "the health of mothers, babies and families are at stake, and there is no more time to lose" (O'Campo, 2013, p. A8).

The use of moral claims may be helpful in bringing action to the SDOH, as claims made on the basis of ethical grounds may serve to motivate national actors to achieve common goals (Ruger, 2006). Health maintains an intrinsic and instrumental value to society, thus naming deprivation an injustice may bring to the fore a moral responsibility to increase individuals' capabilities, potential, and life chances (Ruger, 2006). As discussed previously, however, these moral claims have not yet translated to action on the SDOH in the Canadian setting.

Frame 3: Social determinants only affect the worst off

A third way that messages concerning the SDOH were framed focused on describing the individuals or groups adversely affected by SDOH-related issues. In most cases, this frame was used to present the results of scientific studies or surveys that described health inequalities using measures such as income level or aboriginal status. Some examples included statements highlighting that "the prevalence of stroke in Saskatchewan adults is almost eight times higher for those with lower incomes than it is for higher income persons" (Lemstra, 2011, p. A11), "only 10 per cent of high income Canadians smoke daily, compared to 33 per cent of low income Canadians" (Lemstra, 2012, p. A11), "61 per cent of non-aboriginal residents of Saskatchewan and 37 per cent of its aboriginal residents are literate" (Lemstra, 2013a, p. A13), and that, "Diabetes rates for First Nations people over the age of 45 … is nearly double the 11 per cent rate of non-aboriginal Canadians" (Benjoe, 2013, p. A4). After presenting health inequalities, articles tended to forgo further discussion of the issue in favour of assigning responsibility to governments, often accompanied with a call to action by these actors.

Comparing society's worst off with the better off may be an effective way of presenting health inequalities produced by the SDOH, as it serves to identify differences between groups that may otherwise be masked by population averages (Graham, 2004). However, there are implications of presenting SDOH in this way that may detract from the goal of reducing inequalities. As public health researcher and sociologist Hilary Graham (2004) found in her review of policy approaches to tackling inequalities, the above described "health gaps" approach directs attention to minority groups at the highest and lowest ends of the socioeconomic spectrum and not those in the majority group (i.e., the middle class). Yet while a health gaps approach brings attention to two groups, in practice the discussion and efforts made at the policy level are aimed only at groups facing health and social disadvantage (Graham, 2004). There is little, if any, attention paid to those who enjoy the health and social privileges that accompany occupying space near the top of the socioeconomic hierarchy, nor discussion of policies that seek to redistribute wealth, power, or resources—the root causes of health inequalities (Graham, 2004). A second consequence of a health gaps representation of SDOH is that it collapses the socioeconomic hierarchy into a social divide (i.e., the richest and the poorest), which ignores the stepwise relation of poor health to socioeconomic position (i.e., the social gradient of health) and its ill effects on health (Graham, 2004; Marmot, 2005).

Descriptions of disadvantage

In some cases, articles went beyond naming health inequalities and sought to describe

the health disadvantages of the worst off in detail. Such descriptions may elicit emotive response and moral outrage from their readers, but as noted above, they also separate the experiences of the social and health disadvantaged from hegemonic Canadian society. One example included the report of "homeless patients with cellulitis – deep, severe and fastspreading infections in their feet and lower legs from wearing the same pair of ripped, worn and wet shoes for more than a year" (Kirkey, 2012a, p. A9) in the Northwest Territories. Another article from Edmonton wrote of heavy users of the emergency department, noting that, "Some come in tens of times a year with broken arms, fractured jaws, frostbite, infected wounds and pneumonia" (Sinnema, 2013, p. A5). An article from Vancouver, speaking of the failure of drug treatment programs to treat addiction, wrote that "'tinkering' with individuals for an hour or so a week will not have much of an impact if they return to the bleak, blighted world of a hotel dweller" (Davis, 1999, p. A18). Likewise, a Toronto-based article tied inadequate housing to community violence in St. James Town by referencing the "18 decaying, overcrowded high-rise residential areas squeezed into an area" where children have "seen their friends killed, they've seen people murdered, they've seen people killing themselves …" (McDowell, 2005, p. TO14). Another article reported on a woman from Mississauga who was a "mother of three, who is hard of hearing and has a heart condition, lives on disability support and never has enough money to go around. She knows her own health isn't good but it hit her like a ton of bricks recently that her inability to supply nutritious food is harming her own kids" (Campbell, 2006, p. A14). Finally, another article drew attention to the social divide by noting that the cost of "chronic street people" was "between $172,000 and $220,000" (Egan, 2011, p. C1) per year to the healthcare system. While perhaps a legitimate observation, tying exorbitant healthcare costs to disadvantaged groups may produce negative feelings toward these groups and further separate them from hegemonic Canadian society. Using the above example, the healthcare costs incurred by homeless populations may cause this group to be construed as a dependent "problem group" by the majority of society who fund healthcare through their taxes and occupy space in the middle of the socioeconomic hierarchy.

