Tackling Health Inequities Through Public Health Practice:

A Handbook for Action

THE NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS
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THE INGHAM COUNTY HEALTH DEPARTMENT
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Sources

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-Richard Hofrichter, Editor

Preface

Health practitioners in local health departments (LHDs) face many dilemmas and struggles in seeking to protect and improve the public's health. As the front line of the public health response in local communities, they often must cope with immediate crises and chronic issues with limited resources, restrictive statutory mandates, categorical funding, and political pressures from state and local officials. Addressing the root causes of inequities in the distribution of disease and illness might seem like a luxury. But it is not. Persistent, severe health inequities are increasing significantly, with serious implications for the nation's well-being. While Hurricane Katrina made these health inequities and their underlying injustices salient to a wide population, the day-to-day consequences are a major threat to public health. They must be challenged. The good news is that success will mean fewer resources need to be spent on coping with the consequences. With leadership, strategic alliances, commitment, and public support, LHDs can meet the challenge. At the same time, addressing health inequities will demand a supportive environment for and collaboration with staff as well as community-based organizations.

Social justice has always been a major philosophical underpinning of public health because much of the etiology of disease is rooted in social conditions. Social justice has also often been a motivating force in drawing many people to the field. Elizabeth Fee notes in her introduction to George Rosen's *A History of Public Health*, "When the history of public health is seen as a history of how populations experience health and illness, how social, economic, and political systems structure the possibilities for healthy or unhealthy lives, how societies create the preconditions for the production and transmission of disease, and how people, both as individuals and social groups, attempt to promote their own health or avoid illness, we find that public health history is not limited to the study of bureaucratic structures and institutions but pervades every aspect of social and cultural life." Progress toward the elimination of health inequities will therefore require an expanded and expansive view of the scope of public health practice.

Tackling Health Inequities raises questions and provides a starting point to assist health practitioners in considering the potential for reorienting public health practice to address the root causes of health inequities, particularly with respect to restructuring the organization, culture and daily work of public health. It is meant to inspire readers to imagine or envision public health practice and their roles in a way that challenges contemporary thinking, as emerging trends, social conditions, and policies generate increasing inequities in health. No protocols or tools can eliminate health inequity. It will require taking risks and questioning assumptions. Recent experience in many jurisdictions suggests that many health practitioners are willing to meet the challenge. NACCHO expects to provide guidance and assistance in that endeavor and this book represents one step in a long journey.

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PART ONE

Chapter 1

Introduction

Even though economic growth has increased dramatically in the last half-century, not only are life expectancy rates shorter and morbidity rates higher for many communities of color and people in poverty, but "[s]ince the 1970s, there has been no increase in average well-being, despite rapid increases in wealth."[1] Material success is paradoxically associated with social failure, especially in providing for the conditions of population health. British epidemiologist Michael Marmot notes that "with each mile along the subway line from downtown Washington to suburban Montgomery County, MD, life expectancy increases by a year and a half."[2] How are we to explain this? What are the significance and implications for public health practice? These findings only hint at the larger question which this book explores: the implications of growing health inequities for the work of local health departments (LHDs). Health inequities—which result from an unequal structuring of life chances—are systemic, avoidable, unfair and unjust differences in health status and mortality rates, as well as in the distribution of disease and illness across population groups. They are sustained over time and generations and beyond the control of individuals.[3] What can LHDs do to eliminate them?

PURPOSE AND ASSUMPTIONS

In seeking to identify how LHDs can address health inequities, NACCHO believes that many of them recognize the need to act on root causes, but remain stymied by bureaucratic structures, statutory mandates, and constraints on surpassing the seemingly traditional boundaries of the discipline. NACCHO seeks to provide approaches for how LHDs might effectively act on the source of inequities. *Tackling Health Inequities Through Public Health Practice: A Handbook for Action* offers ideas, insight, and examples for LHDs in order to strengthen their capacity for influencing the root causes of health inequities through a social justice perspective. Social justice is a concept that develops with force from the earliest days of the industrial revolution. Beyond fairness, it is concerned with fundamental aspects of equality—social and economic as well as political, the latter referring to democracy (see section on Developing a Framework below for a more detailed examination of social justice). Such a perspective "explicitly analyzes who benefits from—and who is harmed by economic exploitation, oppression, discrimination, inequality, and degradation of natural resources."[4] The purpose of *Tackling Health Inequities Through Public Health Practice* is twofold:

1) to provide a conceptual framework, raise questions, and spur thought for exploring the nature and causes of health inequity and what to do about them, and
2) to offer a knowledge base, resources, case studies, and suggestions for transforming everyday public health practice, departmental structure, and organizational culture in ways that may advance the attack on health inequities. *Tackling Health Inequities Through Public Health Practice* presents a rationale for incorporating the elimination of health inequities into public health practice within a social justice framework, as part of public health's core mission. Its emphasis is on the way LHDs organize the content and structure of their work and relations with their communities, rather than only programs and services.

Assumptions

Seven basic assumptions guide the work:

1) Health is an end in itself, an asset or resource required by everyone and critical to human development and well-functioning communities
2) Equity in health status benefits everyone.
3) Health is a social concept, not only a medical one, and therefore would be usefully defined broadly, for example, demonstrating its connection to quality of life and well-being.
4) Population health outcomes are primarily the result of social and political forces, not lifestyles or behavior.
5) Health is a collective public good, actively produced by institutions and social policies.
6) An accumulation of negative social conditions and lack of fundamental resources contribute to health inequities, and include economic and social insecurity, racial and gender inequality, lack of participation and influence in society, unfavorable conditions during childhood, absence of quality and affordable housing, unhealthy conditions in the workplace and lack of control over the work process, toxic environments, and inequitable distribution of public goods.
7) Addressing health inequities effectively will require an emphasis on root causes and social injustice, the latter having to do with inequality and hierarchical divisions within the population.

How to Use This Book

While *Tackling Health Inequities Through Public Health Practice* can be read cover to cover, its design enables readers to select material based on specific needs. Thus, it can be a reference tool in a training exercise or dialogue process, a sourcebook for case studies, or a supplement and background material to other works. Its design is not comprehensive, but instead seeks to inspire practitioners to imagine new possibilities and methodologies for "upstream" action to address the root causes of health inequities.

The Organization of the Book

The book is divided into two parts and fourteen chapters. Part I, chapters 1-4 present introductory material as follows:

- Chapter 1, Introduction, describes the historical background and research on health equity and provides a conceptual framework.
- Chapter 2, Initiating Social Justice Action through Dialogue in a Local Health Department, outlines a methodology for engaging local health department employees and neighborhood residents in a nine-month dialogue process to address the root causes of health inequities based in class, racism, and gender exploitation.
- Chapter 3, Transforming Public Health Practice, identifies specific elements or areas of practice through which local health departments can act to address the root causes of health inequities by reorganizing certain features that define the work of public health.
- Chapter 4, Promoting Social Justice through Public Health Policies, Programs, and Services, examines the requirements for integrating social justice into public health practice, including an agenda and examples.

Part II, The Public Health Community in Action: Case Studies and Stories, chapters 5-13, provides examples of successful practices on a variety of subjects in cities across the country. The Appendices offer exercises, selected resources and references, and articles on such topics as measuring health equity, communications, and how social injustice becomes embodied in differential disease and mortality rates.

RECLAIMING OUR HISTORY: EQUITY AND PUBIC HEALTH

The modern institution of public health arose as an organized response to the ill effects of industrialization. Historically, major advances in health status resulted from broad-based social reforms such as the abolition of child labor, the introduction of housing and factory codes, shortening of the working day, reductions in the scale of poverty, improvements in the standard of living, and guaranteeing employment or at least a minimum wage, as well as efforts to improve sanitation, provide adequate housing, and ensure safe food. Improvements in living and working conditions led to reductions in death from major infectious diseases, as well as medicine and immunizations.[5] Later, legislative developments such as the Social Security Act, Clean Air Act, the Mine Safety Act, as well as the establishment of OSHA and Medicare and the expansion of civil rights, were major steps that improved health for millions of people. Dan Beauchamp reminds us, "Public health stands for collective control over conditions affecting the common health."[6]

The history of public health has also always been closely associated with themes of social justice and social movements designed to achieve social equality and democracy.[7] The idea of a basic public responsibility for social health and welfare and the responsibility of those in public health to be advocates for social justice and collective action is integral to public health.[8] Public health practitioners have historically been advocates for social change. They have understood that health is not an individual privilege but a social good belonging to everyone as a social right. Demands for better working conditions and good wages, racial and sexual equality, affordable housing, social services, improved sanitation, an end to segregation, and quality education are some examples of the backbone of social movements for change.[9]

However, today many forces and pressures have led to de-emphasis on the broad aspects of social and economic life, on the deeply rooted social and political determinants of health. The direction of public health for decades has been toward a more managerial and technical role within a bio-medical model to promote individual health, which doesn't typically focus on social injustice and the forces that structure the possibilities for health. Health practitioners are usually forced into this position because of categorically funded programmatic work within specialized sub-disciplines. While this tendency has been useful in many fields of work, including public health, in providing necessary expertise and advances in knowledge, it also limits the ability to address changes and trends in society that affect health, similar to the way specialists in medical practice sometimes fail to see the whole patient. As Nancy Krieger notes, citing numerous senior epidemiologists, "...modern epidemiology often seems more concerned with intricately modeling complex relationships among risk factors than with understanding their origins and implications for public health."[10] In short, health inequities involve phenomena outside of science, scientific measurement and bureaucratic management. But it doesn't mean, as explained in Chapter 3, that public health has no role to play or that its practice cannot change to meet new or intensified threats.

In order for public health to reclaim its historical mission, realize its mandate to protect and improve public health, prevent a decline in health status, and remain accountable, it may be useful explore methods for addressing the widening and persistent social and economic inequities that affect the entire society. Identifying where exposures come from and why some population groups are more likely to be exposed than others is a central task, which can inevitably lead to acting on the material conditions that create inequities in the distribution of disease and illness. This will likely require rethinking basic tenets in the contemporary theory and practice of public health.

RACE, CLASS, AND HEALTH: THE RESEARCH

What are the origins of health inequity? What social processes generate it? Inequities do not occur randomly. They are not primarily the result of accidents of nature or individual pathology, but result from patterned, long-standing historical social conditions generated by social and economic inequality.[11] Communities, for example, with higher rates of economic disinvestments, longer firefighting response times, poor quality of housing, decreased access to nutritious foods, and other multiple stressors, will be more likely to have populations with higher blood pressure and other chronic illnesses. Regardless of specific diseases, those with socioeconomic disadvantage are more susceptible to early death and preventable disease.

Since the time of Rudolf Virchow, a public health pathologist, and sanitary reformer Edwin Chadwick in the 19th century, health practitioners have known about the importance of the relationship between social class and mortality and morbidity.[12] However, while life expectancies may have increased dramatically over the last century, so have inequities in health status. A significant body of research, especially since 1990, clearly documents that socioeconomic inequality, including institutional racism and sexism, poor quality of life, and low socioeconomic status are principal causes of morbidity and mortality.[13] Negative socioeconomic and cultural conditions create multiple chronic stressors, from the physical environment to housing, transportation, education, tax policy, and working conditions, which produce inequitable health outcomes. In addition, those that live in poor neighborhoods are likely to experience more health problems, regardless of their own socio-economic status.[14] As Beaglehole notes, "...a population's health reflects more than the simple summation of the risk-factor profile and health status of its individual members."[15] Moreover, inadequate medical care accounts for only 10 to 15% of premature deaths.[16]

The findings generally on inequality are not encouraging. The gap between rich and poor within the industrialized countries is widening.[17] The more egalitarian countries experience the best health status, not the richest.[18] Those with the most inequality often show signs of social disintegration and weaker social safety nets.[19] Perhaps most strikingly, income inequality in the U.S. is greater than in any other industrialized country in the world.[20] According to the U.S. Bureau of the Census, almost 18% of all children under the age of 18 in the U.S. live in poverty.[21] Inequalities in wealth are even wider than those in income. Inequality in wealth within the U.S. is vast and steadily increasing.[22] And, as might be expected, health inequities in the U.S. are also widening.[23] In addition, the U.S. ranks 29th in life expectancy for men, 21st for women; it ranks 28th in infant mortality.[24] It also has poor rankings on indicators such as homicide rate, number of prisoners as a proportion of the population, mental illness, voting turnout, and public social expenditure.[25]

While class, race, and gender relations interact and overlap, it is useful to separate the threads for purposes of explanation. Debate exists within the research community on how these relations precisely affect population health and on the conceptualization of the issue more generally. However, class, racism, and gender exploitation remain the fundamental, originating injustices through which power imbalances take hold.

Thus, social determinants of health inequity themselves are not causes of social injustice and inequity. They reflect deeper social divisions which generate multiple social risks, reproduced over time. Public health needs a conceptual foundation to explain core characteristics and dynamics of the social structure that link most determinants of inequities in health to social injustice. Hierarchies of power considered through a perspective of class, race, and gender relations provide a groundwork for explaining the seemingly abstract connections between social and economic determinants (poverty, housing, access to transportation), their distribution, and the basis of inequality more adequately. The original injustices, interests and privilege that create inequity require explanation. Society's class structure and inequality of property and wealth clearly intertwine with gender and racial hierarchies. However, racism and sexism take root in various forms of material exploitation. Therefore it may be inappropriate to isolate the social determinants of inequities in health as a list of subjects for "interventions."

Class

In the United States, unlike other parts of the world, analysts often avoid a discussion of class. Or they define it in relation to either income levels or in psychological, subjective terms associated with status.[26] But class has a deeper, more objective meaning. For understanding health inequities, the structure of class relations is a more crucial determinant than income categories defined by the idea of lower, middle and upper classes.[27] For class relations are connected to social power and the ability to influence society's decisions beyond simply a greater capacity to consume goods and services. And class inequality is not the inevitable result of impersonal market forces. The concept of the working class which, for some, has an old fashioned ring to it, really refers to those that lack access to society's productive resources, capital, and assets—to the capabilities that enable living a full and healthy life.[28]

Class analysis provides an approach for analyzing the continuing reproduction of health inequities, the relationship of health to major economic and political processes, and methods for evaluating strategies to eliminate health inequities with an emphasis on policies such as full employment, availability of quality education, public transit, investment in children, access to social assets, social services and other elements of progressive social change.[29] Class, in our approach, is not primarily about income distribution, identity, or one's status in a hierarchy. Rather, it concerns the relationship between social groups and thereby allows us to examine the implications of the distribution of labor, the conditions of labor, labor's market power, the control of production, levels of financial speculation, and the structures of political power.

A strong connection exists between work and health, particularly given its connection to family life and the well-being of communities, and the documented relation between socioeconomic status and health.[30] With rapidly changing patterns of employment, job requirements, and declining social supports that would guarantee income in new welfare provisions, increasing levels of stress exacerbate inequities among the most vulnerable in the population, excluding them from full participation in society's major institutions. Unemployment and underemployment have long been demonstrated to be associated with serious health risks, including suicide, depression, violence, and alcohol consumption.[31] Equally important for health is the level of control employees have over their work conditions and labor markets. Those with less control, which tend to be among those with lower socioeconomic status, have worse health outcomes and greater opportunity for injuries and illness.

Racism

Racial and gendered structures of power and inequalities profoundly influence health status because hierarchies of all kinds determine life chances.[32] As with class, and connected to class, racial and gender discrimination and oppression become embedded in all social institutions, policies and cultural practices, rules, symbolic codes, and conditions in everyday life. The cultural practices that occur within these identities often obscure their connection to class interests. Equally important, racial and gender relations influence class relations. This sometimes hinders sorting out the primacy of one over the other. The issue of race for epidemiology and addressing health inequities is not to confuse racial differences in health outcomes with biological or genetic differences but instead to recognize the effects of racism on health and how racism gets into the body.[33] Racial segregation is an example—supported by the real estate industry, the banks, and federal housing policies. Segregation leads to isolation and economic deprivation resulting from the poor quality of education and lack of good jobs. In poor, segregated communities the lack of investment, along with disinvestment, creates stressors leading to health inequities.

A vast amount of data also demonstrates the relation of racism to inequality in health status and the continuing high mortality rates of African Americans and other people of color.[34] The racial gap begins early, before life begins given the stresses of racism on the mother, and continues throughout. In addition, when controlling for socioeconomic status, racial disparities in health remain due to factors such as segregation and discrimination, which adversely affects mental health and leads to cardiovascular disease and hypertension.[35] As David Williams argues, "...black-white differences in SES [socioeconomic status]...are a direct result of the systemic implementation of institutional policies based on the premise of the inferiority of blacks and the need to avoid social contact with them."[36] Beyond economic circumstances, racism is a powerful force leading to persistent disadvantages in health outcomes. As the most basic type of group oppression, racism takes many forms, restricting opportunities and limiting survival rates. One example is the targeting of polluting industries for communities of color.[37] Another concerns the discriminatory practices that have kept African American, Native American, Hispanic and other populations disproportionately at lower socioeconomic levels. Everything from segregated housing to discriminatory banking practices and poor quality schools has cumulatively created severe stress and unhealthy environments. In addition, racial prejudice itself is a force, collectively, for poorer health outcomes within many communities of color.[38] At every level of income, racial differences in health status persist.

The relation of advances in political power to conditions that affect health status is further demonstrated by noting improvements in the living conditions of African-Americans during the 1960s and 70s based on the civil rights movement, resulting in a decline in their mortality rates.[39] But later, beginning in the early 1980s, inequities increased and continue to increase. Extensive social costs arise from these inequities—threats to economic development, democracy, and the social health of the nation.

Sexism and Gender Discrimination

Gender is also a reality-based social construct related to traditions, roles, behaviors, and relations between and among the sexes. Differentials in health outcomes between the sexes are most often attributable to sexism rather than to biological differences.[40] Gender discrimination results from inequities in political representation, the division of labor, and social stratification, which limit access to resources compared to men and within different groups of women. The division of labor, limited patterns of employment according to gender, unequal pay, and changing household structures have often led women, particularly of low-income, to be denied access to resources and advantages available to men and thereby create systemic disadvantages that may limit life chances and negatively influence health.[41] Often limited to service work, unpaid domestic labor, and part-time work, economic insecurity and the stress of sexual harassment can lead to psychosocial stress.[42] Many women are also primary care givers and single parents. All sorts of government policies (welfare) and definitions (the family, mental health), implemented through gendered rules and practices within predefined roles, determine life chances.

Major health inequities are found among women across socioeconomic status and race, particularly among African American women, with respect to life expectancy, morbidity and mortality rates, rates of depression, and chronic conditions such as hypertension and diabetes.[43] This suggests that interrelated conditions and experiences, including social status, limited employment opportunities, and neighborhood safety, are important determinants of health inequities. Moreover, women bear the burden of disproportionate levels of domestic unpaid labor through familial relations. As Arline Geronimus notes, "American women in ethnically marginalized or economically disadvantaged populations have not enjoyed improved health or prolonged life in equal measure to those in more advantaged groups...especially among African-American women."[44] Gender discrimination itself results from inequities in political representation, the division of labor, and gendered hierarchy and social stratification, which limit access to resources compared to men and within different groups of women.

The particular macro pathways to illness by which health inequities link to exposures are intricate and often difficult to establish. Yet they remain influenced by the way in which production and investment decisions, labor-market policies, activities within financial markets, neighborhood conditions, and racism connect with individual histories to produce health disadvantages.[45] While it is difficult to evaluate precisely and scientifically how given social contexts interact with multidimensional biological and psychological exposure pathways to make people susceptible to disease, these systematic disadvantages are cumulative, persistent, intergenerational, and associated with lower capacity for full participation in society.

Appendix D (3) is a crude attempt to explain how social injustice translates or becomes embodied in the biology of the body. It is oversimplified because the process is less linear and more relational than it looks, but represents a generalized trajectory. In addition, it leaves out the element of popular resistance to the forces that create health inequity. That resistance manifests itself in social movements and contestation over policy, as well as pressure for institutional change. The major point of the diagram, however, is that the social determinants of inequities in health are not the primary variables; they depend on features of the social structure and the ways in which concentrated political power influences the distribution of productive resources over the life-course.

CONSEQUENCES FOR SOCIETY AND THE HEALTH PROFESSIONS

Consequences of Social, Economic, and Political Equality for Society

- Limits people's ability to have *access* to the resources and experiences that would provide them good health and well-being, enable them to achieve their potential, allow them to use their full capabilities, secure well-paid, productive employment, and participate fully in the social life of the community
- Creates psychological stresses that weaken the immune system
- Limits democracy by curtailing access to decision-making processes that affect health
- Reduces the quality of life for everyone

Why should public health practitioners care about the root causes of health inequities?

