You must not confuse poverty with laziness:

A case study on the power of discourse to reproduce diabetes inequalities

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Goal

To investigate the ideological 'work' of ways of speaking (i.e. discourse) in the reproduction of health inequalities

Discourse: System of language and conventions that makes a field of knowledge possible

Ideology: Marxian sense, frame that serves elite interests even when upheld by all segments of society

Why diabetes

- Type 2 diabetes (T2DM) 'good' disease to study health inequalities – it and its complications strongly dependent upon access to social resources (e.g. access to healthy lifestyles ; good medical care)
- Long-standing personal experience in clinical diabetes (physician in Argentina)
- Good exposure to health inequalities among Latinos as a sociologist

Why Latinos

- US Latinos 'high-risk population' – 1.5 to 3 times T2DM and complications
- Also 'at risk' of poverty, unemployment, low paying jobs, limited educational opportunities, food insecurity, restricted citizenship rights, etc.
- Language and cultural advantage (Latina)

Background

- Poverty breeds disease (centuries long evidence). Specific mechanisms/ diseases change, but poor ***always*** have worse health.
- 'Old wine in new academic bottle': Social determinants of health' (SDOH) new found interest, macro / micro mechanisms reproducing the link

Collective commitment to eliminating health inequalities

- Declaration of Alma Ata, 1978 (USSR)
- Lalonde Report, 1981 (Canada)
- Ottawa Charter, 1986 (Canada)
- Acheson Report, 1999 (UK)
- Healthy People 2000, 2010, 2020! (US)

WHO Commission for the Social Determinants of Health, 2008

"A girl born today can expect to live for more than 80 years…in some countries – but less than 45 years…in others. Differences of this magnitude…simply should never happen….

Social justice is a matter of life and death"

So why are health inequalities so resilient..?

Theoretical considerations

- Critical functionalism
- We look at the ideological 'work' (function) of a certain 'way of seeing and talking' about the world and social relations; we examine how these ways reproduce the very problems they express concern about
- We draw from Herbert Gans (The Functions of Poverty) and William Ryan (Blaming the Victim)

Data and Methods: Where/What

- Research site: NGO serving Latinos in Northern California
- Data: interviews ; focus groups; field observations; community food assessments

Data and Methods: How

- Research questions:
  - What do participants believe are the ***causes*** of T2DM and its inequalities?
  - What do they propose as ***solutions***?

Findings: Overall

- ***Causes of T2DM and inequalities:***
  - Overwhelmingly 'within' / 'something about' individuals, families, communities affected
- ***Solutions to T2DM and inequalities:***
  - change individuals/communities affected, patch the system ('managing' poverty and oppression in the hope that health inequalities will disappear)
- ***Pockets of discursive resistance scarce***
- ***Both staff and clients***

'Defective' individuals: 'wrong' attitude

(staff) They start early, you know, 8 dollars an hour…oh my gosh, 8 dollars multiplied by 10 or 12 pesos, that's a huge amount of money. But they don't realize…how expensive it is to live here. One dollar is nothing.

(researcher) So surely your clients have a hard time staying healthy because they are poor, no?

(staff) You know…my mom told us always: "don't confuse poverty with laziness". If you are poor…you can still have a good sense of meaning, love, always respecting everybody, yourself and people around you. It's important to have a job and it's most important [that] you respect yourself.

'Defective' individuals: Ignorant

(client) Well I think that much of our health depends on us. You can go for a walk, that's free. You can cook your own food, and that's healthy. To read, to acquire information, develop good habits - that depends on each person.

Change the victim: Educate them

(staff) [I'd] just say more information …directly to the people, books, classes… to understand where their food is coming from, what they should be eating …education….Maybe if [children] were taught [healthy nutrition], maybe they would like try to do something about it at an early age.

Change the victim: Change our lifestyles

(client) [We need to] raise awareness among Latinos.

(researcher): Raise awareness? What does that mean?

(staff) For example, educate ourselves to have better lifestyles…

Patch the system: More $$$ in programs 'for the poor'

(staff) You need…the health education *that takes on in low-income communities*, communities of *color…appropriate to reach them*…

Patch the system: Help them sign up for programs

(staff) [our staff] will ask you a series of questions and then plug in the numbers and say "oh you know, Claudia, you're a single person, looks like you might qualify for about $175 a month of food stamps. Let's fill out the application and we'll turn it in for you.

Conclusions

- Finding cause of *systematic health problems and their unequal distribution* (T2DM and inequalities) *within* individuals/communities affected and proposing to target/change them as solution *reproduces the problem of health inequalities*
- Allows everybody to continue with 'business as usual', even as we engage with limited social critique that does not threaten system

Why?

- Inequalities are dysfunctional (i.e. bad), but only for the worse off – for privileged (or better off) they are functional (i.e. good)
- 'Ideological work'

Victim blaming ideology

- Psychological mechanism that allows middle class (e.g. health professionals; researchers, etc) to engage in limited social critique (no real threat to system), thus benefitting from system it critiques
- Opportunities to 'do/feel' good (e.g. continuing research on poor that does not challenge status quo; 'business as usual')

Limitations and strenghts

- Sample is small and purposive; not generalizable
- Still useful to illustrate a social mechanism (i.e. language as social institution)
- Offers insights into forms of resistance and pathways towards social change (different thinking/ speaking => different acting)

What to do

- As helping professionals in public health, we can challenge system that produces social inequalities if we choose to
- We can *refuse to cooperate ideologically*, even as we relate to patients, clients or participants in research projects; not call for 'coping' with the sociopolitical context of disease but by challenge it

Discussion/Implications

- *Transforming professional discourse can encourage political empowerment.*
- *A transformed discourse should also recognize limits of professional work and engage other forms of praxis (e.g. social movements, people power).*
- *Real social change will also require that the powerless acquire enough power to demand it (H. Gans).*

Thank you ☺


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