The above example relates to the work of critical population health researchers Lindsay McLaren and colleagues Lynn McIntyre and Sharon Kirkpatrick (2009), who noted in the context of population health interventions that focus on vulnerable groups may increase stigmatization for already marginalized groups. One example from news media reports on SDOH that highlights this issue is from a report on Dr. Reid's town hall tour, which presented the following quote by her, before moving on with the story without further explanation or interrogation: "we talk about success in life in terms of working hard and going up the ladder," said Reid. "With [A]boriginal children, many won't even reach the bottom rung" (Pedwell, 2013, p. L6). Of course, Dr. Reid is referring to the limited access that Aboriginal peoples have to the resources and opportunities that facilitate health compared to non-Aboriginal peoples; however, without further contextualization lay readers may draw assumptions about this population informed by the falsely constructed and racist stereotypes that pervade Canadian society (e.g., negative depictions of Aboriginal peoples as unemployed and dependent) (Loppie, Reading, & de Leeuw, 2014). In such circumstances, the disad-

vantaged groups frame of the SDOH may do little else but utilize the lived experiences of disadvantaged groups to provide a compelling narrative, as they do not provide further explanation into the complexities of the SDOH or suggestions as to how readers might act toward remedying health inequalities (e.g., write their members of parliament in support of policies that create equal opportunities for health).

An additional layer of the disadvantaged groups frame relates to its societal function as a contemporary legend (McIntyre, Raine, Hobson, & Dayle, 2001). As critical population health scholar Lynn McIntyre and colleagues (2001) found, origin stories of children's feeding programs, which rested on heart-wrenching depictions of deprivation, promoted social solidarity and a charitable mindset in society, and justified these programs' existence. What these stories did not do is challenge the social structures that place these groups at disadvantage (McIntyre et al., 2001). As such, stories of misery and deprivation—whether describing the health of disadvantaged or hungry children—depoliticize an issue that is fundamentally produced by our political, economic, and social structures (i.e., the inequitable distribution of power, wealth, and resources) and serve to justify Canada's history of ignoring this issue in public policy (Raphael, 2012).

"Third World" comparisons

At times, the health gaps frame of SDOH issues drew on comparisons to the "Third World" to highlight the poor health conditions of disadvantaged groups in Canada. These included statements that, "Children and babies are dying needless deaths, at Third World rates, right in the heart of our city" (Simons, 2010, p. A4), or that "… some Canadians still live in conditions often described as Third World, with residents of isolated reserves living in overcrowded homes rotten with black mould and with limited access to running water" (Skerritt, 2010, p. A4). Another article suggested that "comparing incidence rates of pertussis between Cuba and Saskatoon Health Region leaves one questioning which is the Third World jurisdiction," (Lemstra, 2013b, p. A9), while yet another quoted a health worker saying that "'Right here in Hamilton, we actually have Third World life expectancy'" (Lemstra, 2013a, p. A11).

Using the "Third World" to draw attention to disparity operates in parallel to framing the SDOH in terms of health gaps, yet on a global scale. Employment of the term "Third World" may bring to mind racialized images of poverty (e.g., AIDS, starving children, disease, violence) that stereotype or patronize persons living in the global South or what Michael Mahadeo and Joe McKinney (2007) refer to as the "majority world." As with the vulnerable groups focus, "Third World" comparisons serve the function of naming inequality without interrogating its root causes. Likewise, "Third World" comparisons swiftly abandon any discussion of conditions in these settings to focus on inequalities in the Canadian setting. As Priya Kurian and Debashish Munshi (2012) have suggested, these comparisons may provide "discursive distancing" of problems, such as health inequalities, to frame them as far away and to "prevent an appropriate response" [p. 993] (i.e., redistribution of wealth, power, and resources in ways that improve global health). As with the health gaps frame, "Third World" comparisons ignore the root causes of health inequality in these settings, which are deeply tied to the actions and policies of wealthy neoliberal nations (Labonté, 2011). This is

especially true in the contemporary context of globalization, which influences health through the distribution of labour markets, power, resources, trade, finances, health systems, and other factors to the benefit of wealthy nations (Labonté, 2011). Furthermore, as mentioned earlier, inequality within and between nations has been shown to have negative societal and health effects. Income inequality within nations, for example, has been linked to the increased spread of infectious disease, child poverty, violence and crime, greater infant and maternal mortality rates, premature years life lost, and early dropout rates, among others (Canadian Institute on Children's Health, 2000; Lynch, Davey Smith, Hillemeier, Shaw, Raghunathan, & Kaplan, 2001; Raphael, 2008, 2003; WHO, 2008; Woodward & Kawachi, 2000). Conversely, public policy approaches aimed at decreasing inequalities (e.g., increasing employment and minimizing inequalities) have been linked to improved indicators of population health (e.g., improved life expectancy, decreased infant mortality and child injury mortality rates) (Raphael, 2003). Given the multiple commitments that Canada has made internationally in support of health and human rights, alongside the lack of action toward improving conditions, "Third World" comparisons may serve a similar function to the contemporary legends of disadvantaged groups (described previously), as they distance the issue of the SDOH and health inequalities and justify Canada's current response of stagnant inaction (Bryant, Raphael, Schrecker, & Labonté, 2011; Manzano & Raphael, 2010; Raphael, 2012; Schrecker & Taler, 2013).