- The consequences of increasing health inequities have implications for much of public health's work, and will influence priorities and use of resources.
- Public health agencies will need to understand and communicate about the forces that produce or undermine health to their constituencies. It is an opportunity to reclaim the issue for public health practice where it historically belongs, connected to all aspects of public health work.
- To identify strategic activities and goals for advocacy and recommendations for policy or social change.
- To support actions that will lead to permanent change in the conditions that produce differential health outcomes, and have a greater effect than more traditional interventions over time.
- Health agencies save resources by not only focusing on prevention but also addressing the prerequisite conditions for health and well-being.

SOURCES OF HEALTH INEQUITIES

Social and Political Forces

How are inequalities produced and maintained? The sources of inequities in health outcomes are deeply embedded in major economic and social institutions. An international study examining relationships between political variables and health indicators found a high correlation between working class power and good population health.[46] In the last thirty years, the power of the working class and labor has been weakening in the U.S. The exporting of production, the decline of labor unions, reduction in the social wage (such as welfare and Medicaid), and reduced voter turnout have influenced this weakening. As employers seek to limit social protections and the economy fails to create necessary levels of employment, populations have thus become more vulnerable to unregulated and chaotic labor markets. Wage cuts, welfare reform, benefit reductions, and threats to privatize social security are some examples. They contrast with policies to invest in workers, neighborhoods, or childhood development to increase productivity. The incessant drive for endless economic growth through reducing labor costs and social investments causes inequities and uneven development, in part because what that growth means is an expansion against stable social life, thus destabilizing communities. Economic growth depends on subjecting people to market imperatives. Constant and rapid shifting of capital, resources, and jobs to locations of lowest production costs and cheap labor anywhere in the world accelerates the disintegration of communities, creating higher unemployment, dislocation, insecurity, and other stressors related to illness.

Among many other possibilities: discriminatory practices by banks, economic disinvestment in communities with significant poverty, exporting jobs, failure to invest in urban infrastructures, downsizing and restructuring, gentrification, targeting of industrial and toxic waste facilities in communities of color, profiteering by drug companies seeking to maintain control of patents, and shifting the tax burden to the less fortunate.

Within the accelerated patterns of globalization in the social order (outsourcing of jobs, greater extraction of natural resources, more intensive use of chemicals and toxic production processes), which lead to ever greater pressures on and degradation of the environment, life-support systems, and the capacities of the ecosystem more generally, infectious diseases are returning along with new risks to health that affect those with less resources. These developments are distributed unevenly in poorer communities.[47]

Nor do inequitable health outcomes function separately from the overall pathology of stressors in society that transforms and organizes time and space in our everyday lives. Examples include speed-up in the workplace, accelerating money exchanges and the circulation of capital around the world, moving the locations of production, mechanisms of resource extraction, increasing discriminatory land use policies, and otherwise shifting social and ecological costs onto society, thereby creating social disintegration.

In recent years, severe cutbacks in social spending across the country, especially for public health and critical infrastructural supports including affordable housing, education, and mass transportation, have exacerbated health problems in already deteriorating communities. Even though new federal resources have been targeted for bioterrorism, funding for addressing the root causes of health inequities and even some traditional public health practices have not increased and even decreased. With greater disinvestment and underinvestment in areas such as childhood development, job creation, and education, movements of resources and jobs overseas, increased deterioration of the ecosystem, and increasing layoffs, health status for many disadvantaged groups is worsening. Renewed forms of segregation and gender discrimination, combined with low-income, further contribute to deteriorating health status. Unstable and changing labor markets, tax policies and subsidies that redistribute wealth upwards, and increasing marginalization of already disadvantaged social groups have led to greater exposure to health hazards and susceptibility to disease.[48] These conditions occur in one of the most unequal nations in the world with respect to both income and wealth.[49]

Barriers in Concepts and Paradigms

Why does government only consider ameliorative responses or limited regulation, rather than transformations of institutions that will eliminate the causes? At the simplest level, addressing "the big picture" of social determinants is somewhat abstract; the phenomena are not especially observable and involve long-term historical forces. The realization of healthy communities is an on-going process, not always conducive to measurement. The cumulative character of racism and socioeconomic status operates across the life course. It is certainly easier to measure improvements in service delivery than achieving well-being in specific populations. In addition, policy makers and health professionals are more comfortable discussing program delivery to high-risk populations and clinical responses that avoid political conflict or contingent historical and economic dynamics that remain outside the boundaries of scientific analysis.

Why is it difficult to imagine alternatives to the current system and name them? At one level, the historical time line of inequality and its insinuation in all of our institutions obscures the structure of disadvantage. But the limited public debate about health inequities has also become domesticated, preoccupied in the search for medical solutions, programs to educate those in poverty, and policies to change behavior, avoiding long-term injustices. Yet there is much at stake in the language used to explain inequality because it will determine strategies and highlight the need for major social transformation. Such transformation will involve equalizing access to capabilities and advantages, leveling the playing field—that is, access to the means of achievement and the freedom to achieve, enabling people to engage in the world.[50]

The social sciences and epidemiology

The social sciences, the health professions, and the discipline of epidemiology often have a tendency to avoid both the study of social factors and becoming involved in social policy decisions. As in most professions, critical reflection on its own historical and political development, presuppositions, and epistemological traditions is often lacking. Until recently, epidemiology as a discipline primarily examined risk factors—the agents of disease—within methodological approaches emphasizing observed phenomena, particularly on the body, not structured social relations. Its theoretical paradigms, driven by the biomedical sciences and often choosing not to question the values that shape its perspectives, have downplayed the historical conditions and social context that make populations vulnerable, including ecology, class, and racism. Although "individual risk factors or increased molecular understanding is likely to be extremely limited in understanding variations in disease incidence or prevalence between groups," most of the professional discourse on low-income individuals and high-risk populations focuses, as we have noted, on service delivery, access to care, and modification of individual behavior.[51]

This is due partly to the prevalence of the biomedical paradigm. Many analysts still consider ill health only in relation to altered biochemical processes, lifestyles, and/or random events in the environment, absent social, economic and cultural context. Epidemiology, until recently, has been uninterested in developing useful explanations to deal with social forces. The continuing commitment to a biomedical paradigm limits investigations into complex historical issues connected with racism, ecology, social class, and gender discrimination. Public health practice cannot isolate itself from these concerns but rather must incorporate them within the appropriate scope of public health practice.[52]

Reform vs. structural systems change

In order to reduce inequality, it is necessary to ask: what maintains and perpetuates social inequality? Often much of the public discussion on inequality, instead of examining root causes and the political strategy that it requires, remains focused on access to health care, improving social cohesion, within an underlying assumption that market forces will resolve the issue. Opinion leaders and policy makers give minimal attention to these issues. Thus, public policy and funding emphasize primarily diseases and tracking diseases rather than the conditions and social processes that produce disease and chronic illness. The emphasis of programmatic interventions responds to the consequences of inequality instead of inequality itself. Supporters of remedial approaches tend to accept social conditions without exploring how they got that way. Can we find a way to integrate political and social analysis into the work of public health at the level of institutions in order to prevent future inequities?

DEVELOPING A FRAMEWORK: SOCIAL JUSTICE

The so-called disparities in health status among different population groups are unjust and inequitable because they resulted from preventable, avoidable, systemic conditions and policies. If health inequities are unfair, effective action to eliminate them demands a perspective and conceptual framework grounded in values of social justice. Otherwise responses will likely remain in a reactive mode, continuing to rely on cures, treatments, or individual interventions, rather than transforming institutions, policies, and practices that cause health inequities. While behavior clearly influences premature mortality and health, behavior always occurs within a socioeconomic context and conditions that continue over time. Although the pathways by which inequality develop are intricate, they are still tied to the way systemic forces such as investment decisions, labor-market policies, and neighborhood conditions become linked with individual life histories.

But what is social justice and what is its connection to public health? Social justice has been the foundation of public health and at least two basic themes constitute its core principles.[53] The first is a demand for social and economic equality, particularly in relation to sharing of social benefits. This requires an equitable distribution of advantages across society: collective goods, institutional resources (e.g., social wealth), and life opportunities. Excluding questions regarding income distribution, equality means ensuring the development of everyone's capacities to experience life fully. This includes a fair distribution of advantages, as well as greater control of social and environmental conditions.[54]

The second theme is political equality or democracy—the ability to participate effectively—based on principles of inclusion rather than exclusion. It requires access to productive resources. Greater democracy means subjecting more issues and investment decisions to public decision-making, expanding the political agenda. Achieving social justice requires a type of social change that enables claims for freedom, equality, and democracy to be adequately expressed.[55]

Social injustice is a negative consequence of unequal privilege, power, and exploitation and reflects deep social divisions in society. The broader context is not just governmental but the whole range of our commercial and cultural institutions.

What has social justice to do with health? Social justice and equity have been central to the mission and vision of public health because health is a prerequisite for human development. The idea of a basic public responsibility for social health and welfare and the responsibility of those in public health to be advocates for social justice and collective action has been the foundation of public health.

TAKING ACTION[56]

Chapter 3 discusses advancing health equity through transforming public health practice, culture, and structure. The task certainly seems daunting, given the powerful forces this chapter has examined. However, a preliminary step is to recognize that realizing the changes necessary to eliminate health inequities does not require quick, massive action all at once, but rather moving in a different direction and perspective. Social inequalities cannot be reduced primarily through programmatic interventions, given what we know about the relation between social hierarchy and chronic stress. In addition, we need to begin asking different questions in order to create institutional change rather than the more traditional emphasis on individual behavior. For example, as Doak Bloss notes in Chapter 2, in addition to asking "Why do people smoke?" the social justice question becomes "What social conditions and economic policies, along with systematic practices of tobacco companies, predispose people to the stress that encourages smoking?" In addition to asking "How do we connect isolated individuals to a social network?" we can ask "What institutional policies and practices maintain rather than counteract people's isolation from social supports?" As well as asking, "How do we create more green space, bike paths, and farmers' markets in high-risk neighborhoods?" we can ask "What policies and practices by government and commerce discourage access to transportation, resources, and nutritious food in neighborhoods where health outcomes are poorest?"

In short, a central question from a social justice perspective is "Why is there inequality and how can our organizational structure, policies, and practices change to eliminate health inequities?" Our world is contingent upon an ever-shifting political and social environment, not fixed for all time. The achievement of the end of slavery, women's suffrage, the eight-hour work day, and health and safety laws were major transformations involving long struggles and conscious strategies. They also depended on a shift in consciousness and values that legitimized new ways of thinking. Support for equality has increased and eroded in different historical moments. In public health, we need to rethink our mission and the preconditions for what is possible and also remember that health inequities are avoidable, not inevitable. At the same time, change will not occur without taking risks and organized action. Nor will it happen without an analysis and questioning of power relations in a community.

NOTES

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A. The Praxis Project, Washington, DC, is a national, nonprofit organization that builds partnerships with local groups to influence policymaking to address the underlying, systemic causes of community problems. Committed to closing the health gap facing communities of color, Praxis forges alliances for building healthy communities. Their internationally recognized staff employ broad experience in training, advocacy, policy development, media relations and technical assistance to support local organizations as they work to advance visions of healthy, just communities. www.thepraxisproject.org

B. The People's Health Movement. The goal of the People's Health Movement is to re-establish health and equitable development as top priorities in local, national and international policy-making, with comprehensive primary health care as the strategy to achieve these priorities. The People's Health Movement aims to draw on and support people's movements in their struggles to build long-term and sustainable solutions to health problems. The People's Health Movement is organized in regional and country circles. PHM is coordinated by a global secretariat and is supported by a steering group consisting of the representatives of 8 organizations and networks that cosponsored the first Assembly:

- Asian Community Health Action Network (ACHAN)
- Consumers International (CI)
- Dag Hammarskjöld Foundation (DHF)
- Gonoshasthaya Kendra (GK)
- Health Action International - Asia Pacific (HAIAP)
- International People's Health Council (IPHC)
- Third World Network (TWN)
- Women's Global Network for Reproductive Rights (WGNRR)

C. People's Health Movement - USA Circle

The PHM-USA Circle is the smallest, but beginning to organize various outreach activities as a way to build awareness of and support for the People's Health Movement. A strategy to achieve primary health care in the U.S. cannot be done in an isolated way without broader participation in an international movement. Current activities include:

- Building awareness among U.S. and Canadian-based groups and networks who oppose the ways in which corporate-led globalization is worsening people's health and how the initiatives of the People's Health Movement offer alternative visions of health and development.
- Reaching out to health professionals interested in health and human rights.
- Reaching out to people organizing around universal health care in the U.S.
- Educating and inspiring students within the healthcare field about the possibilities of improving people's health worldwide within the context of a profit-driven health care system.
- Putting primary health care back at the top of the agenda for people involved with international health and development.
- Building a People's Health Movement-USA web site and listserv as a means of sharing information and engaging in debate and discussion.

- Organizing educational and media events in North America for visiting international representatives of the People's Health Movement.

D. The Centre for Social Justice is an advocacy organization in Toronto, Canada, that seeks to strengthen the struggle for social justice. The Centre is committed to working for change in partnership with various social movements and recognizes that effective change requires the active participation of all sectors of the community. Although the Centre is based in Ontario, their work increasingly takes them across Canada and into the international arena. The programmatic content of the Centre's work may change from year to year, but there is an ongoing interest in working strategically to narrow the gap between rich and poor, challenging the corporate domination of Canadian politics, and pressing for policy changes that promote economic and social justice. The Board of Directors is drawn from partnerships with community and faith groups, unions and universities. http://www.socialjustice.org/

E. The Politics of Health Group (PoHG) consists of people who believe that power exercised through politics and its impact on public policy is of fundamental importance for health. PoHG is a UK-based group but with a clear international perspective and members throughout the world. http://www.pohg.org/uk

F. The Global Equity Gauge Alliance was created to participate in and support an active approach to monitoring health inequalities and promoting equity within and between societies. The Alliance currently includes 11 member-teams, called Equity Gauges, located in 10 countries in the Americas, Africa and Asia. GEGA's work is informed by a perspective that places health squarely within a larger framework of social justice. While some health variations between people are inevitable, for example the fact that the elderly generally have worse health than younger populations, many health inequalities are avoidable and associated with unjust social constructs. Furthermore, empirical evidence in both rich and poor countries demonstrates that such inequalities cut across all societies, and that health is closely associated with underlying political, economic and cultural influences and with social position. It is these inequalities with which Equity Gauges are concerned. http://www.gega.org.za/

Two listservs, one in the United States and one in Canada, provide valuable resources on health and social justice issues every day:

A. The Spirit of 1848 is a network of people concerned about social inequalities in health. Their purpose is to spur new connections among people involved in different areas of public health, who are working on diverse public health issues (whether as researchers, practitioners, teachers, activists, or all of the above), and live scattered across diverse regions of the United States and other countries. In doing so, the network hopes to help counter the fragmentation that many public health professionals face: within and between disciplines, within and between work on particular diseases or health problems, and within and between different organizations geared to specific issues or social groups. By making connections, the group attempts to overcome some of the isolation that health professionals feel and find others with whom they can develop thoughts, strategize, and enhance efforts to eliminate social inequalities in health. Their common focus is that health professionals are all working, in one way or another, to understand and change how social divisions based on social class, race/ethnicity, gender, sexual identity, and age affect the public's health. As an activist and scholarly network, members have established four committees to conduct their work.

To subscribe: spiritof1848-subscribe@yahoogroups.com

B. The Social Determinants of Health listserv is intended as an international forum for those concerned with the latest developments in theory, research, and practice regarding the social determinants of health. Social determinants of health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. Social determinants of health determine whether individuals stay healthy or become ill. Social determinants of health also determine the extent to which a person possesses the physical, social and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment. Social determinants of health are about the quantity and quality of a variety of resources that a society makes available to its members.

To subscribe to the SDOH list, send the following message to listserv@yorku.ca in the text section, not in the subject header: SUBSCRIBE SDOH your first name, your last name.

What is Social Justice Practice in Public Health?

- Sustained action on the underlying injustice rather than treating symptoms or consequences.
- Increasing the voice and influence of affected communities.
- Convening relevant parties and institutions that can change social conditions
- Support for health equity as a social right

Chapter 2

Initiating Social Justice Action through Dialogue in a Local Health Department: The Ingham County Experience

Doak Bloss

INTRODUCTION

In January 2005, the Ingham County (Michigan) Health Department initiated its Social Justice Project. Its objectives were to illuminate the ways in which the department's policies and practices had a bearing on the root causes of health inequity—the systematic and unjust differences in the distribution of illness and disease—in Ingham County, either positive or negative, and to create and implement an Action Plan for improving the department's responsiveness to those root causes. The engine for this work was an internal dialogue process that the department had previously used, with great success, in efforts to engage and mobilize neighborhood residents around self-defined community health improvement goals, and to develop community support for an "organized system of care" for the uninsured. The Social Justice Project was the department's first attempt to use this specific dialogue method to engage and mobilize its own employees around an initiative intended to change the department's internal practice.

The process that occurred in Ingham County in 2005 provides an opportunity to consider the practical challenges involved in attempting to change a local health department's approach to social justice issues from the ground up. These challenges include overcoming the modern mindset of what public health workers do, identifying the appropriate leadership role a local health department should play in its community, and finding an effective balance between facilitating and promoting change in a bureaucratic institution.

By their nature, bureaucracies do not welcome change. They do not invite transformation, and often their normal response to the threat of change is to resist it, reject it, or, worst of all, assimilate it in a way that blunts any real impact on the status quo. If local health departments are bureaucratic institutions—and in my experience they are—then any quick and deliberate attempt to transform their practice to focus on the elimination of the root causes of health inequity will quickly and predictably fail. The call for change must come from within, from the occupants of the bureaucracy itself—public health workers—and from the community the department serves. Furthermore, it must come as a consequence of accrued evidence and realization that what we are doing now to "preserve and protect the public health" is inadequate, because the social forces that advantage one group of people over another in our society are too deeply entrenched ever to be undone by conventional public health programming and regulation.

A new frame for the work of public health is needed—one that does more than simply adjust or recast the statutory mandates and programmatic objectives of the current frame. Local health departments must adopt as a core goal the identification and elimination of policies that maintain an uneven playing field on the basis of class, race, gender, and other forms of difference. The Ingham County experience was an attempt to explore whether a dialogue process—sustained, applied, and conjoined with other dialogue processes occurring in the community—could be a vehicle for creating this new frame.

Dialogue may mean different things to different people, and certainly not all forms of dialogue can be expected to succeed in serving as such a vehicle for change. In this chapter, *dialogue* should be understood to mean *a facilitated process designed to elicit, gather, and synthesize the collective wisdom of a group of people in answering a specific question, through the broadest possible participation and achieving the broadest possible ownership of the resulting decisions.* Students of the Brazilian educationalist Paolo Freire may find resonance with this definition, in that it at least implies consistency with the Freirean values of respect, egalitarianism, and intentional enhancement of community. Although the dialogue process used in Ingham County was not explicitly informed by Freirean theory—the facilitator of these dialogues (myself) had in fact not heard of Freire until after it was well underway—a belief in the transformative power of dialogue was central to this endeavor. Dialogue, we believed, could bypass the change-resistance mechanisms of bureaucratic structures, incorporating and empowering voices that would otherwise go unheard. A successful dialogue would, we hoped, achieve a critical mass of community and department consensus on the need to focus resources on the social determinants of health inequity. Realistically, our level of success in accomplishing this cannot be known for several years. At this point in the process, however, we can examine the groundwork for the dialogue process, and our discoveries along the way.

The overriding intent of this chapter is to assist those who are considering a similar use of facilitated dialogue to bring about a transformation of public health practice within local health departments. It should not be seen as a "how to" course in facilitation techniques or a curriculum for raising awareness of social justice issues, although I briefly describe both the dialogue methodology and the educational content used in the process. Most importantly, this chapter seeks to illuminate the likely road ahead for local health departments interested in using dialogue in this way. I begin with an overview of the Social Justice project and dialogue process that was used to move it forward. Then I focus on three specific challenges that shaped the work and the thinking of the participants, which I believe are likely to occur in some form in any local health department implementing a similar process. Finally, I offer three preliminary conclusions about the use of dialogue to create change in a local health department—specifically, change that instills in our daily practice new responsiveness to the root causes of health inequity.

