Dominant Narratives in Health

What are "dominant narratives" of health?

Narratives are the lenses through which people perceive and interpret events, issues, and the causes of and solutions to social problems. "Dominant narratives" are those in wide circulation that serve to reinforce the status quo to maintain power and influence.[1] They tend to crowd out alternative narratives, experiences, and understandings of health and health systems that challenge injustice and inequality. They are also frequently harmful or "malignant" in nature, especially because they position themselves as factual truths rather than subjective stories about health.

Where did you find the following narratives?

The following list is a work in progress. It is based on a gray literature review of reports from several health equity professional, research, and advocacy organizations, including the Association of American Medical Colleges Center for Health Justice, the National Association of County & City Health Officials, the Open Society Foundations, the Robert Wood Johnson Foundation, and the Collaborative on Media and Messaging for Health and Social Policy. For more information on sources and citations, email bf379@cornell.edu.

American Exceptionalism

Narratives of American exceptionalism suggest that U.S. health systems are the best in the world, especially when it comes to patient care and innovation. These narratives also sometimes suggest that such an exceptional system must be non-political or -discriminatory because it is based purely in the latest science. Patients are lucky to be served by the most robust health system in the world under this framework. Maintaining this appearance of exceptional quality may come hand in hand with denialism or revisionism of racism and other forms of persistent inequity in health systems. If inequities are acknowledged, it is suggested they can be fixed through programmatic adjustments and case-by-case reforms rather than fundamental changes in the logic of the health system.

Inherent Scarcity

The most basic premise of the inherent scarcity narrative is that because our healthcare resources are finite, we must be realistic that there is not enough to go around equally. Failures in providing quality care or exclusion of certain groups is justified as an effect of inherent scarcity rather than a failure of individual professionals, systems, legislation, or government bodies. These narratives displace responsibility from those public-facing elements of health systems that would otherwise be the subject of public ire. They also work to shore up support for those system nodes by presenting them as financially struggling and in need of our support.

[1] For more definitions of narrative and narrative power, see the Narratives for Health project, at https://www.countyhealthrankings.org/strategies-and-solutions/narratives-for-health

Financialization as Public Good

Financialization describes the growing tendency to treat healthcare institutions as "salable and tradable assets from which the financial sector may accumulate capital" (Bruch, Roy, and Grogan, 2024). This approach demands short-term profit growth from health systems in order to benefit elite financial stakeholders. Narratives supporting this trend frame the financialization of health as a public good and alternatives (e.g. socialist health systems, universal healthcare) as bad for patient outcomes. They also depict "freedom to be healthy" as freedom to buy, sell, own, and have purchasing preferences in a health system marketplace.

Hierarchies of Expertise

Narratives perpetuating hierarchies of expertise in health position some individuals as holders of knowledge and others as recipients of knowledge. The roles are rigid, and knowledge sharing is framed as a unidirectional, top-down process. Health professionals are the experts, and thus their assessment of a patient's health should be valued more than the patient's self-assessment. The hierarchy becomes particularly rigid when the patient is a person of color, a woman, or on Medicaid/Medicare, among other positionalities deemed of less expertise. Narratives of this kind also privilege certainpractices of expertise over others; for example, a clinical, biomedical birthing plan is framed as more valuable than an at-home, doula-led birthing plan.

Individualism

Narratives of individualism in healthcare take as given that primary responsibility for health and wellbeing rests with the individual. These often overlap with "bootstrap" narratives that suggest individuals could overcome poor health if only they would take initiative to pull themselves out of habits, communities, and contexts that work against their wellbeing. Medical conditions are framed as biologically or behaviorally determined in individuals or groups rather than a reflection of societal factors. This can often lead to stereotyping, stigmatization, and blame of individuals or groups deemed willingly "non-compliant" with good public health practice.

Deservingness

Narratives of individualism in healthcare often go hand-in-hand with narratives of deservingness. These narratives suggest that in an individualistic health environment, those who do not follow best practices for maintaining their wellbeing and acting as "good" citizens forfeit their right to good health and services necessary to achieve it. Such deservingness narratives are commonly mobilized in debates around who should be eligible for Medicaid and other need-based assistance programs. Under this framework, those who receive U.S. health services but do not meet normative criteria of deservingness are positioned as illegitimate drains on individual taxpayers.

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