Closing comments

In light of the above findings, equity-minded news media reporters and publications may wish to present stories on the SDOH in ways that establish collective awareness and the will to act among the general public. News media can assist by bringing public awareness to the SDOH and its complexities (e.g., reporting on research and advocacy activities) and also by reporting on the ways in which the public can get involved (e.g., supporting certain political candidates, writing members of parliament). News media can also help frame the SDOH as an issue of importance to the general public through messages that enhance understanding of the topic. Practitioners in public health have previously noted that the general public continues to misunderstand the SDOH as characteristics of individuals rather than the structural, societal-level factors that influence individuals (Health Nexus and Ontario Chronic Disease Prevention Alliance, 2008; Healthy Public Policy, Health Promotion, Disease and Injury Prevention, and Alberta Health Services, 2011). The Canadian Council on Social Determinants of Health (CCSDH) (2013) has suggested a number of ways to effectively communicate SDOH messages, such as using value-driven and emotionally compelling plain-language statements, providing context for numbers and facts, and customizing the message for different audiences. In its guidelines for common messaging, it includes specific ways to "hook" (e.g., "We want our family to be healthy") and "prime" (e.g., "Without health, opportunities for life experience are limited") the public to serve as an entry point into the discussion and increase its receptivity to the message without resorting to descriptive stories on the deprivation of vulnerable groups (CCSDH, 2013, p. 10).

As with any study, this analysis is not without its limitations. First, there is the recognition that news stories serve as constructions by reporters who seek out and tell stories

of certain occurrences (Gasher et al., 2007). However, news media reports on issues such as the SDOH still represent an important data source as representations of how the public may be exposed to these issues. A second limitation of this study is its focus on print media. For example, the perspectives of SDOH reported on social media, which is increasingly populated with news stories and integrated into the daily lives of many Canadians, was not captured. Future work may seek to determine how representations of the SDOH in other forums differ from print news media. Finally, due to limitations of space, it was not possible to speak to the multiple nuanced frames that exist for SDOH. Other frames that emerged in this study, which researchers may wish to explore, include examining differences in SDOH representations between newspapers and in different geographic settings, the metaphors used to call to action various actors in the SDOH (e.g., "heads in the sand," "wake-up call" [Mulgrew, 1999, p. B11]), or the presentation of SDOH issues in terms of lifestyle and personal responsibilization.

Conclusion

This article has focused on the representation of the social determinants of health in Canadian news media from 1993 to 2014. As content analysis revealed, news media coverage of the SDOH has increased steadily since 1993, especially following the announcement of the World Health Organization's Commission on the Social Determinants of Health in 2005. As this article has described in detail, the social determinants of health were reported using a range of descriptions and definitions related to many different determinants of health and health outcomes. References to the social determinants of health were most frequently positioned in the middle or end of news media articles, which may indicate a lack of perceived importance of this topic by news reporters, as well as the likeliness that messages related to the social determinants are not reaching the large proportion of readers who merely scan news articles.

A framing analysis of news articles revealed that the social determinants of health were presented as an urgent issue in which the action was framed as the responsibility of government, saving healthcare costs, and a morally just endeavour. Yet articles also framed social determinants of health and health inequalities as issues that only affect those who face the greatest health and social disadvantage in our society. This frame was illustrated through use of a health gaps approach, emotive descriptions of disadvantaged groups, and by drawing on "Third World" comparisons. Problematically, such framing may serve to disconnect hegemonic Canadian society from the issue of health inequalities and its negative societal impacts and may further the disadvantage that these groups face through stigma and marginalization. Importantly, this frame ignores the root causes of health inequalities within and between nations; that is the inequitable distribution of wealth, power, and resources.

Notes

1. For example, see: Epp, 1986; Health Canada, 1998, 2001; Lalonde, 1974; PHAC, 2007.

2. *The Globe and Mail*, *The Vancouver Sun*, *Star – Phoenix*, *Edmonton Journal*, *Ottawa Citizen*, *The Gazette*, *Winnipeg Free Press*, *Calgary Herald*, *National Post*, *The Record*, *The Windsor Star*, *The Province*.

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