BACKGROUND: THE LEGACY OF COMMUNITY VOICES

Although the term "social justice" was not commonly used to describe it, Ingham County's social justice work began at least as early as in 1998, with the implementation of its *Community Voices* initiative. Funded primarily by a grant from the W.K. Kellogg Foundation and a smaller grant from the Robert Wood Johnson Foundation, this initiative stressed active community engagement as a means to improving access to health and health care. The dialogue method described in this chapter was used both at the grassroots level and at the systems level to establish consensus and action planning for improved community health and an organized system of care for the uninsured in Ingham County.

At the grassroots level, the health department implemented a total of seven "community health summit" processes between 1999 and 2002. Three of these focused on Lansing neighborhoods, two on rural Ingham County communities, and one each on the health needs of African Americans and Latinos. In each case, Ingham County allocated grant dollars to community groups to organize and lead these summit processes, each of which took between six to twelve months to complete.

During the same time period, at the systems level, the Ingham County Health Department (ICHD) facilitated a very similar process around the focus question, "What do we need to do to create an organized system of care for the uninsured?" Health department staff conducted interviews about the challenges of covering the uninsured with representatives of four stakeholder groups: employers, consumers, providers, and insurers. Then, over a six month period, participants reconvened for facilitated dialogue on three aspects of the challenge of covering the uninsured: the uninsured population, health care services, and funding.

Many tangible outcomes resulted from these dialogue initiatives. At the grassroots level, work groups succeeded in organizing and implementing a wide range of health improvement projects through neighborhood network centers,[1] all grounded in the notion that social connection was the key ingredient to community health, and that ordinary people going door-to-door to engage residents in conversation created a fundamentally different sort of relationship from that which a professional health care worker would be likely to establish in an office or classroom. At the institutional level, by 2001 stakeholders who two years earlier had expressed deep skepticism toward the concept of an organized system of care were on record endorsing the Ingham Health Plan, a coverage model that leveraged the county's funding for clinical services to draw down new Medicaid dollars to fund a health care benefit for the uninsured. By late 2002, fueled by grassroots outreach workers working door to door in Lansing neighborhoods, the Ingham Health Plan had enrolled over 16,000 uninsured adults—62% of the total uninsured adults in the county.[2]

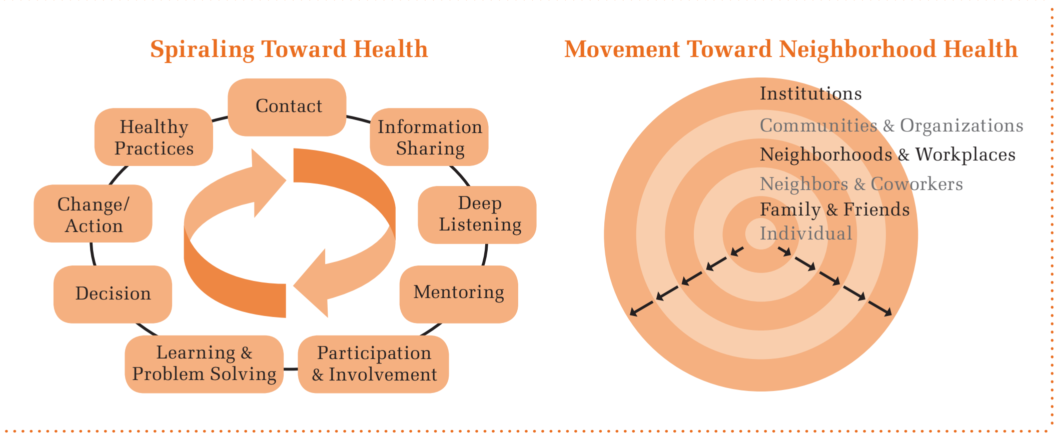
Changed Thinking about Assets and Resources

As asserted in Chapter 1, an initiative that connects the dots between social injustice and health inequity must seek a new framework for the work of public health. It requires a transformation in the way public health workers think and act in their communities. In Ingham County, this change in thinking clearly began with the dialogue processes that occurred through *Community Voices*.

Attempts to portray this transformation can be found in conceptual diagrams created in 2004, after the dialogue processes described above were over and their action plans implemented. The first of these was created by Ann Francis, a neighborhood health team coordinator at the Allen Neighborhood Center (Figures 1 and 2). This neighborhood center, established through recommendations from the 2000 East Side Health Summit, has been extraordinarily successful in funding and implementing neighborhood-based health improvement initiatives. In describing the neighborhood's "spiral toward health," the people at the Allen Neighborhood Center have emphatically turned conventional institutional thinking on its head. Improved health is not the result of institutions injecting their expertise into communities, they have told us; rather, it is the product of persistent, person-to-person interaction moving outward through concentric rings of engagement. Thus, organized individuals change institutions, not vice versa.

Allen Neighborhood Center's Conceptual Model for "Spiraling Toward Health"

FIGURES 1 & 2



Spiraling Toward Health

Movement Toward Neighborhood Health

As a consequence of *Community Voices*, the health department as an institution also began to rethink its strategy for allocating and using resources. At the programmatic level, the department has gained a new appreciation of the value of having neighborhood residents actively working to achieve the department's community health goals in such areas as smoking cessation, enrollment in coverage, and cancer prevention and detection. More fundamentally, department administrators have begun to ask the following two questions of themselves, and to urge other institutions to do likewise: 1) How can we get community groups, organizations, and neighborhoods to see our resources as their assets? and 2) How can we get our own organization to view the community's assets as our greatest resources? (Figure 3).

Rethinking Assets and Resources

FIGURE 3

Ingham County Health Department launched its Social Justice Project in this context of changed institutional thinking. As with these earlier initiatives, facilitated dialogue was to serve as a catalyst for transformation, this time within the department itself.

THE SOCIAL JUSTICE PROJECT

The Social Justice Project was the first substantial attempt to apply the *Community Voices* dialogue process internally within the health department. Leadership for the effort was provided by myself, in my role as Access to Health Coordinator—a position created specifically to coordinate the various activities of the *Community Voices* initiative in 1998. My hiring in itself was somewhat unusual: I possessed no formal training in public health, and became involved with the health department through my facilitation (as a private consultant) of community and interagency processes throughout the 1990s. Once hired, I reported directly to the Health Officer, in effect occupying a position outside the conventional boxes of the department's organizational chart. My role in the department has shifted variously since 1998, but has always had a focus on community engagement and the facilitation of dialogue.

Recruitment and Participation

The plan for the Social Justice Project was to convene a team of diverse Health Department employees,[3] between 15 and 25 in number, who would explore through dialogue the root causes of health inequity. This Social Justice Team would generate recommendations over a five month period, and then, in collaboration with the department's senior staff, formulate an Action Plan to guide departmental and community action to address the root causes of health inequity.

To recruit the members of the team, I issued a "call for participants" to approximately forty managers within the department, inviting them to nominate people to be on the team. In addition to describing the project's objectives and process, and the time commitment team members would be expected to make (a minimum of eight hours per month), the invitation included a form for numerically scoring employees on eight characteristics that were desired for the team:

- ***Independence***: Candidate brings an open and self-challenging approach to her/his work life, eager to identify and implement changes that will improve service delivery and organizational culture.
- ***Awareness***: Candidate has a concept of the term "social justice" and is at least minimally aware of the connection between social justice and health.
- ***Commitment***: Candidate believes she/he can have an impact on the root causes of social inequity.
- ***Respect/Influence***: Candidate is respected by peers and exercises a positive influence on those with whom she/he regularly works.
- ***Connectivity***: Candidate understands more of the health department than just the area where she/he normally works; and/or demonstrates a desire to have greater connection to other parts of the health department.
- ***Communication***: Candidate communicates well in a group setting by sharing own thoughts, listening well to others, and integrating diverse ideas.
- ***Team Player***: Candidate enjoys a reputation for working well with others.
- ***Creativity***: Candidate enjoys and excels at brainstorming and innovation; welcomes and promotes change.

For the first phase of the project (the dialogue process), senior staff—the Health Officer, the Medical Director, and the directors of the eight major organizational units—were intentionally excluded from participation in the team, although each was invited to observe team meetings and received team reports. The primary reason for excluding senior staff was the concern that their regular participation might inhibit the team's candor in discussing issues of race, class, and gender discrimination, especially as they might be experienced within the department itself.

All twenty-one employees nominated for the team agreed to participate. These included three nurses, three health analysts, two program coordinators, two middle-managers, two communications specialists, two accounting staff, two clerical staff, one nurse practitioner, one health educator, one outreach specialist, one medical assistant, and one sanitarian. Demographically, the team was composed of seventeen women and three men; eleven Caucasians, seven African Americans, two Latinas, and one Native American.

Timeline and Products

The initial phase of the dialogue process consisted of eight meetings of the Social Justice Team between February 28 and July 8, 2005. Two meetings each were dedicated to three root causes of health inequity: 1) socio-economic or class exploitation; 2) institutionalized racism; and 3) gender discrimination and exploitation. Meetings were either 3.5 or 2.5 hours in length, with the longer meetings devoted to full-fledged dialogues on the root causes of health inequity, and shorter meetings devoted to validating the findings developed from those dialogues. For each of these three root causes, the process yielded preliminary recommendations for how the health department might respond, in the form of actions it could take or strategies it could apply.

In June, the members of the Social Justice Team met with members of the senior staff for a two-day workshop entitled "The Culture of Power and Privilege." One purpose of this workshop was to build a relationship between the team members and senior staff around the issues that the team had been wrestling with for the previous five months.

The Five Overarching Goals of the Social Justice Action Plan
(September 2005)

Policy Reform:
Illuminate for the community barriers to economic freedom for women, immigrants, people of low socio-economic status, and people of color that are embedded in public and institutional policy. Encourage a coordinated community effort to eliminate these barriers.

Information and Communication:
Ensure community access to accurate information on health inequity, responsible media coverage of health equity issues, and the inclusion of historically underserved groups in community dialogue.

Community Engagement and Mobilization:
Establish the community will to create a "Culture of Equity" in Ingham County.

Partnerships for Economic Justice and Equal Opportunity:
Motivate recognition across public systems of their responsibility to end inequities in access to education and economic resources.

Public Health Work Force Mobilization:
Ensure that the work force of ICHD is 1) aware of the many ways in which conditions that lead to health inequity are rooted in social injustice; 2) accountable for the department's responsibility to work for social justice and health equity in daily practice; and 3) comprised of people at all levels of the organization whose identities, experience, and demographics reflect the diversity of the populations we serve.

In July and August, the team and senior staff met together four additional times, to translate the twenty recommendations that had emerged from the dialogue into five overarching goals, with objectives and action steps for each.

Parallel Community Processes

Simultaneous with the health department's internal process, two community collaborative bodies also addressed issues of health inequity and social justice. Although both initially focused more on "disparity" than on root causes, the involvement of members of the Social Justice Team in their processes helped to direct focus further upstream, toward the social determinants of health inequity.

The first of these collaborative bodies was the Capital Area Health Alliance, which convened six community dialogues in 2005, working toward a new iteration of the Action Plan for an Organized System of Care it had created in 2001. In several of these dialogues, findings and data from the Social Justice Project served as trigger information. The second collaborative body, informally known as the "Onion Group,"[4] was a health-focused team from the Lansing Commission on Race and Diversity. Members of the ICHD's Social Justice Team were active participants in the Onion Group, and again shared the findings and data from their own work as part of its process.

By informing and participating in these two external processes, the Social Justice Team set the stage for community members to become involved in the department's social justice work in 2006.

THE DIALOGUES

The Social Justice Team engaged in three dialogue processes over the first five months of the project—each focusing on one of three root causes of health inequity: socioeconomic or class exploitation, institutionalized racism, and gender exploitation and discrimination. The structure for each dialogue was built around a specific sequence of inquiry—activities and questions leading to a focus question to which the group generated multiple answers. The facilitator translated these answers into recommendations for action, which were then reviewed, revised, and validated by the group at a shorter, follow-up session. The dialogue methodology was modeled on techniques taught in the Technologies of Participation® (ToP) training developed by the Institute for Cultural Affairs.[5] Anyone interested in learning more about this facilitation methodology is urged to visit the ICA web site at www.ica-usa.org and consider attending a ToP® training.

What follows is a description of the dialogue process that led to the ICHD Action Plan for Social Justice, with an emphasis on the kinds of trigger information used to engage the team, and the unique challenges experienced by the team as it struggled to confront the root causes of health inequity.

The Focus Question

Each dialogue was built around the task of answering a single question related to one of the root causes, which was presented at the start of the session. The focus questions for the three dialogues were as follows:

Socio-economic or Class Exploitation:
"In terms of policy or practice, what actions or strategies by ICHD would reduce the impact of class or socio-economic status as a root cause of health inequity?"

Institutionalized Racism:
"What are some ways ICHD can reduce the impact of racism as a root cause of health inequity?"

Gender Exploitation and Discrimination:
"What are some 'upstream' ways ICHD can work toward the elimination of gender exploitation and discrimination as a root cause of health inequity?"

In retrospect, each of these focus questions could have been expressed more simply: "As an organization, what do we need to do to eliminate X as a root cause of health inequity?" The potential drawback of such a construction was that it might play to an ever-present concern of many of the team members, i.e. that the root causes were so pervasive that our team could do nothing to eliminate them. Indeed, the focus questions reflect an evolving intention to balance two opposite concerns. The first was that the team, overwhelmed by the enormity of the goal of eliminating something as huge as class prejudice, racism, or gender discrimination, would retreat to situational, "downstream" adjustments in practice (changing the way we schedule patients in our health centers, etc.). The second was that the team, taking the challenge truly to heart, would set lofty goals for itself with no specific strategies for how to achieve them (e.g, "reform welfare"). This balancing act is the core challenge of creating an effective focus question for a social justice dialogue; ideally, it should aim dialogue participants as far upstream as possible, while still staying focused on tangible, achievable actions.

Trigger Information

Over the course of the three dialogues, we used several different types of "trigger information" to stimulate the group's exploration of root causes of health inequity. These included written materials and data, summary presentations, experiential exercises, and the sharing of team members' personal experiences. They are briefly described below not because they are necessarily the most effective content one might use for such a dialogue, but rather to spur the thinking of other dialogue facilitators. Overall, the goal was to provide a balance of factual and experiential stimulation to the team members.

Written Materials and Data

- The 2002 NACCHO concept paper, "Creating Health Equity through Social Justice"[6] was used in the orientation session to provide a grounding in public health's historical legacy in addressing the social conditions that create or deter health.
- Wherever possible, we shared health status statistics from ICHD's own Behavioral Risk Factor surveys, particularly those related to early death, the correlation between physical and emotional health, and social capital.
- The Aspen Institute report, "Structural Racism and Community Building"[7] provided a framework for the dialogue on racism, particularly through its data on the persistence of inequities in education, employment, and net worth for people of color, and its discussion of white privilege, national values, and framing mechanisms that organize racial stereotyping.
- For the dialogue on gender discrimination, the team reviewed short articles on gender-based discrimination published by the World Health Organization.

Summary Presentations of Written Material

- Each dialogue included a visual summary of the written materials provided for that session. These were custom-made graphic representations of the major ideas discussed. Lasting no more than 20 minutes, they were important in assuring that all team members (including those who failed to read the advance materials) were starting from the same place.[8]

Experiential Exercises

- The dialogue on class exploitation employed the "Ten Chairs" exercise developed by Teaching Economics as if it Mattered,[9] which translates the disproportionate accumulation of wealth in the U.S. through a decidedly unequal game of Musical Chairs.
- The "Privilege Walk," several versions of which are available from organizations that train on multicultural awareness, was incorporated into the two-day session involving both the Social Justice Team and senior staff. This exercise requires people to take steps forward or backward in response to certain statements indicating economic or social privilege, thereby dramatically demonstrating the enduring difference in access to social resources for whites and people of color.
- The class dialogue included a candid interview with a grassroots community outreach worker who had sought assistance from a social service agency for other people, and experienced sharply different attitudes from the agency when seeking assistance for herself.
- One video resource was used for the gender dialogue—the *Primetime Live* story, "The Fairer Sex?" which portrays via hidden camera the different responses to a man and a woman interviewing for a job, applying for an apartment, etc.[10] Other video resources could enhance other dialogues, most notably the three-part documentary form California Newsreel, *Race, the Power of an Illusion*.[11]

Visioning/Personal Recollection

- At the start of the race dialogue, participants were asked to recall one of their earliest experiences of noticing racial difference, and then, on a voluntary basis, to share it with the group. This was unquestionably one of the most evocative and powerful trigger experiences of the entire dialogue series. There was striking difference in the painful, early childhood experiences of participants who were black or Latina and the experiences of most white participants, many of whom recalled living with the idea that they occupied a world "without prejudice" until an incident in adolescence showed them otherwise.

The "trigger" materials described above were all selected specifically to spur dialogue on one of the root causes of health inequity. In addition, as the process developed, individual members of the team identified articles, books, films, and web pages that they had found stimulating and shared them with the team. Furthermore, the facilitator developed several other exercises in response to the fundamental challenge of shifting from a conventional public health focus on the *consequences* of health inequity to one that confronted root causes. These are discussed in the next section of this chapter ("Challenge #1: Shifting from Consequences to Root Causes").

Open Dialogue

Following the trigger information, the facilitator prompted an "open dialogue" about what the team had just seen and heard. The facilitator tracked this conversation by writing down key points made by each speaker on index cards and affixing them in "threads" on an adhesive board.[12] This produced a literal picture of the group's collective thinking, while allowing individuals to move back and forth between topics without concern for whether they were "on point." In addition, the various threads of

Excerpt from the "Open Dialogue" section of the Report on the Gender Dialogue

Bullet points are derived from various "threads" of index cards tracked on an adhesive board.

FIGURE 4

- A common example of gender oppression tied to women's reproductive function is the abandonment of women by their partners, resulting in young women who are essentially single mothers from conception. Abandonment is experienced in other ways as well. Because they are socialized to assume the caretaking role in a family, women are likely to find themselves caring for a male partner who becomes ill. Men are less likely to assume this role in a reverse circumstance.
- Women are frequent victims of violent crime perpetrated by men, very often their fathers, husbands, or boyfriends. In some areas, this problem is ignored outright by law enforcement, and casually justified by the notion that "the woman asked for it." Violence against women is not taken up as an issue by the community except by a few small organizations, and is assigned a low priority by policy makers, largely because there is no perceived material value to addressing it.
- As an issue, violence against women intersects with the concerns mentioned earlier about the options granted to pregnant women in the workplace and in the community. Plainly stated, women are denied reasonable options that would be afforded to men in comparable circumstances.
- Men are also victims of the oppression of women by men, as suggested by data on early death and men's propensity for self-destructive behaviors. In a broader sense, stereotypical gender roles inhibit males' ability to express themselves fully as human beings, which results in many negative physical, mental, and emotional health consequences.

index cards served as an efficient tool for organizing the written report on this part of the session. This was an important part of documenting the process. Discussion points made during the Open Dialogue often helped to explain the thinking behind the recommendations each session produced (see Figure 4).

The objective of Open Dialogue is to allow the participants in the dialogue to share their experience and insights freely, without the burden of responding directly to the session's Focus Question. The facilitator's job at this point, in addition to capturing what is being shared, is to elicit the diverse experience and insights of the participants so that they can inform the process of answering the focus question.

Summary Questions

The next step in the dialogue process was to ask a series of short-answer questions to the participants that would help them summarize all of the information they needed to consider in answering the focus question. The construction of such a question sequence is one of the things taught and practiced in the ToP® training, both as a standalone method for efficiently and collectively reaching a decision and as part of a larger planning process.

A number of variations in the "summary question" sequence were applied in the three Social Justice dialogues. Probably the clearest and most effective was the one below, which was used when the team addressed institutionalized racism as a root cause of health inequity:

Summary Questions – Race Dialogue

1. Of everything that you've seen and heard so far this morning, what stands out for you as particularly surprising or important?
2. What if any new thoughts about racism have you had in the last few hours?
3. What fears or concerns prevent ICHD from responding directly to racism?
4. If Ingham County were to address racism in a meaningful way, internally or externally, what would it look like?
5. Who are the community change agents—people, groups, or institutions—that might accelerate a meaningful strategy for eliminating racism?
6. What are the potential rewards to the community for addressing racism more directly?
7. What can ICHD do to engage those change agents or realize those rewards?

An important function of the summary questions is to create a bridge between the random, free-flowing responses of the "Open Dialogue" and the more focused, intentional nature of the final exercise to answer the focus question. By limiting team members to short answers to specific, sequenced questions, the group naturally falls into a more concentrated, thoughtful attitude—one characterized by periods of silence and deep listening.

Answering the Focus Question

The exercise used to answer the focus question consisted of three parts:

1. *Individual Brainstorm*, during which each participant quickly writes down her or his best answers to the focus question.
2. *Group Sharing of Answers*, in which two or more team members compare their lists, and decide upon a set number of answers they can support together, which they then write on index cards with a felt marker.
3. *Pairing, Clustering, and Naming Answers*, during which the facilitator reads off answers one at a time, placing them on the adhesive board and following the group's lead in identifying pairs, then clusters, of answers that seem to be headed in the same direction. In the end, the clusters are named and further discussed to tease out what, specifically, the group is recommending as an action or strategy for change.[13]

Using this method, the three dialogues of the Social Justice Project produced a total of 20 recommendations (seven each from the Class and Gender dialogues, and six from the Race dialogue). We should acknowledge, however, that even though the resulting recommendations were framed as an "end product" for each of three dialogues, another phase of work ahead for the team involved translating these recommendations into an Action Plan, in collaboration with senior staff. The dynamics of this phase are discussed in the next section of this chapter, where I attempt to describe three important challenges the team faced in doing this work.

THREE CHALLENGES

Challenge #1: Shifting from Consequences to Root Causes

In addition to confronting difficult issues of prejudice and privilege in their organization and their community, the Social Justice Team struggled through the dialogue process with two underlying concepts of the Social Justice Project: 1) that the health department had a responsibility to address root causes of health inequity in its daily practice, and 2) that it could have a meaningful impact on issues that were so pervasive and overwhelming in our society.

The emergence of this first concern occurred during the orientation itself, when, after an hour or so of general concurrence with the idea that attitudes and policies based on class, race, and gender were strong determinants of health outcomes, one member of the team had the courage to voice a different perspective. In her work helping people to quit smoking, she said, one of the most critical factors was helping them accept personal responsibility for change. While, as a Latina, she knew first-hand the experience of prejudice in our society, she expressed concern that a new focus on issues like racism could very well work against her goals as a health educator. At some level, aren't we all responsible for own choices?

The conversation that followed—which dominated the remainder of the orientation session—was the beginning of an important internal debate within the team. In the moment, virtually everyone on the team tried to dissuade this one dissenting voice from her viewpoint, pointing out how "personal responsibility" was often used as a means of denying prejudice and reinforcing racial and ethnic stereotypes. If we pretend the playing field is level when in fact it is not, we only maintain the status quo and fall into the trap of "blaming the victim." On the other hand, in the weeks that followed it became clear that the concern expressed by this health educator was not hers alone. In numerous water cooler conversations that occurred after this and subsequent meetings, many team members expressed anxiety and confusion about the feasibility of the team's work. Since their focus had traditionally been so exclusively on responding to the consequences of health inequity—smoking, infant mortality, lead paint in housing—some even began to feel a dissonance between the ideas of the Social Justice Project and their normal work roles. Besides, did we really think that our department alone would be able to meaningfully change the underlying conditions we were talking about?

To help the team members wrestle with their internal conflicts about the shift from consequences to root causes, I developed a number of exercises to augment the dialogue process. A summary of these, in the sequence they were used, follows.

1. ***Changing the Questions.*** At the second meeting of the team, the facilitator introduced the idea that, in our traditional roles as public health workers, our work is shaped by questions that focus on health outcomes. To make clearer to ourselves what it means to shift toward a focus on root causes, perhaps we need to reframe these questions that guide our work. Four examples were offered, as shown in Figure 5.

"Changing the Questions" Examples

FIGURE 5

INSTEAD OF ONLY ASKING....	PERHAPS WE SHOULD ALSO ASK...
Why do people smoke?	What social conditions and economic policies predispose people to the stress that encourages smoking?
Who lacks health care coverage, and why?	What policy changes would redistribute health care resources more equitably in our community?
How do we connect isolated individuals to a social network?	What institutional policies and practices maintain rather than counteract people's isolation from social supports?
How can we create more green space, bike paths, and farmers' markets in vulnerable neighborhoods?	What policies and practices by government and commerce discourage access to transportation, recreational resources, and nutritious food in neighborhoods where health is poorest?

The following assignment was then given to the team members: "Construct a question that your unit of the Health Department currently asks as a routine part of its work, and create an alternative question that reframes this question in a social justice context." The assignment proved to be difficult for many of the team members, who at the next meeting talked more about the struggle itself than an actual reframed question they had come up with. It did, however, illuminate the range of awareness and understanding that existed at this point within the team with regard to upstream vs. downstream approaches.

2. ***Role Play Dialogue.*** At the fourth meeting, team members were paired off and asked to role play a conversation about the issue of addressing a root cause of health disparity (racism), vs. addressing the behaviors that contribute to poor health. The following points of view were assigned to the two players in each conversation:

FIGURE 6

Points of View for Role Play Dialogue

PERSON "A"	PERSON "B"
Changing behaviors is the best way to improve health. Focusing on things like racism just distracts people from taking personal responsibility for their behaviors. We can't end racism—it's too big and too pervasive.	Our mission is to preserve and protect the public health. If racism prevents people from having a good education, a good job, and good health, we have to address racism. We have a responsibility to look at underlying social forces that predispose people to ill health.

In several of the pairs, the person playing the "A" role found it difficult to maintain the pretense of resistance, because it did not match their own point of view. It was also common for pairs to move to a middle-ground position rather than resolve the difference of opinion, probably to avoid conflict. The exercise served as a rehearsal for many conversations the team expected to engage as the rest of the department began to hear of the team's work. Most importantly, the team found ways to point out that a focus on root causes does not negate all of the work we do to help people adopt healthy behaviors.

3. ***"How Far Upstream?" Exercise.*** This exercise was introduced during the seventh meeting to explore the team's understanding of activities that are truly upstream, i.e. addressing the root causes rather than the consequences of health inequity. Four levels of "upstream-ness" were proposed, and three groups of five participants each then talked about ten proposed activities, attempting to determine which level the activity represented. The definitions of the four levels are shown in Figure 7.

The team found this exercise extremely helpful in revealing and challenging ideas about what activities will really impact root causes. One common discovery was that certain activities, such as "publishing a report," "convening a dialogue," or "disseminating the findings of focus groups" on issues pertinent to class, race, and gender discrimination could be Level 1, but only if they were followed up with concerted action. A report that exposed health inequities would not necessarily eliminate the causes of inequity unless it was intentionally used to that end.

In some cases, individuals believed that activities most people considered Level 3 or 4—for instance, a safe sex pamphlet in Spanish—could be considered more upstream because they were targeted at people who were otherwise denied access to information. The prevailing view, however, was that the only acceptable norm was to provide such information to all, and that the pamphlet's purpose was clearly downstream, i.e. changing an unhealthy behavior.

"Levels of Upstream-ness" for the "How Far Upstream?" Exercise

FIGURE 7

LEVEL 1: *"Upstream"*	An activity that attempts to eliminate those things in the social structure that deny certain people voice, power, and political influence in society *(such as class exploitation, racism, and gender discrimination)*
LEVEL 2: *"Moderately Upstream"*	An activity that directly attempts to give people access to the things that will help them obtain an equal footing with those who are currently privileged *(such as quality education, low-interest loans, inclusion in social networks)*
LEVEL 3: *"A Little Upstream"*	An activity that moves people from conditions that impede health into conditions that support health *(such as secure and good-paying jobs, quality and affordable housing, access to transportation)*
LEVEL 4: *"Downstream"*	An activity that relieves stress or changes unhealthy behaviors *(such as support groups, smoking cessation campaigns, family planning education)*

"Placing an ad for a vacant administrative position in publications targeted to communities of color" was also considered Level 1 by many, but not all. Again, the key considerations were 1) whether this was undoing an existing failure of the organization to adequately recruit qualified minority candidates for positions, and 2) whether the activity actually resulted in attracting people of color to apply for positions of power in the organization.

Another common discovery by the group was that activities that were considered Level 1 could also be seen to achieve the things described as Levels 2, 3, and 4; that Level 2 activities also achieved the things in Levels 3 and 4, etc. This "cascading" effect in essence validates the concept of addressing root causes in order to prevent the subsequent inequity that results. While it is of course important to keep addressing behaviors and consequences, an effort to address root causes looks very different, and is something local health departments have largely stopped doing.

Challenge #2: The Leadership Role of the Health Department

As mentioned earlier, throughout the dialogue process there was a tension over just how much the health department—and the Social Justice Team—could be expected to do to address the root causes of health inequity. At one end of the spectrum, some team members tended to focus on situational concerns that they noticed, either in the department or the community. Others were quite willing to recommend broad, sweeping policy changes, many of which were well beyond the power of the health department alone to effect. Over the course of the three dialogues, the team moved gradually toward a sensible middle ground: recommendations that placed the health department in a catalytic role, helping to move both ourselves and other institutions to changes in policy and practice.

This tension resurfaced when the Social Justice Team began meeting with senior staff in July to translate the twenty preliminary recommendations into an Action Plan. During the first of these sessions, some of the comments by team members again focused on very specific incidences of social injustice that they believed were occurring in our community, and implied that it was our responsibility to call attention to them. This alarmed some senior staff, who expressed concern that the Social Justice Team now intended for the health department to respond immediately to every incident of social injustice that anyone in the health department detected, rather than systematically laying out strategies for addressing the root causes of health inequity. In turn, some members of the team saw this as an indication that top administration was inclined to ignore the hard work of the team, and openly considered abandoning the project as a consequence (but only for a week or so).

Two things were transpiring here, and both are predictable. In any process that is bottom-up rather than top-down in nature, tension inevitably arises when the senior administration of a health department enters into a dialogue that has heretofore involved only midlevel staff. Secondly—and more critically—in any process that challenges a health department to take a leadership role in addressing class, race, and gender discrimination as root causes of health inequity, inevitable tension will occur about what that leadership role entails.

The Ingham County Health Department, which has over 300 employees, is very much a hierarchical environment, with some people clearly having more power to bring about change than others. In such an environment, it is only natural that team members would feel some cynicism toward top management's sincerity in empowering them to explore the root causes of health inequity. The first joint meeting of the team and senior staff provided an excellent opportunity for this cynicism to get expressed, as indeed it was. At the next action-planning session, the Health Officer and other administrators had the opportunity to clarify both their position on the scope of the recommendations, and their support for them. The remainder of the action-planning process proceeded without incident.

Also fundamentally at issue, however, throughout the entire dialogue process, was whether ICHD could and should play a more assertive role than it typically does in raising issues in the community. In the Greater Lansing region, ICHD enjoys a well-earned reputation for creatively brokering resources and fostering collaborative responses to community problems. It has been a major proponent, for example, of ongoing assessment processes whereby agencies collectively track community well-being. But it does this primarily by convening and facilitating, not by asserting or demanding action. If the department were to play a similar role in promoting health equity through social justice, ICHD could be expected to propose the creation of new, collaboratively derived assessment tools for measuring health equity. The question remains: in this instance, should we do more? Should the health department, as some members of the Social Justice Team believe, carry a brighter banner for others to follow? If we were to do so, how might this diminish our reputation as a neutral convener and facilitator of collaborative action?

And who, ultimately, decides? One of the clear lessons of the *Community Voices* initiative was that neighborhoods and communities are their own best advocates for change. Empowerment of grassroots partners through dialogue led to new, bottom-up infrastructure aimed at creating social cohesion in vulnerable parts of our community, and new support for covering the uninsured. In the case of the Social Justice Project, public health workers were similarly empowered by dialogue to recommend action to improve community health by attacking the root causes of health inequity. They will soon be joined by two parallel dialogue processes conducted by the Lansing Commission on Race and Diversity (Onion Group) and the CAHA Access to Health Dialogues. There is every possibility—every hope—that the combined energy of these three groups will create a critical mass of community support for change. If that happens, no one at the health department will need to carry the banner alone.

Given the wide differences that exist between local health departments and the way they function in their communities, it may be useful to think of the department's "change agent" role on a continuum (Figure 8). In some instances, under certain circumstances, ICHD's most appropriate role may be to aid others in community planning by providing accurate information. In other cases, it may be to engage the community by facilitating dialogue, or mobilizing the community around catalytic action. In cases where no other role will be effective in impacting a problem—structural racism, for example—it may indeed need to "lead the charge" because no one else will do so.

The Role of a Health Department in Effecting Change: A Continuum

FIGURE 8

Challenge #3: How Explicitly "Transforming" Can Dialogue Be?

On its surface, dialogue facilitation appears to be a passive function. Its goal is to enable a diverse group of people to share insights, listen deeply, and generate recommendations derived from its collective intelligence. A central premise of this handbook is that local health departments today need to *transform their policy and practice* in order to create health equity through social justice. Can such a passive enterprise as facilitated dialogue possibly do this? Two dilemmas of facilitation are wrapped up in that question: the supposed neutrality of a good facilitator of dialogue, and the temptation to pre-determine the outcome of the dialogue.

As facilitator of each of the dialogues described in this chapter, I found it very difficult to facilitate questions of social justice in quite the same way I have facilitated a hundred other dialogues over the last decade. Throughout the process, I adopted a much more assertive role than I normally do, overtly advancing social justice concepts rather than patiently eliciting them from the group. The first meeting's conversation about "personal responsibility" was a good example of this. Normally, whenever I am faced with a situation where one member of the group holds an "outlier" position, my course of action is to help that person be heard and understood by others. In this case, when the health educator asserted that a focus on root causes might undermine her clients' struggle to take personal responsibility for their health, I overtly challenged the opinion, leaving her to fend for herself against the tide of contrary opinion already present in the room. While a more facilitative approach would probably have been more effective in this case, I have a growing conviction that one cannot facilitate issues of social justice from an assumed stance of neutrality, of "having no opinion," because having no opinion is precisely the stance that allows members of privileged groups to discount their privilege and maintain the status quo. I have to believe social injustice is real, and is at the root of health inequity, if I am to facilitate *this* dialogue effectively.

Still, I believe that effective dialogue is premised on what James Surowiecki has termed, in the title of his intriguing 2004 book, *The Wisdom of Crowds*.[14] According to Suroweicki, if certain conditions are in place—namely diversity, independence, and de-centralization—any random group of people will be smarter in addressing a problem than a group of certified experts. The basic reason for this is that the random group brings an abundance of knowledge, experience, and insight to the problem-solving process, whereas, in most cases, the "experts" each bring essentially the same knowledge, experience, and insight: conventional "expertise." Shouldn't this be equally true when the focus of dialogue is on exposing and eliminating something as pervasive as institutional racism? Conventional experts will lead us down conventional paths and most likely enable us to resign ourselves to the status quo. It is only through the voices of those who experience discrimination and exploitation in all its modern, veiled forms that we can hope to reach consensus on the need to transform institutional policy and practice. The facilitator's job is to empower those voices.

A well-facilitated dialogue can be seen as an attempt to set the conditions for applying Suroweicki's premise. Facilitators present objective information. Participants share impressions and experiences, and collectively identify their insights. Everyone together produces promising actions and strategies, which they then systematically collect, articulate, and validate. But how can these conditions be met if, hanging over the entire enterprise, is the explicit expectation that we must "transform public health practice?" The assumption that current conditions are inherently wrong or inferior (public health's abandonment of its historic role in advancing social justice) automatically skews the dialogue toward a particular set of outcomes, and could very well in the process disenfranchise the contribution of some participants. Sooner or later, this is a challenge that anyone attempting to facilitate dialogue on social justice will be forced to confront.

In trying to resolve this challenge for myself, I was frequently drawn back to my experience with the *Community Voices* initiative—in particular, the comparative ease with which change occurred when the questions we asked avoided an assumption that change was necessary.

Prior to the *Community Voices* dialogues that were conducted in 1999 and 2000, most health care stakeholders in Ingham County actively opposed the pursuit of "universal health care" as a goal. The dialogue process that followed therefore framed the question instead around a less daunting proposition—"organized systems of care for the uninsured"—which, it turned out, virtually all stakeholders had an interest in achieving. The recommendations from the dialogue process were instrumental in rallying community support for a new, collaboratively managed health care plan that achieved coverage of 62% of the county's uninsured within four years. Similarly, local policymakers opposed the concept of "neighborhood network centers" because they saw it in terms of a competition for resources. But the *Community Voices* summit dialogues framed the question around a more universal question: how do we create health in our community? The summits resulted in the funding of neighborhood hubs for grassroots-driven health initiatives throughout the city of Lansing.

So what does this tell us about the use of dialogue in addressing social justice? That we must avoid words like "transformation" or "fundamental change in the social structure" so as to avoid alarming those who are invested in maintaining the (inequitable) status quo? Let's hope not. But it's all in the timing. At times, those words help move a team, or a health department, or a community forward. At other times, they will do exactly the opposite.

CONCLUSIONS

Although it is certainly too soon to judge how successful the Social Justice Project will ultimately be in transforming public health practice in Ingham County, three preliminary conclusions can be drawn about the use of dialogue as a means toward that end.

1. ***Dialogue processes of this nature must be sustained over time, with consistent participation and decision-making by a core group that eventually expands to include others.***

For many local health departments, resource limitations are likely to discourage embarking on an extended dialogue process like the one initiated in Ingham County. Rather than dedicate twenty or so staff to the effort over several months, a more short-term or incremental approach may be favored—a two day retreat, perhaps, or a single session to outline options for the department. While such short-term efforts will not necessarily diminish a department's ability to address the root causes of health inequity, they are likely to do little to improve it unless the department is willing to invest in a more extensive process—one that truly challenges its participants' assumptions and eventually the assumptions of the department itself.

If the participants in the Ingham County team are at all representative, ideas about the appropriate role of public health workers are deeply ingrained. So is a sense of helplessness in the face of social forces that seem beyond their power to undo. Many of the participants in this eight-month process vacillated regularly between extremes of hope and despair about the team's potential to bring about real change. Interestingly, team members did not simply settle into these attitudes and stay there; the most doubtful participant one week might well become the leading proponent of perseverance in the next. This to me is one hallmark of a team that is committed and mutually supportive—qualities that can only be created through sustained and intensive collaboration.

Any local health department that empowers a team of public health workers to tackle social justice issues through dialogue needs to be clear and consistent in its support of their struggle. Specifically, it should not interpret the team's early vagueness or inconsistency as a sign that the process is faltering. *It is very difficult to rethink the core purpose of one's profession*, and this is exactly what we are asking public health workers to do. Moreover, we should fully expect that the struggle will begin anew as each new set of participants joins the process. The Action Planning phase of the Ingham County process, during which senior staff interacted directly with the team for the first time, brought with it a whole new wave of doubt about administration's sincerity in supporting the team's work. Over the course of four facilitated meetings, this settled into a new, common understanding of how and why the team's recommendations would be implemented. As each successive unit of the health department is introduced to these issues through the Action Plan, I expect we will encounter new skepticism and resistance, which will only erode after sustained exposure to the link between social injustice and health inequity.

2. *Dialogue facilitators (and participants) should anticipate and accept that conflict, resistance, and tension are natural and inevitable elements of the process.*

Opportunities for miscommunication and misunderstanding are abundant in the course of a dialogue process that focuses on class exploitation, institutionalized racism, and gender discrimination as root causes of health inequity. I have touched on some of these: the tensions that arise over "personal responsibility," the cynicism workers in any bureaucratic environment are likely to feel toward organizational change, the perception that it is now the health department's job to correct every incident of social injustice that occurs in the community. An even more obvious source of potential conflict exists: differing outlooks on race and racism, and the different ways team members are likely to express themselves on these issues. No facilitator of the kind of process described in this chapter should expect to avoid conflict, resistance, and tension when race is under discussion.

Excellent resources are available in communities for helping personnel become more adept and graceful in addressing multicultural issues, both in the workplace and in life.[15] These resources can certainly augment and enhance a dialogue process like Ingham County's, and the two-day workshop attended by both senior staff and team members was in part meant to serve this function. We also have in our community an initiative called "Breaking Bread Together," which specifically seeks to improve understanding across racial and ethnic differences through facilitated conversations in private homes, and several team members have been trained as facilitators for this initiative. As helpful and important as these efforts are, however, I want to draw a distinction between them and the kind of dialogue process described in this chapter. The purpose of our dialogues was not to improve multicultural understanding; it was to change how our health department addressed the root causes of health inequity. Certainly, one hopes that in the course of the project, greater multicultural understanding did occur for many of the participants—and I believe it did—but even if it did not, the work of changing public health practice remains, and is a unique endeavor.

What I'm hoping to dispel here is the notion that everyone must be "on the same page" for work of this nature to move forward. I personally question whether such a same page has ever existed in the world, and certainly would not advise anyone to wait for everyone to get on it before forging a functional working relationship through dialogue. In the case of Ingham's Social Justice Team, many troubled conversations occurred before and after team meetings, especially in the early weeks of the project. Several team members believed that others on the team weren't "getting" social justice, or understanding the appropriate role of the health department, or acknowledging their own subtle prejudices toward a particular target group. Were they correct? In some cases, probably yes. Did it matter? I don't think so.

The facilitator's tasks in this type of dialogue are to get people to think and talk as honestly as they can; to articulate the *collective* wisdom of the group as it emerges; and to assure continuous forward motion toward action. With regard to the problem of participants being at differing levels of understanding during the dialogue, the facilitator's task is not to remedy the dissonance but rather to identify it, move beyond it as efficiently as possible, and return to the work at hand: how do we, as a health department, address the root causes of health inequity? In answering that question, it is important that participants bring differing—and even conflicting—experiences and insights. Therefore, we must stay mindful that conflict, resistance, and tension are predictable if not inevitable in this work, and remember that an institutional commitment to social justice does not require us to "fix" the perceptions of others.

3. *The goal of transforming public health practice should be explicitly understood at the outset by key actors in the process (although not necessarily explicitly stated throughout the process).*

Often, people, groups, and institutions do not like change. Therefore, they are more likely to transform when they don't know that a transformation is taking place. In practical terms, what does this mean for someone contemplating a sustained dialogue process intended to transform a local health department's practice as it relates to the root causes of health inequity? How much does one tip one's hand to the department at large that the intent of the Social Justice Project is to change how we all do our work?

For any individual health department, of course, the exact answer to those questions will depend upon its unique organizational culture, top administrators' level of commitment to tackling social justice issues, and the values and attitudes of the community the department serves. The chief lesson to be drawn from the Ingham County experience as it has unfolded thus far is that department administrators (the Health Officer, at least) should know that *transformation of public health practice* is a goal of the project. Without this understanding, any work by the facilitator or the team will run the risk of appearing to overstep its boundaries as soon as anything that smacks of transformation emerges from the team's work. If our intent is to make a fundamental difference in the way public health workers think and work, we must do it with administrative permission to bring about that level of change. We must also do it under a banner that acknowledges social justice as a concern of the health department (as opposed to less fundamental terms such as "diversity," "disparity," or "cultural competency").

But there is a larger question to resolve: what does transformed public health practice look like? Although no one can absolutely describe the elements of a local health department that has successfully reclaimed its social justice legacy, Chapter 1 of this handbook offers broad suggestions. Transformed public health practice will likely require changes in workforce development and education, public policy development and analysis, addressing health inequity through the essential services of public health, etc. If that's so, then why don't we simply focus on those features of our practice? Why do we need a dialogue process that engages public health workers in an examination of the local impact of racism on health inequity?

This returns us to the problem outlined at the beginning of this chapter. A facilitated dialogue process has the potential to create a unique impulse for change that moves outward from the ranks of the organization, and outward from grassroots community partners. That impulse, unlike one that is top-down in nature, fosters change from the inside-out—change that is less susceptible to the change-resistant mechanisms of bureaucratic institutions. Such a process will only have meaning if those who empower it in the first place know its potential to generate significant changes in practice. Such a process will also likely be sabotaged if its goal is widely portrayed as undoing the status quo.

In Ingham County, the Social Justice Project was initiated by the Health Officer and assigned to me in my role as the department's "facilitator-at-large." Early communications about the project deliberately avoided any references to "transforming public health practice." Rather, they described more innocuous goals such as "improving our responsiveness" to the root causes of health inequity. I believe the mildness of such terminology was important to the initial phase of work. It allowed the team to operate for at least a while "under the radar" of middle-managers and others who might fear the team's objective. This gave the team time to develop its own understanding of the work, and for team members to gain trust in each other as well as tolerance of each other's idiosyncrasies.

I find it both intriguing and heartening that the five broad goals that emerged from the Ingham County process (Figure 4), which were developed without anyone having read Chapter 1 of this handbook, are strikingly parallel to the suggestions contained in that chapter. They include policy reform, responsible media coverage, grassroots and community partnerships reframed to focus on economic justice, and a call for changes in the awareness, accountability, and composition of our workforce. The goals, and their accompanying action steps, will soon become a platform for action both within the department and in our community. I believe at least some of these actions will involve health department personnel, and personnel from other institutions in our community, doing things they have never done before. Will these personnel recognize that a change has occurred? Possibly. Would the change have occurred if they'd simply been told to do these things by the health department and its leadership at the outset, without benefit of the Social Justice Team's dialogue process? I doubt it. Will this mean that the Ingham County Health Department's daily practice with regard to root causes of health inequity has been transformed, and that dialogue had something to do with it? Time alone will tell.

NOTES

1. In keeping with the Action Plans generated by their summits, the activities taken by grassroots workers displayed a broad interpretation of what constituted "health." While some projects addressed conventional health promotion targets such as smoking cessation and breast cancer prevention, others aimed more toward the social determinants of health: home ownership and improvement, GED acquisition, assistance in filing for Earned Income Tax Credits, etc. Most of these projects have only grown and proliferated in subsequent years, as new sponsoring partners become aware of their success and neighborhood groups modify and replicate each others' ideas.
2. The IHP, which is managed by an independent nonprofit corporation created in 1998, continues to cover between 15,000 and 16,000 uninsured adults annually, many of them people who have suffered a temporary job loss or other life crisis. Over 36,000 different people have been enrolled in the plan at some point since its inception. The Ingham County Health Department handles day-to-day operation of the plan (enrollment, member services, utilization management, etc.) through its Health Plan Management unit, which was created in 2004. In developing this capacity, ICHD also succeeded in "exporting" it to other counties. Over fifty counties in Michigan are now participating in similar county coverage plans modeled on the IHP and contractually supported by the Health Department.
3. Ingham County Health Department employs approximately 300 people, which is a considerably large size for a county health department in Michigan. Major units of operation include Environmental Health, Public Health Nursing, Disease Control, Health Plan Management, Community Health Clinical Services, Public Health Preparedness,

Community Health Assessment, and Financial Services. "Senior staff" refers to the heads of each of these units, the Health Officer, and the Medical Director.

4. So-named in the belief that any exploration of race and other forms of difference required a committed "peeling away" of the layers of denial, guilt, fear, and other unhelpful emotions in order to be authentic.
5. Although the facilitation method and dialogue process used in Ingham County is not identical to that taught in the Technologies of Participation® training, it is unquestionably grounded in the core ideas of that training, particularly the sequence of questions asked, which ICA labels as "Objective, Reflective, Interpretive, and Decisional" or "ORID." Readers of this chapter should not regard the process described here as reflecting the content of the ToP® training, and should certainly not view it as a substitute for enrolling in ICA's excellent training course—more information about which can be found at www.ica-usa.org.
6. Washington, D.C.: NACCHO, 2002.
7. Keith Lawrence, Stacey Sutton, Anne Kubisch, Gretchen Susi, and Karen Fulbright-Anderson, Washington, D.C.: The Aspen Institute (June, 2004).
8. Copies of many of these presentations, in Power Point format, are available from the author: dbloss@ingham.org.
9. Visit www.teachingeconomics.org.
10. CorVision, 1994 from a news segment originally aired ABC news, 1993.
11. California Newsreel, 500 Third Street, Suite 505, San Francisco, Califonia 94107; www.newsreal.org.
12. The adhesive board or curtain is an important tool for anyone using Institute for Cultural Affairs' Technologies of Participation methodology. Essentially a portable, plastic surface sprayed with artist's spray mount, it provides a viewing area for ideas and thoughts to be arranged and rearranged during the course of a facilitated dialogue.
13. Again, readers are urged to consult ITI's Technologies of Participation © training for guidance in applying this group facilitation method.
14. James Surowiecki, *The Wisdom of Crowds: Why the Many Are Smarter Than the Few and How Collective Wisdom Shapes Business, Economies, Societies and Nations* (New York: Doubleday, 2004).
15. Michigan State University Extension Multicultural Education Programming. Such an excellent resource exists in Ingham County, at any rate, and they will travel. Michigan State University Extension offers a number of multicultural education programs. Interested parties may contact Karen Pace at pace@msue.msu.edu for more information.

Getting to the Roots:
Why Is Jason in the Hospital?

- "Why is Jason in the hospital?
  Because he has a bad infection in his leg.
- But why does he have an infection?
  Because he has a cut on his leg and it got infected.
- But why does he have a cut on his leg?
  Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.
- But why was he playing in a junk yard?
  Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.
- But why does he live in that neighborhood?
  Because his parents can't afford a nicer place to live.
- But why can't his parents afford a nicer place to live?
  Housing is really expensive. His Dad already works two jobs and his Mom is sick a lot.
- But why...?"

Adapted from: Canadian Federal, Provincial and Territorial Advisory Committee on Population Health. (1999). *Toward a Healthy Future: Second Report on the Health of Canadians*. Ottawa. http://www.hc-sc.gc.ca/hppb/phdd/determinants/index.html.

Chapter 3

Transforming Elements of Public Health Practice: Preliminary Considerations

Richard Hofrichter

This chapter briefly explores rethinking several features or elements of public health practice and organizational structure that, taken together, may enhance developing the capacity of local health departments (LHDs) to address the root causes of health inequities and not merely the consequences. They involve ways to affect the production of health and illness within specific population groups, expand the definition of public health practice as a social enterprise,[1] create systems integrating relevant organizational entities, and engage in planning and prevention activities, in conjunction with other community organizations. Unfortunately, no simple one-to-one correspondence exists between principles and practice; a handbook cannot easily describe, for example, how to conduct the ten essential public health services differently or offer a protocol of specific steps. However, it is possible to examine some of the challenges and possible directions that LHDs might take. Almost all of our analysis concerns changing the organization and conduct of public health practice, rather than specific programs or interventions. A guiding assumption in this chapter is a commitment to a public, collective responsibility for establishing the conditions that produce health.[2] Another is that today's dominant public health paradigms do not incorporate fully the requirements for tackling health inequities because their sources remain outside both the scope of public health work and its methods.

DIFFICULTIES LOCAL HEALTH DEPARTMENTS FACE IN ADDRESSING HEALTH EQUITY

LHDs face many problems in seeking to address health inequity. A necessary relationship is absent between what we know about the degree and character of health inequities and the capacities of the public health system. LHDs often lack both human and financial resources, as well as the capacity for research and policy development, thereby reducing their ability to define priorities. Legal and bureaucratically defined mandates, institutionalized rules and regulations also limit the range of practice, leading many departments to believe that acting on health inequity is not within their capacity or scope of work. Others avoid the issue because they believe that the success of such work cannot be properly evaluated, since the outcomes, within traditional measures, are often not observable, if at all, for years. Political pressure and bureaucratic inertia to stick to traditional activities under the core functions plays a role, and many times internal agency support is absent. The staff typically lacks training and functions under fragmented authority. New responsibilities such as dealing with bioterrorism affect or restrict the possibility for other work.

A dissonance appears to exist in the workforce between expectations and requirements to tackle health inequity. Clinically oriented, the current workforce may not wish to contend with health inequity. At a broader level, the public sphere has shrunk. The disease focus, the absence of vision, and fragmentation within the discipline have often led to pessimism in public health, without agents of change for support. Public health practitioners, not trained in risk taking, sometimes find they are calming people down rather than firing them up for the kind of activism that would lead to change. Different skills are needed for this work.

Limited knowledge of and clarity about the subject of health inequity and principles of social justice, as well as an inability to communicate it effectively and frame the issue, are important factors hindering LHDs. This includes the absence of research on the specific nature of local inequities or tools to monitor them. Equally important, many practitioners may view their progressive programs on various diseases like diabetes as based on social justice principles, yet however vital and effective such programs may be, they often remain symptomatic and remedial, rather than focused on targeting the determinants of inequities. In more general terms, great difficulty exists in articulating an independent role for public health, compared with other sectors already directly linked to the social determinants of inequities in health, such as inadequate housing or poor education. Public health may seek to define its value either independently or in conjunction with many institutions. At the same time, it might be counterproductive or even unfair to frame injustices through a public health perspective in its most traditional role.[3]

Standard workforce recruitment and training practices pose difficulties as well. Often existing job classifications and accreditation rules limit the ability to hire people with the necessary background for acting on health inequities. Moreover, the talents and attitudes necessary for success—such as creativity and commitment to the issues, beyond exclusively technical skills—may be overlooked in hiring.

The continuing codification of various aspects of public health practice, based on the drive to establish its legitimacy, cannot itself overcome these obstacles by incorporating or operationalizing social justice into day-to-day work. This is because the difficulty lies in the need to expand the boundaries of public health practice in ways that connect separate programs and services so as to confront imbalances of power in communities that generate inequity.

Finally, the general public has little knowledge or appreciation of what public health is or does. These difficulties place boundaries on the sustained practices necessary for tackling health inequities. As a result, public health has been forced to retreat from its historical mission, hindered by immediate needs to focus on bacteriology and clinical medicine. Yet there is much that public health can do if it can broaden its capacity to incorporate the social context in which disease and illness occur.

TRANSFORMING PUBLIC HEALTH PRACTICE

Given the framework presented in Chapter 1, the staff dialogue process in Chapter 2, and the characterization of LHDs in the 2003 Institute of Medicine report,[4] what are the elements of public health practice and its infrastructural components that might be changed to address health inequity more effectively and make use of available knowledge? What kind of social processes and institutional structures are necessary? How can LHDs gain traction on this issue to link their commitment to action? How can a social justice framework be incorporated into the overall design of an approach to practice in all parts of the LHD, rather than remain isolated as a special initiative? How do we translate the extensive knowledge on the relation between social and economic inequalities and health inequities in a way that will lead to a transformation in the practice, structure, culture, and knowledge base of public health? Essentially, our objective is to move from an improvisational approach to a more comprehensive one, returning to a larger social context that defined the origins of public health. A tension or contradiction that remains unresolved is the extent to which necessary changes can evolve from practice as it currently exists or instead require an entirely new approach. Whatever road is taken, resolving the dilemma and establishing an effective organizational structure and culture is crucial to success.

Before exploring case study examples in Chapters 5-12, this chapter considers some of the core elements or arenas for change within departments that would enable them to address health inequities. Organizational transformation does not necessarily require large financial resources; rather, it concerns conducting the work of public health differently, developing a supportive infrastructure within the agency, and creating the space for action. Stated another way, the dimensions through which transformation needs to occur, as discussed below, concern capacity building as a means to legitimize and naturalize the practice of social justice.

The following discussion briefly outlines specific areas of practice and offers general suggestions about how it might be possible to reorganize the way the work of public health is done. How do we link the understanding of social injustice to people's everyday action? While the analysis may appear overly broad and visionary, a detailed blueprint or protocol would be inappropriate if not impossible. Change in any given health department will emerge in two ways: 1) from a separate dialogue process with staff and community members on practice, based on the model in Chapter 2 that focuses on gaining insight about the relation between social and economic inequality and social injustice, and 2) the naturally occurring reflection from these dialogues that may lead to questioning contemporary procedures and practices.

Support Equity as a Value and Social Right

The support for health equity as a goal of public health practice and a basic social right requires explicit expression, along with a rationale and a method to ensure its implementation. Evidence alone will not result in change without commitment. This would include support for the enforcement of laws and regulations associated with housing, the environment, the workplace, and basic sanitation. Doing so would enable practitioners to review and evaluate priorities, policies, and resources to determine their effect on population health and address health inequities more effectively. It would also generate the momentum to transcend remedial action in favor of more fundamental, coordinated practices directed at root causes. The challenge for practitioners is to rethink the framework that guides the work of public health. Such a framework would include, at a minimum, meeting basic human needs and equitable distribution of social resources. More than ever, population health depends on the provision of public resources. Finally, supporting equity in action means establishing goals by targeting the social determinants of inequalities in health for the population, instead of diseases or mortality rates. This is a prominent approach in Sweden.

Leadership

Standing up for health equity demands leadership. It requires commitment, along with a willingness to express what needs to be done, given the accumulated knowledge about the causes of health inequities and the influence of social policy. Thus, health officials would seek greater decision-making authority and support for public policy directed specifically at the elimination of health inequities. Even though the local health department is one among many entities that have a role, it will need to build support among colleagues in other agencies as a means to give priority to the health impact of many activities and decisions at the state and local level. Leadership also means inspiring others. Because the causes of population ill health result primarily from conditions created by long-standing injustices—such as racism, sexism, and exploitation in the labor process rather than individual behavior—health professionals must advocate for public policies such as adequate and affordable housing, anti-discrimination laws, public transportation, and the reduction of sprawl. Health officials are in a position to demonstrate the links between health and unemployment, social exclusion (from resources necessary for healthy lives), poverty, quality education, and central features associated with the organization of society. Staff would be given latitude to work on health equity. Finally, LHDs could seek grants related to eliminating health inequity—in traditional grants and new grants. That is, they could consider activity related to social determinants as a screen in budget decisions.

Interagency/Multi-Disciplinary Coordination

The production of health depends on a variety of conditions, processes, institutions and knowledge, beginning in childhood and overlapping many jurisdictions. Thus, health is never about the work of one agency but requires a system of institutions. In orchestrating action to eliminate health inequities, public health practitioners in our ideal department would collaborate and coordinate with the many agencies and entities that constitute the system of public health. We might find health practitioners linking their practice with city planning, economic redevelopment, transportation, housing, social welfare, and education—beyond the health professions—along with neighborhood and non-profit organizations. The location of public health practice, often perceived as within organizations designated as health departments, inhibits the capacity to establish the conditions for healthy communities. Part of intersectoral collaboration efforts would involve, at a minimum, sharing data across agencies, which would link to health outcomes and exposures. For example, financial housing data and the condition of housing might be linked with pesticide use and exposure data that could inform public policy.

Workforce Development and Education

How can the public health workforce respond more systematically and effectively to the source of health inequities? What is the necessary infrastructure? Do we need people with different competencies? In order to eliminate inequities in health outcomes, the theory, practice, and scope of work within the field of public health would change its focus upstream to the structures that influence quality of life, addressing the prerequisites for population health. This includes a range of activities from seeking to integrate public health into social policy to redefining through expansion the content of public health practice, recognizing the contribution of many disciplines and skills to succeed. Practitioners would support the redirection of social and political priorities and resources. They would begin to link activism and science more effectively.

Recruitment (hiring criteria, job descriptions, and qualifications)

New staff have multi-disciplinary training (e.g., the social sciences, community organizing, urban planning), the ability to conduct qualitative research, and an understanding of health inequities. They are racially and ethnically diverse. Their competencies are appropriate to tackling the root causes of health inequities. Beyond technical skills, the department seeks creativity, commitment, connectedness and communication skills.

Training

Staff members would be educated about social justice and its historical link to public health. The department would work with schools of public health to ensure inclusion of social justice in the curriculum. Training occurs in the substance of social justice and social justice practice would occur over a long period of time, with regular updates. It would be a permanent, ongoing activity. Staff members would participate in regular meetings with neighborhood coalitions, would learn how to interact, and would learn the basics of community-based participatory research.

Integration of Disciplines

Public health practice cannot advance health equity without a more coherent philosophy and theory—one that links economics, ecology, sociology, and geography and avoids disciplinary boundaries. Schools of public health would cross-train on environmental concerns to overcome over-specialization. Workforce recruitment—hiring criteria, job descriptions, and qualifications of new recruits—must consider people with multi-disciplinary training (e.g. the social sciences, community organizing, urban planning), as well as candidates with the ability to conduct qualitative research and an understanding of health inequities.

Working and Collaborating with Communities

The LHD cannot perform its work in isolation from the community it serves. The relationship is ongoing and organic, not based on formulas or techniques, but principles and a principled way of interacting and making decisions. Community residents and their organizations must be active partners in any efforts to eliminate health inequities and the LHD must be accountable to the community. The entire staff would work to make common cause with those who are most marginalized and the social movements associated with them. Thus, public health professionals must be *representatives* of the community by seeking to advocate for social change that transforms the conditions that cause ill health and by strengthening community assets, skills, and capacities. The work begins by building trust and solidarity with community and workers' organizations. In part this may mean breaking with a command and control model of operating to one based on a more participatory, democratic approach to setting priorities and conducting research within neighborhoods. This type of relationship also contrasts with pure service delivery or programs attempting to control diseases. The LHD becomes, in this model, more of a facilitator, while still able to apply its expertise. Most important then is how LHDs work with communities and how they support and assist the communities against threats to health. Establishing a long-term relation will require, in most cases, that LHDs change their organizational culture.

Community collaboration in this model is inescapably a method of community organizing for social change. It requires a long-term commitment; it's an alliance. The terms of the relationship are always being negotiated, in part because conditions are fluid—as is the concept of community. It requires shared decision-making and mutual disclosure of information, particularly at the beginning phases of conducting activities. A clarification of interests and values is always necessary because conflicts are many times not just about misunderstandings or misperceptions. If the community believes that it is being poisoned and its goal is getting assistance, the health department need not enter into debates over risk and comparing risks and supposed benefits. A toxic waste site in the neighborhood is a problem of toxic waste, not risk. The community does not wish to debate about probability theory; it wants a remedy. More specifically, responding to health concerns requires working with the community to determine risk, not merely communicating it, and providing an explanation/analysis of findings, not just the findings. The methodology or analysis by the experts may be flawed. Setting priorities and designing research must also be a prerogative of communities. Determining what data to collect depends in part of how the community defines its priorities. These priorities may be different from the LHD.

The field of popular epidemiology emerging in recent years supports innovative approaches to improving community health, including consideration of disproportionate risks in exposure experienced by communities of color and those with low-income residents. Relying on community knowledge through qualitative assessments and insight, popular epidemiology is a philosophy and a method or practice—a type of public participation whereby lay people detect and act on environmental hazards, and learn to collect data on conditions in the community that create health inequities. According to sociologist Phil Brown, popular epidemiology is "the process whereby laypersons gather scientific and other information, and also direct and marshal the knowledge and resources of experts in order to understand the epidemiology of disease…yet [it is] more…since it emphasizes social structural factors as part of the causal disease chain. Also, it involves social movements, uses political and judicial approaches to remedies, and challenges basic assumptions of traditional epidemiology, risk assessment, and health regulation."[5] It enables people to determine how they know what they know. Community knowledge provides a rich, historical source unavailable from purely technical knowledge or ordinary perception. It may be useful to suggest actions that neighborhood residents can take to bring about change. This will potentially motivate them to act and create commitment. Similarly, the principles of community-based participatory research represent an important step toward clarifying values, collaborative methods, and relationships in how LHDs will work on research projects with the community.

Given these approaches, perhaps the most important way LHDs can assist communities is to assist in strengthening internal leadership capable of mobilizing neighborhood residents to collective action to address health inequities. This means community organizing and involves providing resources that would shift power out of bureaucratic institutions directly into communities. It also means an offer of technical assistance to groups engaged in population health work and the deployment of permanent resources at the neighborhood level.

Communications Strategy and Public Education

Part of the process of gaining support and generating public debate on health inequities will require that health practitioners work with the mass media and develop strategies that would lead to a greater emphasis on root causes of ill health and poor quality of life, particularly the way in which social policy can make a difference. The media must, however, be ready to hear a new message and that message must come from constituents, especially an organized public. The objective is to raise awareness and understanding about the sources of health inequities and the collective action necessary to generate dialogue and take action to eliminate those inequities.

What are some possible messages to the media in trying to shift the focus to the institutional story and trends behind health inequities? They might include "health problems reflect socioeconomic conditions and the standard of living;" "social inequality leads to health inequality;" and "everyone benefits from equality." At the same time, basic messages also explain that health is about more than health care, healthy behaviors, and public health programs. The legitimacy of being health experts can get traction for the issue of health inequity, along with a confident, moral message. The basic elements of the social justice message are: 1) injustice exists, 2) it is systemic—meaning that there are institutions and policies responsible; 3) something can be done about it.[6]

Find a headline such as “Does poverty cause disease” or “Economic inequality related to health status.” The object is to find a way to make the issue compelling by reframing it so that people think about health in ways that link it to actionable social conditions and more fundamental injustices. However, new and more formal relationships with the media may be required to tell the story of health differently. The work is not so much about persuasion with facts as providing insights that will shift consciousness. However, critical understanding of health inequity is about more than producing messages; it is about how people identify themselves and recognize the role that institutions play in establishing health. Health professionals can provide context that gives meaning to seemingly disparate experiences. This involves, at a minimum, posing questions about things like the sources of toxicity in neighborhoods that draws the link between policy, health outcomes, and the capacity to imagine alternative futures.

A Good Framing Strategy Should:

Translate individual problem to social issue. The first step in framing is to make sure that what you say is consistent with your approach. It’s hard to justify an environmental approach to an issue if all media interviews frame it from an individual perspective. Further, a social issue is news, an individual problem is not. Translating an issue helps others to see why it is important and newsworthy.

Assign primary responsibility. Consistency is key. If the issue is tobacco sales to kids, it’s hard to justify a new ordinance if spokespeople assign primary responsibility for the problem to parents. Framing for content means framing your message in ways that support your initiative goal and explains to others why the target you chose is the right entity to address the issue.

Present solution. The message should clearly articulate what the initiative can address. To use youth access to tobacco as an example, the solution offered is to make it harder for merchants to profit from youth smoking.

Make practical policy appeal. This is where the initiative comes in. It should be communicated as practical, fair, legal, affordable and the right thing to do.

Develop pictures and images. If a picture is worth a thousand words and the average media bite is seven seconds, developing compelling visuals that illustrate your perspective is critical.

Tailor to audience. Remember whom you are communicating with in each case. Communities are fragmented with lots of different interests and concerns. Tailor your message to your audience, which is usually your target.

-Developed by the Berkeley Media Studies Group, Berkeley, California

Health Promotion

Traditionally, health promotion in the United States stresses individual behavioral and lifestyle change. A social justice perspective emphasizes raising consciousness about social and environmental forces that shape health. The actions that flow from this vision suggest the need for collective social change instead of exclusive reliance on self-protection. Its focus is on social responsibility. This perspective also seeks to mobilize community resources for the production of health and removing health damaging conditions. Health promotion, in this view, complements the approach to communications and education described above. Perhaps more important, the method of health promotion would be based on dialogue—not a professional education model—and on an equitable partnership with community-based organizations.

Building Alliances and Coalitions

The work of achieving health equity cannot be accomplished through isolated actions by a local health agency. A necessary step is to identify organizations that engage in social justice activity and make alliances with them, particularly as part of broad social movements—civil rights, human rights, environmental justice, advocates for affordable and safe housing, etc. The idea is to establish common ground on related issues, create solidarity, mobilize supporters and their networks, and develop a coherent agenda. It may be possible to form an association of social justice activists outside the boundaries of the LHD. Consider, for example, the establishment of a community advisory board on health equity. Whatever the specific method, it is important for staff to work with grassroots organizations on a regular basis. The public health agency can thus facili-

Mapping Potential Allies

1) How are resources allocated to support the various groups and/or communities with which I want to work? Have there been tensions over resources? How did these tensions evolve and who were the key players?
2) What is the group's experience with previous collaborations? Were they satisfying/did they meet their needs? Was it a positive or negative experience overall? Why?
3) What are the prevailing attitudes about collaboration? Are there issues (i.e. in professional training or culture, mistrust, etc.) that make collaboration difficult? Easier? What concerns the group most about getting involved with a collaborative project? How can those concerns be allayed?
4) Who are the key opinion leaders in the group? Who is most open to collaborating? Who is least open? Do we or someone we know have a relationship with any of them? List names.
5) What would the group need to get out of collaborating with others? What can we offer? What would the group be willing to contribute? What do they risk in joining us?
6) What interests do we both share? Will this collaboration offer a vehicle for mutual benefit?

-Developed by The Praxis Project, www.thepraxisproject.org

tate or support existing coalitions among at-risk population groups. In addition the agency can conduct strategic planning processes with community members, planners and stakeholders. They can also convene and facilitate meetings with other agencies. In building alliances, it may be useful to conduct an analysis of power relations among allies for strategic purposes. Thus, depending on the specific objectives, identify who has power to move the agenda or pressure those who do have power. In creating alliances, it is important to determine whether potential allies have power, what risks they are willing to take, how strong their interests correlate with your own, and what you can offer them.

Public Policy Development and Analysis

A major goal of public policy within the campaign to eliminate health inequities is to equalize access to capabilities and advantages, which means, according to Amartya Sen, providing access to the means of achievement and the freedom to achieve, enabling people to engage in the world.[7] Of course many jurisdictions have health and nuisance codes that allow public health to intervene to address inadequacies in housing through structural remediation like replacing mold-damaged material. But practitioners also need to consider tax policy, employment policy, trade policy, transportation policy, labor market policies, support for living wage campaigns and so forth. Healthy public policy will require strategizing, not one issue at a time but with a plan for reordering priorities, particularly social investments in the infrastructure to improve the lives of children. To begin this work, LHDs would identify local policies and arenas that affect the social determinants of health and then, in conjunction with their communities, establish policy agendas linked to reducing health inequity. Social policies would be evaluated according to their effect on health equity. In thinking about policy, practitioners should note that not all policy involves legislation. Administrative rulemaking, moratoriums, and mandated research are important areas for potential policy development, as well as legislation.

In an article in the *American Journal of Public Health*, James Colgrave asks a critical question associated with the direction of public health:

> Are public health ends better served by narrow interventions focused at the level of the individual or the community, or by broad measures to redistribute the social, political, and economic resources that exert such a profound influence on health status at the population level?....A large and growing body of research [suggests] that broad social conditions must be addressed in order to effect meaningful and long-term improvement in the health of populations.[8]

Broad measures that attend to the social system instead of primarily at-risk individuals will be necessary. Making major improvements in the health of vulnerable populations and anticipating future increases in health inequities requires policies aimed at structural and institutional change. Such an agenda would focus on the foundations of health and the social roots of suffering, premature death, and disability as they are connected to patterns of disease and illness over time within populations.

What types of strategies aim to remove or lower risk for whole populations? Supporting mass transit policies and conducting health impact assessments on urban design will be more useful than the traditional emphasis on exercise and diet alone. Public and organizational policies that make taxation more equitable, create affordable housing, improve neighborhood conditions, reduce poverty, lower unemployment, advance a living wage law, invest in social infrastructure such as schools and day-care centers, and generally improve the health of disadvantaged populations are likely to reduce health inequities. The idea is not only to reverse conditions that lead to inequitable health outcomes, but to produce the conditions that create health before inequities develop.

Attention to the values that underlie policy and policy menus are critical, given the principle that people have a social right to healthy conditions and that the patterns of illness are not a function of choice or fixed conditions. Healthy public policy must therefore be supported, even though policy effects are difficult to measure over time, particularly when seeking to change institutions, structures, and factors such as air and water quality. Success is also difficult to evaluate because narrowing the gap between socioeconomic groups is a long-term objective, rather than general improvements in health status. However, an objective is to move policy in a different direction, at a macro level, even if measurement is difficult or impossible.

Advocacy

To realize the values of social justice it is necessary for health practitioners to be advocates—which means working to organize the community and engaging in the political process to consider decisions in relation to population health effects. This objective was clearly stated in the IOM report of 1988 and reinforced in the 2003 IOM report.[9] In seeking to inform opinion-makers, shape the debate, support coalitions, and influence decision makers through both the agency's expert role and the community's knowledge, advocacy cannot be mere passive dissemination of information; it demands a strategic plan to deploy information and build social momentum. The basic advocacy role can be described along the following dimensions: 1) inclusion of health equity and social justice in the statutory mandate for public health; 2) health equity in performance standards and accreditation; 3) support conferences for and by community members and health workers and invite to conferences; 4) support communities seeking better quality housing or getting landlords to make repairs or increasing the affordability and availability of housing; and 5) offer community organizations technical assistance with things like conducting their own health assessments, planning and evaluation and guidelines for community development.

Monitoring and Surveillance

Monitoring patterns of socioeconomic inequalities more effectively requires analysis of the measurement of group deprivation over time. As a means to build the capacity of local health departments and their communities to address health inequities, it is necessary to monitor the nature and level of health inequity in a community and the sources of health inequity. In the last few years, a number of organizations such as the Global Health Equity Alliance[10] and other researchers[11] have begun to develop approaches to measuring health inequity that offer innovative tools. Traditional business and economic indicators that receive wide coverage in the news provide a limited and skewed view of the nation's well being. Thus, an effective, systematic, and official narrative that provides a full picture of social well-being or health equity is lacking. It also requires a coherent system of social reporting that can frame a perspective. These tools are a way to measure, monitor, and communicate a concept of health equity that can inspire people to action and place health equity on the national agenda. They offer a portrait of conditions to focus public attention on health inequities and make rational assessments to move public policy. In addition, such a tool can facilitate the community's capacity to express its voice on community health concerns related to inequity.

What is a health equity index? According to the Equity Gauge Alliance, "An Equity Gauge [what we will call a health equity index] is an active approach to addressing inequity in health that not only monitors equity, but also incorporates concrete actions to bring about sustained reductions in unfair disparities in health and health care.... This active approach requires the involvement of a range of actors in society including researchers, health workers, policy makers, the media, the general public, and NGOs concerned with development and justice."[12] More generally, data collection and analysis is a means to inform decision-making by building equity into a standard, everyday process that creates consciousness about the issue of health inequity. Since science is not neutral—the choice of scientific questions depends on values about what is important—alliances will need to be developed between scientists, health departments, and social movement activists.

Another promising approach to monitoring inequity is Health Impact Assessment (HIA). It is a method to engage communities and generate attention to public health consequences both of specific projects as well as public policy. The most common elements involve an "attempt to predict the future consequences for health of possible decisions; and that it seeks to inform decision-making."[13] Our definition emphasizes a multi-disciplinary and qualitative approach, focused primarily on indirect impacts beyond biomedical perspectives, that can examine social and economic conditions, however difficult. We would also contend that communities must participate fully in the process if it is to be legitimate and successful, even though difficulties exist in defining the community.

Overall, research methodologies must incorporate qualitative measures appropriate to the level of analysis for addressing health inequities and population health. Such methodologies would have a more macro-level perspective related to the characteristics of the larger social system and its institutions. Otherwise it will be extremely difficult to transcend individualist, behavioral lifestyle approaches to health policy.

Addressing Health Inequity through the Essential Services of Public Health

The ten essential services define the practice of public health. According to Bernard Turnock, they are a "formulation of the processes used in public health to prevent epidemics and injuries, protect against environmental hazards, promote healthy behaviors, respond to disasters, and ensure quality and accessibility of health services."[14] Below are some actions that could be taken with respect to some of the essential services that address health inequity. An important question is whether an eleventh essential service specifically devoted to health inequities is necessary.

Essential Public Health Service 1: Monitor health status to identify community health problems

1. Analyze community contextual characteristics of place on health outcomes and health inequities, and develop community profiles
2. Identify data from other agencies on the social determinants of health, e.g. housing conditions, location of jobs, poverty, level of racial segregation, access to transportation, unemployment, economic and labor market conditions, school dropout rates, etc.
3. Identify data that indicates level of inequities in health status, e.g. nationally, African-Americans have a 2.4 times higher infant mortality rate
4. Conduct health impact assessments on public policies
5. Analyze data to look at trends and identify population health risks

Essential Public Health Service 2: Diagnose and investigate identified health problems and health hazards in the community

1. Using community health data, identify health problems and chronic exposure to environmental health hazards and *the sources of those hazards*
2. Minimize, contain and prevent adverse health events *and attend to the ongoing conditions that produce them* resulting from communicable diseases; food-, water-, and vector-borne outbreaks; chronic diseases; environmental health hazards; biological, chemical and radiological threats; negative social and economic conditions; and large-scale disasters

Essential Public Health Service 3: Inform, educate and empower people about health issues

1. Provide information, targeted to various audiences, to help those in the community understand what decisions they can make *through collective interventions on the sources of patterned negative health outcomes to be healthy, and the policies to support and methods to organize and change conditions*

Essential Public Health Service 4: Mobilize community partnerships to identify and solve health problems

1. *Participate in community-based planning and social movement activities to support healthy communities*

Essential Public Health Service 5: Develop policies and plans that support individual and community health efforts

1. *Act to eliminate health inequities across population groups*
2. *Promote social investments in communities, e.g. education, childhood development, that sustain and improve community health*

A BRIEF NOTE: WHAT IS A SOCIAL JUSTICE PRACTICE?

While there is no bright white line distinguishing a social justice-related intervention from one that is not, we can offer some general guidelines. A social justice perspective concerns a philosophy, an approach, a way of working, as well as coordinated activity to tackle health inequities. Because health inequities derive from social and economic inequality, a social justice approach stresses imbalances in the distribution of power and targets its efforts to change that imbalance. Thus, initiatives associated with social justice in relation to root causes of health inequity would be those that primarily emphasize fundamental public resources for healthy communities that address the reduction of social and economic inequality affecting disadvantaged populations. They might include: a) a living wage campaign—approximately 70 cities are now engaged in such campaigns and 121 ordinances have been enacted since about 1994. Essentially, these campaigns are about enacting local ordinances requiring private businesses that benefit from public money to pay their workers a living wage, above the minimum wage. The campaigns usually call for some degree of research into work and poverty in the area, research on city contracts, subsidies and related wage data, and often cost of living studies; b) development of a health equity index, report card, gauge or other analytic tools to measure and promote the level and source of health inequities and indicators such as local resource distribution, housing, education, zoning and other determinants of health inequity (see Monitoring and Surveillance above); c) a comprehensive staff training program or dialogue on health inequity; d) land use planning initiative to ensure that economic redevelopment does not create further toxic environments and unhealthy places; e) development of a method or system to ensure access to healthy food, transportation, or high quality education; f) addressing institutional racism (segregation, red lining by banks, legacy of slavery, toxic environments) through an educational campaign within the department and in the community that explains how racism affects health status; and g) mobilizing the population to action, forums for discussion and mechanisms to involve residents in evaluating and monitoring conditions.

This perspective contrasts with treating primarily the consequences or symptoms of the social and economic inequalities that create health inequities, even though such actions would be valuable. Thus, for example, a rat elimination program would not qualify because it fails to address the source of the rat problem, which is related to the lack of affordable housing, which in turn may be related to discrimination. Similarly, seeking to educate the target population to change their behavior, or lifestyles, or other individualistic interventions through traditional health promotion, e.g. an asthma program to provide vacuum cleaners to poor people may be useful in addressing immediate needs, but not the originating injustice. If certain neighborhoods have excessive amounts of certain chemical agents in the water supply, a program to inform citizens to drink bottled water or put filters on their sinks might be useful, but not effective in dealing with the source of the inequity, e.g. targeting communities of color for toxic facilities.

In general, a social justice perspective is activist in its orientation, so that the health department views itself as a change agent, committed to tackling underlying causes, beyond programs and services. With a connection to social movements, it requires changing the bureaucratic structures that inhibit moving forward and attending to emerging social trends and political power arrangements that can enhance or constrain an effective approach.

SUMMARY: ENSURING THAT ACTION PLANS ARE EFFECTIVE

- Address structural, infrastructural, institutional forces and the social determinants versus respond to symptoms, e.g. immigration policy vs. services; changing economic practices vs. cleaning up toxic sites
- Target community conditions, not just diseases
- Focus on barriers like statutory authority, limits
- Examine public and organizational policy, rules and regulations, that will facilitate or inhibit working upstream
- Seek to become part of decision-making, policy discussions in related agencies
- Conduct regular community forums
- Increase the voice and influence of affected communities, e.g., promoting community health vs. individual health
- Convene, integrate/take leadership by bringing together stakeholders and institutions that can change social conditions
- Include social justice in meetings, media presentations
- Expand definition of public health practice
- Use social determinants as a screen in budget decisions
- Find ways to express and translate ideas of health equity—relying on popular culture, cultural activism
- Identify local policies and arenas that affect social determinants of health
- Use bioterrorism financial resources to do social justice work
- Create a newsletter to highlight social justice issues. Capitalize on what is already in the media
- Discuss racism, class exploitation, and gender inequality
- Invest in children, youth and related interventions
- Identify local policies and arenas that affect social determinants of health
- Seek grants related to eliminating health inequity—in traditional grants and new grants
- Find ways to expand or revise statutory authority to expand the legitimate scope of public health work

CONCLUSION

A growing number of LHDs are beginning to experiment with new ways to approach health inequities, many of them improvisational. Success will depend on developing a comprehensive plan of action that will take time. Generally, implementing a social justice perspective demands that practitioners ask questions within a broad, developmental conception of social change, such as: what structures and processes cause health inequity? Why is there health inequity? The transformation of public health practice in the interest of realizing health equity depends on rethinking basic assumptions about what is possible and necessary to break free from limited categorical approaches and a reductive biomedical model focused on genetics and molecular-level analysis. It will mean transcending a crisis mode of functioning to long-range planning for health, recognizing the accumulation of disadvantages over the life course and increased involvement in the design of community development initiatives. A social justice perspective then considers basic causes of health inequity, rather than remediation; the source becomes primary over the effects. It will demand sustained attention to the preservation of natural resources, effects of ecological degradation, as well as the social disorganization caused by economic decay and other phenomena that create collective, population-related risks. Change will also require re-imagining a form of public health practice based on principles of social justice and collective responsibility for the public's health, along with the creation of an infrastructure and network of support to sustain it. Perhaps most importantly, this work cannot be accomplished without full democratic partnerships with affected community constituencies both in deliberative planning processes and providing technical assistance incorporating their knowledge. This is a return to the roots of public health practice.

The next chapter by a former local health department director provides an overview of how social justice may become a focus of public health practice.

NOTES

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3. I wish to thank Adam Karpati for these points.
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9. Note 4.
10. See http://www.gega.org.za/index.php.
11. See for example, Marianne M. Hillemeier, John Lynch, Sam Harper and Michele Casper, “Measurement Issues in Social Determinants: Measuring Contextual Characteristics for Community Health,” HSR: Health Services Research 38(6), Part II (December, 2003): 1645-1718.
12. Note 10.
13. John Kemm, “Perspectives on Health Impact Assessment,” Bulletin of WHO 81(6) (2003): 387.
14. Note 1, p.327.

Market Justice vs. Social Justice

■ Personal responsibility and individual rights	■ Social responsibility to protect common good
■ Causes of inequity: genes, bad behavior, accident	■ Causes of inequity: racism, class and gender exploitation
■ Resolution: behavior change, treatment of symptoms	■ Resolution: tackling racism, class and gender exploitation through political action
■ General approach: acceptance of risk as fact of life	■ General approach: activist perspective to creating conditions for health

Chapter 4

Promoting Social Justice Through Public Health Policies, Programs, and Services

Alonzo Plough

INTRODUCTION

Public health policies, programs, and services—collectively termed public health practice—in the United States have been the subject of a series of reports by the Institute of Medicine (IOM)[1,2] and considerable commentary by the federal government, professional associations, and academic institutions.[3–5] However, social injustice as a focus of practice is rarely discussed.

Most assessments of the state of public health practice have dealt with such issues as organizational structure, funding shortfalls, and capacity limitation. They have typically focused on defining functional capacity (to provide the 10 essential public health services*) and the growing gaps between population health challenges and resources invested in the public health system.[6]

Broad assessments of a system in "disarray," particularly at the local level, abound. Federal- and state-level attempts to bring coherence to public health practice through standards and performance measures are presented as remedies for the diagnosis of systemic dysfunction. Current strategic planning at the Centers for Disease Control and Prevention (CDC) looks to the private sector and individual health care providers as an underused component of public health practice.[7]

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*The ten essential public health services are: (1) monitor health status to identify community problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships and action to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public health and personal health care workforce; (9) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and (10) research for new insights and innovative solutions to health problems.

These analyses also mention, one way or another, the imperative of public health to improve the social conditions in specific communities that largely determine health and well-being. Social determinants of health, communitybased public health, community-based participatory research, and the social/ ecological model* all appear as descriptors of a component of public health practice. However, this domain of practice is not considered essential. No national standards or performance measures explicitly deal with the promotion of social justice as a public health practice core capacity.

To better understand how social justice can and does become an object of public health practice, there must be (a) a recognition that public health practice is overwhelmingly a government activity—in organizational delivery and in financing, and (b) a debunking of much of the conventional judgment that public health practice is in disarray. Because the performance of activities and interventions to promote social justice challenges the broader political economy and explicitly identifies social injustice as a causal element in the poor health status of a particular community, government public health practice is placed in a difficult context. How health departments approach this problem will depend on (a) the level of government—federal, state, or local—in which the agency is located, (b) the political ideology of elected officials who oversee the agency, (c) the capacity and commitment of public health officials, (d) the ability of agency staff members to meaningfully engage community residents in collaborative endeavors, and (e) the competing demands of public health challenges, such as SARS, bioterrorism preparedness, routine outbreaks of disease, inspections of various facilities, and service delivery mandates. An operational focus on root causes of poor health, such as poverty, income and wealth inequality, and racism—all factors related to social injustice—requires a public health capacity not often discussed. This is the capacity to effectively manage the urgent demands of public health practice while simultaneously and explicitly understanding the social context and root causes of the poor health of populations. Importantly, this understanding of social context and root causes must inform both current practice and future strategic planning.

PUBLIC HEALTH AGENCIES AND SOCIAL JUSTICE

Federal Agencies

The capacity to address social injustice in public health practice, or the ability to develop it, varies with the level of government in which a health agency operates. Federal agencies such as CDC and the Health Resources and Services Administration (HRSA) have a national scope, extensive grants and contracts, and multiple delivery and research programs that could focus on social injustice as a core problem in public health practice. Although there are some isolated examples of social justice as a key component of

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*The social/ecological model describes how social, physical, and genetic factors influence health status. This includes contextual and relational influences on health, such as social and community networks, living and working conditions, institutional influences, and political and economic policies, all of which interact to shape population and individual health.

federal agency policy, these do not represent a central tendency. Too often, such promising policy directions like HRSA's 100 Percent Access and Zero Disparities initiative during the Clinton administration or the environmental justice focus of CDC's National Center for Environmental Health during the same period have had marginal funding and program development. The administration of each U.S. president has a different capacity to envision social injustice as an operational policy and program direction. As a result, there has been little sustained effort to address this fundamental problem at the federal level.

State Health Departments

State-level public health practice faces similar challenges, with frequent changes in governors, high turnover of public health officials, and widespread inability to gain sustained political support for explicit public heath activities to address social injustice. As is the case with federal-level public health practice, state health departments are often not directly connected with community-based public health practice. The default mode of public health practice at the state level is the pass-through of federal funds to local agencies, very general and aggregated statewide policy development, and regulatory activities. Advocacy and activism of health officials—which are essential ingredients for successful policy interventions to reduce social injustice—are very constrained at this level.

The average tenure of state public health directors is only 2.9 years.[8] As a result, directors are usually just starting or about to leave positions, making it quite difficult to provide the sustained and visible leadership needed to address social injustice as an essential function of public health practice. A review of the websites of the 50 state health departments found only one department with an extensive and explicit incorporation of social justice as a standard of practice.[9] The Association of State and Territorial Heath Officials (ASTHO) website contains no reports on or any references to addressing social justice as a core public health practice strategy.

Clearly, federal- and state-level public health agencies could influence critical policy areas that are shaped at the state level of government, such as education, taxation, housing, and economic development. The scale of federal- and statelevel bureaucracy and the siloed nature of agency behavior make such direct action and collaboration difficult, especially on politically charged topics.

Federal and state public health agencies, however, can facilitate social justice interventions at the local level through funding that is sufficiently flexible to allow for community-driven approaches to prevention that can address social determinants of health. Funding approaches, such as the Racial and Ethnic Approaches to Community Health (REACH) program that has funded local coalitions to address health disparities in AIDS/HIV, diabetes, and infant mortality, have resulted in effective community-level interventions that address root causes of ill health and represent a social justice framework. The Steps to a Healthier United States (STEPS) grants program holds similar promise, although this program has been implemented too recently to evaluate its impact.

Local Health Departments

The local level of government public health practice is best situated to explicitly address social injustice. Local health departments represent the backbone of the government public health system, but they have been poorly represented in studies and reports on the current and projected status of public health practice.[10] Both of the influential IOM reports indicate that the public health system—from the perspective of conventional standards and technical capacity—is in disarray. Local health departments in particular are cited as having limited public health capacity.

There are a number of flaws, however, in the conventional analysis of local public health capacity.[11] In the United States, 70 percent of the population and almost all highly populous urban areas—where health disparities based on race, ethnicity, and poverty abound—are served by metropolitan health departments that are highly functional and have developed many effective policies, programs, and services. These health departments are also the most community-embedded components of the government public health structure and are beginning to develop public health practice models that explicitly consider addressing social injustice as a core organizational competency.

The best examples of a commitment to social justice as a part of public practice are associated with the policy commitment of the National Association of County and City Health Officials (NACCHO) to social justice. There are numerous references to social justice on the NACCHO website, which operates as a technical resource to local public health practitioners.[12]

Its board has adopted a resolution that has, in part, urged "support for ideas, activities, social movements, and policies that advance action to build health equity through social justice" (p. 1).[13] In 2002, NACCHO revised its strategic plan to define as a core strategic action of local public health practice the capacity "to address issues of health equity and social justice, oppose racism, and support diversity and cultural competence" (p. 3).

In the world of public health practice, this dramatic difference in a professional association's explicit support for incorporating social justice as a core competency and providing tools, training, workshops, and other technical assistance to local practitioners to implement strategies and specific actions is profound. This support has provided grants and other resources that build strategic action in many local communities across the nation. Importantly, such a professional practice framework provides a much-needed legitimacy for advocacy work at the local level. When a local board of health member or city official questions why a health department is involved in land use or environmental justice as a policy and program area, the ability to point to a national organization's strategic plans and practice guidelines often provides the evidence for these actions being seen as "standard" public health practice.

Local public health practice is grounded in specific communities and is part of a local network of community-based organizations and public and private institutions with a shared local governmental context. The broad range of social conditions that adversely influence health outcomes—such as unemployment rates, poverty, disinvestments in public education, unsafe neighborhoods, and suburban sprawl (as a deterrent to community cohesion)—have a daily immediacy at this level of public health practice. The definition of public health as a ‘‘social enterprise’’ with a mandate to align the technical tools of epidemiology and assessment with effective community partnerships and advocacy can become operational in local health departments with the leadership and commitment to engage with their communities in challenging social injustice. The much longer tenure of local public health officials, compared with their state counterparts, increases the possibilities for catalytic leadership and sustained practice efforts grounded in a social justice framework. Staff members of local health departments are also members of the community, helping to increase linkages between communities that experience health problems related to social injustice and local public health programs and services that should be accountable to these communities.

Clearly, all government public health agencies—including local health departments—are challenged in creating authentic community partnerships. To be effective in a community-linked approach to addressing social injustice requires public health agencies to incorporate new approaches to collaboration that go far beyond the traditional expert-driven approach to professional public health practice.[14] Roz Lasker and Elisa Weiss[15] present a very thoughtful approach to the essential principles of collaboration required to facilitate activities that address the root causes of health disparities and other social and economic conditions that decrease the well-being of communities. The key components of their community health governance model suggest that effective collaboration requires empowerment, community building (the bridging of social ties), and community engagement. All of these are essential activities of public health practice, without which public health agencies would probably revert to the rhetoric of community engagement without the impact from true power sharing with community members. Too often, public health agencies use the language of the social determinants of health and the need to reduce health disparities but do not internally transform in ways that would allow for the nontraditional actions required to address social injustice as a risk to the public’s health. Using the language of social justice while applying the traditional top-down tools of public health practice has a limited impact.

The major challenge of public health practice is to move theoretical knowledge about the relationship of social injustice to increased health risks and poor health outcomes into broad and sustainable changes in agency policies and practices. These changes include (a) providing support and training to staff members in partnership development, and (b) creating the capacity to extend public health practice beyond the agency walls to dynamic partnerships with other disciplines, such as economic development, land use planning, housing, transportation, and education.

Local public health practitioners are particularly effective when local data are generated and communicated through accessible reports that highlight the impact of specific social and economic factors on health outcomes. Effective use of local media is an essential tool of public health practice in broadening the public’s awareness of the impacts of social injustice on community health. Careful, data-driven presentations to local elected officials and health board members are essential components of public health practices that address social injustice. However, this type of political advocacy is not always the most significant form of community and political mobilization activities. Effective local public health practice depends largely on capabilities to (a) build on a general base of community-driven partnerships (some of which are not explicitly health focused), (b) identify root causes and leverage points for change, and (c) select the most effective set of tools and strategies that match specific manifestations of social injustice. Root causes of social injustice are often best addressed by focusing on policies concerning labor and employment, taxation, environmental conditions, housing, land use, and child development and support. The critical responsibility of public health practice that is oriented to social justice is to recognize the broader context of causation and to not constrict programs and interventions to those that are based on individual behaviors or a specific disease.

PUBLIC HEALTH PRACTICE ORIENTED TO SOCIAL JUSTICE

Two Case Studies

This section examines two examples of how public health policies, programs, and practices can highlight the relationship between social injustice and the public's health. Each example provides some practical insights into how community partnerships can be used to deepen knowledge of root causes of poor health, mobilize and activate political and community leadership, and make initial efforts sustainable. The case studies are drawn from local public health agencies in San Francisco and Seattle. Each case study focuses on a health-related problem with significant social determinants, with each public health agency and its community partners deploying different strategies to link the broader social justice problem with a specific approach to health improvement at the community level. The scale of impact and the possible sustainability of the efforts in each of these case studies are different. They highlight the complexities of addressing social injustice through public health practices and policies that are primarily governmental.

Case Study 1

The San Francisco Department of Public Health is a city and county health department serving a diverse metropolitan population. Its practice framework is linked to the strategies to promote social justice in local public health practice at a national level. For example, its environmental health section supports the Program on Health, Equity, and Sustainability, the goal of which is "to make San Francisco a livable city for all residents and to foster environmental, community, and economic conditions that allow residents to achieve their human potential."[16]

In 2002, the department facilitated a process to address environmental health disparities in asthma, particularly in relation to indoor-air exposure to poor children. Recognizing that some neighborhoods have a high concentration of substandard housing and drawing on published studies relating poor indoor-air quality to the presence of mites, cockroaches, and mold, the department raised the level of community awareness through data presentation and community mobilization. Setting the context with an estimate of 54,000 residents diagnosed with asthma, the department pointed out the disproportionately more severe outcomes among communities of color and placed this risk in a broader community context by stating, "The health and well-being of San Francisco's residents, families, and community are at stake."[16]

An important community-mobilizing strategy was the development of the San Francisco Asthma Task Force. Chaired by a local nongovernment social-service provider, the composition of the group reflected the diversity of the community, including representatives of nonprofit organizations and community-advocacy organizations and community members, many of whom had experienced asthma in their own families. The task force developed focused working groups that had a diversity of members. These working groups gained information from tenants with asthma, property owners, managers, builders, and contractors to develop a community-based definition of the problem. Then teams from the Department of Public Health and the task force applied the interdisciplinary tools of environmental health, environmental epidemiology, building and housing code enforcement, and tenant organizing to further define intervention and policy approaches. Through an open community process, including retreats, the task force developed recommendations that focused on improving indoor-air quality for lower-income tenants. The final report of the task force highlighted the structural deficiencies of buildings that exacerbate asthma by exposure to molds, fumes, and other hazards. These factors, which represent significant forms of housing injustice, were presented by the group as root causes of asthma. There was explicit recognition, based on the findings of the work groups, that low-income people have few housing options and are disproportionately exposed to these factors.[17]

Recommendations resulting from this locally driven public health partnership reflect insights gained and action strategies developed when public health workers and community partners create dynamic collaborations to address social injustice. The major action strategies that it developed to address environmental determinants of asthma included the following:

1. *Establishing a cross-agency group to inspect public-housing properties and to create accountability mechanisms that rapidly brought conditions into compliance with the housing code.* This strategy involved creating interagency collaborations among the health department, the housing agency, and agencies involved with code enforcement, the police, and the legal and judicial systems, all of which focused on improving the underlying social conditions that account for income-based disparities in asthma.
2. *Establishing standards and guidelines for comprehensive healthy housing, including roles for property owners—requiring government entities to strengthen the relationship between building codes and landlords' legal obligation to tenants to reduce housing-related health risks.*
3. *Instituting a legal housing-advocacy program for poor patients identified with asthma.* This intervention implemented a monitoring and engagement strategy that raised awareness about environmental determinants of asthma and linked poor asthma patients using hospital emergency departments with information and housing advocates.

This case study demonstrates how many of the elements of a social justiceoriented public health practice are developed and implemented. While the overall project recognized the clinical and disease control issues, its thrust addressed the root causes of asthma in housing and economic policies. The health department was a key participant, but the project was broadly based in the community and led by community organizations. Finally, recommendations addressed the social context of risk and incorporated nontraditional approaches for providing public health programs and services.

Case Study 2

Public Health–Seattle and King County is a large metropolitan local health department serving nearly 2 million people. The department has long recognized the critical importance of social justice in public health practice, as reflected in its mission and value statements and its organizational structure. A specific interdisciplinary unit—Community-Based Public Health Practice (CBPHP)—was established in 1998 to develop community-driven activities grounded in a deep understanding of the social determinants of health.[18] A major focus of CBPHP was eliminating disproportionately poor health status in communities of color.

To develop an approach to this problem that was oriented to social justice, the department initiated a series of surveys and studies that documented growing disparities among economically marginalized King County racial and ethnic groups. Specific examination of disparities in infant mortality, teen pregnancy, diabetes, and other poor health outcomes set the stage for a more contextual examination of root causes of these problems.[19] The results of these studies were published in an easily accessible form and were made widely available on the Internet and through other communication channels. Health department staff members worked closely with advocates to increase community awareness of these problems and to engage community members in strategies to improve the underlying social and economic bases of the poor health outcomes. This work involved specific community-driven assessment of health and examination of the critical social contexts in specific communities, including American Indians and Alaska Natives, African-Americans, members of specific Asian and Pacific Island groups, and Hispanics.

The King County Ethnicity and Health Survey revealed that discrimination influenced all health disparities. For example, 32 percent of African- Americans thought that they had been discriminated against when receiving health care services at some time.[20] Lower percentages of members of ethnic groups also reported experiencing discrimination. Because discrimination is a potent cause of social injustice, a broader strategy was required for effective advocacy and change. Community partners and health department staff members recognized that racism was the root cause and that how racism influenced health status and health-seeking behavior of specific ethnic populations had to be addressed. In the health care setting, perceptions of discrimination can powerfully impact health-seeking behavior and, potentially, health status. Giving voice to individuals who had experienced racism in health care settings provided a more grounded presentation of the problem. By presenting the issues in human terms, the report presented a dramatic and compelling sense of the problem—much more than could have been achieved with a presentation of statistical data. As a result, the information was more likely to improve staff behavior in institutions where discrimination had occurred.

The health department contracted with a community-based organization to develop and conduct the Racial Discrimination in Health Care Interview Project.[21] The results were reported in a community report and a public health report that was broadly distributed among health care practitioners and their institutions, as well as political and community leaders.[22] The reports highlighted the extensive range and frequency of perceived discrimination among those interviewed. The discrimination events, which had taken place at nearly 30 different public and private health care facilities throughout King County, included racial slurs and blatant examples of rude behaviors and differential treatment. As the report stated, most interviewees reported changing their behaviors as a result of discrimination they had experienced. Some reported delaying treatment due to their negative experiences and not knowing where else to seek care.

These descriptive and experience-based examples from the survey were presented in numerous public settings, including press conferences with the county executive, community meetings, conferences of health professional associations, and board of health meetings. They generated much media attention. The results of the series of studies on race, ethnicity, and health were presented to the chief executives of the major hospitals and health plans in the region. A call to action was delivered in all of those settings, seeking a broad community consensus to adopt the recommendations of the reports, including training health care providers, establishing uniform institutional policies to enforce nondiscrimination, and collecting data and performing monitoring by including questions regarding discrimination on patient satisfaction surveys. Many of the recommendations were implemented by local institutions. The work to eliminate discrimination continues.

Additional Examples of Public Health Practice That Address Social Injustice

These two case studies provide good examples of how public health practice can incorporate a social justice framework that influences policy and service. There are many other ways that government public health, especially at the local level, can address injustice. One example is using public health surveillance data to identify the adverse health effects of social injustice. Public health agencies can closely monitor a set of social indicators—such as measures of poverty, income inequality, housing costs, parents who read to young children, and unemployment—that are highly related to health and human development. It is increasingly important to link these types of social indicators to the more traditional vital statistics and health status measures and to use census tracts and ZIP codes as units of analysis. By this approach, public health departments can develop, with their community partners, neighborhood-focused assessments that can assist communities in advocating to improve social and economic conditions that underlie health disparities. Sometimes the advocacy might be focused on ensuring access to preventive services, such as prenatal care for poor women through community and public health clinics. Increasingly, such assessments find that addressing factors such as inadequate housing, lack of jobs with a livable wage, unsafe workplaces, and community exposures to environmental hazards are even more important than providing traditional, client-focused public health services. Given recent budget cuts for public health services in most jurisdictions, it is unlikely that public health agencies can directly ensure that all appropriate services are available and accessible. However, public health practice can align funded services to populations with the greatest needs and aggressively present the political and social context for the critical gaps in access to preventive services.

AN ACTION AGENDA FOR A SOCIAL JUSTICE CORE COMPETENCY IN PUBLIC HEALTH PRACTICE

For public health practice to better address social injustice, there will need to be a fundamental shift in what is currently viewed as core or essential public health activities. Evolving local, state, and federal standards for public health in the United States clearly prioritize the traditional role of disease prevention and health promotion, although this is greatly complicated by the even higher prioritization of bioterrorism preparedness. Although community involvement, even community engagement, is seen as a core public health activity, its goals are articulated and its outcomes are measured primarily as changes in individual behavior that reduce conventional disease risk factors. For example, it may be stated that more people eat a healthy diet or perform physical exercise or that more young people understand the risk factors associated with drug use due to community assessment and partnership activities.

A public health practice competency addressing the impact of social injustice on health goes beyond affecting individual behavior change and improving the effectiveness of practices within the traditional boundaries of health services. It focuses on enabling more accountable public and private decisions concerning the basic needs of groups of people who have poor health because of discrimination based on race, income, language, ethnicity, or sexual orientation. Its outcomes can be measured by sustainable reductions in the social determinants of this discrimination.

What Are Some of the Barriers to Wider Acceptance of a Core Public Health Competency Demonstrating Ability to Reduce Social Injustice?

First, as reflected in curricular and other requirements of schools of public health and public health programs, academic public health faculty members are just beginning to develop courses that train students in methods and skills relevant to reducing the impact of social injustice on health. Research and courses on health disparities, minority health, and social determinants of health are more prevalent than ever before in this country, but these courses focus on description of problems and policy issues—generally not on methods of engaging communities to develop sustainable actions to address the root causes of health disparities. Courses on community-based public health practice should go beyond community-based assessment of conventional health risk factors and should focus on community-organizing and empowered collaborative practices that can address root causes of social injustice. These courses could link to public health practice settings, where people who have suffered poor health due to social injustice could serve as adjunct faculty members.

A second and closely related barrier to wider acceptance of this core public health competency is the lack of federal funding to support the development of public health practice approaches to address social injustice. This inadequacy includes limited funding for campus/practice/community partnerships to develop and disseminate best practices. More extensive federal funding to local health departments is required to enable their staff members to understand how to develop effective community partnerships and to develop expertise in nontraditional areas of practice. Clear but flexible mandates for authentic community partnerships in policy and program development are needed.

State health departments need to recognize that the community-driven nature of the social determinants of health requires a decentralized focus on local leadership and community development. This requires a shift in focus away from aggregated state plans for reducing disparities to legislative and regulatory policy approaches to reduce the impact of social injustice on the public's health. It requires legislators and policymakers at all levels of government to understand, for example, that housing and land-use/zoning decisions have a major influence on the public's health.

The third and final barrier to wider acceptance of this core public health competency involves raising money to support its promotion during a period of budgetary constraints. Public health practitioners at all levels will need to creatively use data on the social determinants of health to inform and influence the decisions of elected officials. The greatest challenge may be the perception that social injustice is rarely eliminated by public health services alone—although services can reduce the impact of social injustice on individuals who receive these services. A public health practice commitment to incorporating social justice as a core capacity means going far beyond providing services—it means being a catalyst for sustainable structural change to reduce social injustice.

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PART TWO
THE PUBLIC HEALTH COMMUNITY IN ACTION: CASE STUDIES AND STORIES

Introduction

The case studies in this chapter serve as examples or illustrations of actions taken by contributing health practitioners in their efforts to address the root causes of health inequities. They range widely from programs, tools, administrative practices and projects to ways of working with communities and ideas or innovations that arose in response to a local public health need. All meet at least a few of the following criteria: a significant local public health department role, collaboration, innovation, responsiveness, sustainability, and evaluation. Some are based on direct experiences within local health departments, while others derive from academic research. Not all succeeded. The purpose is to inspire health practitioners and to offer guidance.

Many of the articles examine how the practice, initiative, program, organization of work, resource or tool may advance health equity (particularly from the point of view of collaborators, the department, and the community). Where relevant, they describe the role of the health department, who was involved, the character of participation from other organizations and agencies, the benefits and limits of participation, and the synergies and conflicts between organizational agendas and agency agendas. Some explore how the initiative got started and the elements required for success. They also consider difficulties: the structural obstacles, how were they met or overcome, and how they may have limited effectiveness, if at all. An important issue in most cases was the effect on long-term relationships, sustainability of work, and social change.

These case studies have limits in what they can offer. They represent activities tied to a particular place and set of circumstances, many of them in large cities on the West coast. Some reported here were not intended to address health inequity directly. However, all highlight the importance of initiatives designed to achieve a broader level of social change beyond remedial action designed to establish the conditions for health in a community.

Chapter 5

Health Impact Assessment in Land Use Development: A Case Study in Health Equity Practice

Rajiv Bhatia

INTRODUCTION—BRIDGING INSTITUTIONAL BOUNDARIES FOR HEALTH INEQUITIES

In 1986, the World Health Organization's Ottawa Charter for Health Promotion defined the fundamental resources for health as "peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity."[1] Considering such fundamental human needs in the context of urban planning can prevent disease and illness. For example, ensuring sufficient, safe, and affordable housing might prevent asthma and lead poisoning, lessen hunger, ease stress, and limit homelessness.[2,3] Similarly, increasing residential density close to transit or job centers could enhance public safety, decreases our reliance on automobiles, encourage walking or bicycling, and prevent air pollution, greenhouse gases, and transportation-related injuries.[4,5,6]

Public health practitioners acknowledge that diverse public policies affect health; still, the primary strategies of public health involve surveillance, screening, and behavior change, generally ignoring health's social and environmental determinants. In part, the problem results from the fragmentation of our public institutions.[7] How do pubic health practitioners participate in the activities of related public institutions? What can practitioners do to influence policy processes in ways that will protect public health?

Internationally, one method to challenge the isolation of health policy from social policy is health impact assessment (HIA).[8] HIA is defined as "procedures or methods by which a proposed policy or program may be judged as to the effect(s) it may have on the health of a population."[9] HIA aims to be multidisciplinary, inclusive, and transparent. Practitioners have applied HIA to neighborhood renewal and land use and transportation planning.[10] In the United States, HIA might be a vehicle to support collaboration among public institutions, public transparency and accountability in policy making, and greater awareness among public and policy makers of the societal dimensions of health.[11]

HEALTH EFFECTS OF HOUSING: EVIDENCE FOR PUBLIC HEALTH ENGAGEMENT IN LAND USE PLANNING

In San Francisco, a local and regional housing crisis helped to catalyze efforts to engage public health with city planning. By the end of the 1990's economic restructuring combined with increasing demand for urban housing contributed to a severe housing crisis in San Francisco. Most new employment opportunities provided less security, poorer wages, and fewer benefits than the manufacturing jobs they replaced. At the same time, new higher wage workers from throughout the region became attracted to the urban experience. In 2004, only 7.3% of San Francisco households could afford the median sale price of a house.[12]

Significant public health research has established the nexus between adequate housing and health. For example, low-income populations are forced to make difficult choices among rent, food, clothing, transportation, and medical care or to work long hours and multiple jobs to afford rent.[13] In our practice of enforcing housing and environmental regulations, we recognized how unmet housing needs created profound costs to the health of low-income and vulnerable populations. Lead poisoning and asthma prevention efforts demonstrated that low-income households often accept older and poorly maintained housing with inadequate heating, lead based paint, unprotected windows, and inadequate ventilation.

Many San Francisco residents were concerned that high housing costs were leading to involuntary displacement. For example, rents were rising rapidly in some neighborhoods and some rental units were being converted to ownership housing. Public health evidence had established that displacement could result in psychological stress, the loss of social networks, and residential segregation. Chronic stress can affect the human immune and endocrine systems and increase infection rates.[14] For children, relocation can lead to grade repetitions, school suspensions, and emotional and behavioral problems.[15] High housing costs and forced displacement can result in a loss of social networks which provide material and emotional support, buffer stressful situations, prevent damaging feelings of isolation, and contribute to a sense of self-esteem and value.[16,17] Finally, displacement might contribute to residential segregation by concentrating poor families in poor neighborhoods. Research has associated segregation with diverse adverse health outcomes, including violence and pre-mature mortality.[18,19,20]

AN APPROACH TO HEALTH IMPACT ASSESSMENT IN LAND USE PLANNING

In San Francisco, one of the Health Department's first efforts to apply HIA to urban planning consisted of critical analyses of development projects through the environmental review process required under the California Environmental Quality Act. Where a public agency decision may adversely affect the environment, CEQA requires an Environmental Impact Report (EIR) to analyze effects on the environment and their potential mitigations. Moreover, in California an EIR must also analyze any direct or indirect adverse impacts on humans resulting from a project's environmental effects.[21]

In San Francisco, the Department of City Planning (DCP) implements land use planning and zoning and also provides oversight for all local public agency EIRs. SFDPH routinely reviews these EIRs to ensure adequate study of impacts on air quality, noise, and chemical hazards. In 2003, SFDPH began to appraise selected land use and transportation planning and policy proposals using a more comprehensive set of criteria for healthy neighborhoods. Community stakeholders, legislators, or public agencies requested or solicited these reviews; however, the requests occurred in the context of the existing agency—community partnerships. The approach, embedded in the practice of one of the deputy public health officers (the author), resembles a "rapid" or "desktop" approach to HIA.

Table 1 describes the general sequence of steps that guided these reviews. Screening of proposals for review involved considering the objectives of the project, the potential pathways between decision outcome and health outcomes, the incidence of related health outcomes in the population, the potential magnitude and distribution of effects, the consideration of health issues in the decision-making process, the existence of health evidence, and the relationships between evidence and stakeholder positions. Literature on social determinants of health, health disparities, place and health, and the concept of social change processes guided the identification of pathways[22] (Table 2). The appraisal involved mapping pathways, assessing relevant empirical research, conducting secondary data analysis, and, in some cases, conducting focus groups, monitoring exposure, or quantifying impacts using empirical models. Informing decisions occurred through testimony at public hearings, informal presentations, and formal agency comment on the EIR. Evaluation of the practice involved monitoring changes in decision outcomes and the use of health-based arguments by stakeholders.

THE TRINITY PLAZA REDEVELOPMENT

The first review concerned the demolition of the Trinity Plaza Apartments, which comprised 360 rent-controlled units, and the reconstruction of 1400 new condominiums. DCP officials initially concluded that the redevelopment of the site would not have adverse housing impacts because the proposal would increase the total number of dwelling units.

Residents and tenant advocates challenged the City's determination in public testimony, arguing that displacement of people was a physical impact leading to mental stress and the destruction of a cohesive community. The SFDPH review subsequently identified several health consequences of the redevelopment proposal, including psychological stress, fear, and insecurity due to eviction, crowding or substandard living conditions due to limited affordable replacement housing, food insecurity or hunger due to increased rent burdens, and the loss of supportive social networks due to displacement.[23,24,25,26,27] Furthermore, SFDPH qualitatively assessed the health impacts of eviction through focus groups with affected tenants.

Providing evidence that related the demolition to adverse health impacts met the CEQA threshold requirement to study any environmental change adverse to humans. DCP officials acknowledged this requirement but challenged us to demonstrate how adverse consequences could be analyzed. How could one estimate the socio-economic status of displaced tenants and their future housing choices, level of crowding, commute lengths, and relationships with family or friends? Officials also worried that requiring such health analysis within an EIR would demand greater agency time and resources and invite legal challenges and controversy.

DCP officials ultimately revised their determination for the Trinity Plaza proposal and required the project's EIR to analyze residential displacement and any indirect impacts on health. Facing tenant organizing, public criticism, the potential for adverse EIR findings, and a possible citywide legislative moratorium on demolition, the developer ultimately agreed to negotiate with tenants and, in 2005, a revised proposal called for replacement of the 360 rent-controlled units, continued leases for existing tenants, as well as a 1000 square foot meeting space and a children's play structure.[28]

The Rincon Hill Special Use District and Smart Growth

Soon after the Trinity Plaza review, community organizations requested SFDPH to weigh in on two high-rise condominium projects in the proposed Rincon Hill Special Use District. The Rincon Hill District is south of downtown and adjacent to the South of Market neighborhoods where community organizations were working to prevent displacement. Staff of the DCP also encouraged SFDPH to document the relationships between real estate development and health, believing that documenting the health benefits of neighborhood schools, pedestrian friendly streets, and community centers might provide support for requirements for developer funding of these improvements.

Developers already promoted the environmental benefits of building housing near public transit and jobs.[29] However, in its review, SFDPH raised concerns about the costs of housing (a studio apartment had an estimated cost of approximately $700,000) arguing that, while housing for people who worked nearby was needed, only a small proportion of workers would be able to take advantage of housing that was prohibitively expensive.[30] The mismatch between job income and housing costs thus missed an important opportunity to reduce commutes, energy consumption, and pollution. SFDPH recommended a jobs-housing balance analysis disaggregated by income be conducted as part of a revised EIR.[31]

In their response, DCP officials labeled housing affordability as a social concern not related to environmental quality. They further claimed that it was speculative to predict the environmental effects of changes in housing affordability, stating that people choose residence based not only on job location and housing costs but also on amenities, the location of family and friends, and the quality of schools.

The SFDPH review also criticized the project for potentially reinforcing segregation. San Francisco law required the project developer to provide 12% of the developed units as affordable to households with moderate incomes; however, some developers elected to build these required units in a high-poverty neighborhood outside the Rincon Hill Plan Area. Our review suggested that adverse impacts of segregation, including higher rates of mortality and violent injury and lower opportunity for educational and economic success could indirectly result from building an exclusive high-income neighborhood. Finally, the project did not provide for a neighborhood school, raising potential for consequences on traffic air pollution, physical activity, and children's educational success.[32]

DCP approved the EIR for the project without any further environmental study. However, questions about the project's affordability, its effects on social integration, and its demands on public infrastructure remained. Community organizations appealed the approval of the EIR to the City's Board of Supervisors, and one legislator, using findings of the SFDPH review, negotiated a higher proportion of affordable units. Zoning rules subsequently approved for the Rincon Hill Area in 2005 required all below-market-rate units to be constructed within the adjacent South of Market planning district and included fees on developers for street improvements, parks, and a community center as well as "community stabilization" funds for affordable housing and community economic development.

EVALUATING HEALTH IMPACT ASSESSMENT

Conceptually, health analysis in urban planning can potentially lead to greater awareness among the public and policy makers of the social dimensions of health, greater partnership among health and urban planning institutions, and greater transparency in the policy-making process, ultimately preventing avoidable disease and injury. Evaluation of our efforts is ongoing and involves an internal staff-driven process and seeks to answer several questions: How can we successfully build partnerships for healthy land use? What is the capacity needed for HIA? What are the impacts of HIA not only on policy and development decisions but also on organizational relationships and structures, public understanding of the urban planning and health relationship, and processes for urban policy analysis.

COLLABORATION

While our agency played the lead role in initiating and catalyzing HIA efforts, the work could not be possible without extensive public and private collaboration. Collaboration with private non-profit organizations built on existing relationships with organizations already engaged in environmental justice land use and urban planning policy. These groups informed us about the land use plans and projects most important to community interests and about community perspectives of the health and social impacts of these projects. We shared our assessments with community organizations so they might use the information in advocacy and public education.

Collaboration with staff in the city's planning department was equally critical to the success of our efforts. Planners helped us to understand the procedures for conducting environmental impact assessment and the reasons, both political and technical, why health impacts analysis did not occur. We were also able to discuss with planners the possible strategies and mitigations to prevent adverse health impact in the projects we evaluated.

Taking leadership on the conduct of HIA has had its own effects on our Department's community and organizational relationships. Planning staff have stated that these partnerships bring not only hands-on support but also have contributed to the personal meaning attributed to their work. Similarly, we routinely participate in discussions on land use positions and strategy with San Francisco community organizations. Relationships with community based organizations have provided us with key insights about where public health skills and evidence might be valuable in land use policy processes and about the critical need for public agency accountability to policy goals. One community organization recently recruited one of our Department's staff to their non-profit board and nominated her to a city legislator to be a member of the city's Planning Commission.

ORGANIZATIONAL CAPACITY

The early phases of HIA efforts required our Department to develop new capacities and skills. To a large extent, our agency's roles are consultative as we are not the agency responsible for land use decision-making. Capacity building has involved significant investments of time in becoming familiar with urban planning institutions, laws, and processes; international practices of impact assessment; and the academic literature on these subjects. Capacity building has also required relationship development with both public agency staff and community organizations, including many one-on-one meetings, participation in coalition and collaboration efforts, and attendance at public hearings. As the work is consistent with the mission and vision of an environmental health agency, our Department has assigned two full time staff to pursue opportunities for HIA in city policies related to land use and transportation planning.

Many analytic methods for conducting health assessment of land use plans and project already exist, and public health practitioners can also use these methods along with EIA to gain consideration of social and economic determinants of health. However, growing a practice of HIA would benefit from the development of analytic methods that forecast the effects of changes in social and environmental measures on traditional human health outcomes (e.g., life-expectancy, hospitalization rates, disease incidence). Recent research has begun to link land use, urban design, and transportation system characteristics with outcomes such as physical activity, air pollution, environmental noise, body mass index, and social cohesion.[33,34,35,36] This research might be used with existing EIA metrics. For example, health effects analysis can link changes in motor vehicle traffic volumes to health-related outcomes such as injuries, sleep disturbance, noise related stress, diabetes, respiratory disease, and social cohesion. In a more recent example, the author used an empirically-derived road facility safety performance function and the EIR's estimates of changes in roadway volumes to quantitatively forecast changes in pedestrian injuries.

IMPACTS ON PLANNING AND POLICY

It is not possible to attribute changes to the scope of environmental analysis and design of the projects exclusively to health appraisals as policy decisions occurred in the context of vigorous public debates. Some of the issues raised in the health reviews (e.g. housing affordability) were already high on the public agenda. In these cases, a key contribution of the health appraisal was the enumeration of causal pathways between the project decision, social and environmental conditions, and human health outcomes. Several stakeholders and legislators based public positions, in part, on health based arguments.

Communicating our findings directly to DCP also created awareness and concern on the part of staff responsible for reports and positions. For example, DCP staff changed their position on the need to study displacement in the context of demolition, and also expressed interest in learning how design changes could mitigate health impacts. The health impacts of residential segregation appeared to have contributed to the agency changing its position to require below market-rate units to be built near market-rate housing developments.

Finally, SFDPH contributed new data into the planning process. Community stakeholders used maps of the locations and size of city parks, maps showing the locations of pedestrian injuries, and maps illustrating overcrowding and segregation to successfully argue for development impact fees for the new neighborhoods.

OBSTACLES

Obstacles to HIA relate to the novelty of a public health role in land use policy and the high-stakes, political nature of land use policy. High-level administrators in the Department of City Planning still question the value of health analysis, citing concerns about increased information demands, increased stakeholder participation and management needs, and the potential political consequences if HIA findings translate into impact fees or exactions on development. Some developers have openly criticized the Department for providing health analysis and taking positions on development projects. Others have attempted to marginalize our work, associating HIA with Not-In-My-Backyard (NIMBY) and other anti-development interests.

Next steps: Institutionalizing HIA in San Francisco

Since 2004, the San Francisco Department of Public Health has facilitated the Eastern Neighborhoods Community Health Impact Assessment (ENCHIA) in order to understand how development in several San Francisco neighborhoods helps create the conditions for optimal health. Involving a Community Council of over 20 diverse organizations, ENCHIA developed a vision of a healthy San Francisco, identified measurable community health planning objectives, produced data and maps to assess how San Francisco is meeting these objectives, and researched urban policy strategies to support health.

The experience and research of ENCHIA is now being integrated into a *Healthy Development Measurement Tool* in order to support evidence-based and health-oriented planning and policy-making. As currently drafted, the components of the tool include:

- ***Twenty-two Healthy City Vision Objectives*** organized into four elements that, if achieved, would result in greater and more equitable health assets and resources for San Francisco residents.
- ***Measurable Community Health Indicators*** for each of the 22 objectives to help measure progress towards the objectives and evaluate the benefits of projects, plans, and policies.
- ***Baseline Data*** for each indicator to inform us how we are doing today.
- ***Development Targets*** to provide specific planning and development criteria that advance community health objectives.
- ***Evidence-based Health Justifications*** that provide a rationale for why achieving each target would improve human health.

The Tool is currently undergoing external technical review by local agencies and national experts. Following that review and pilot testing, participants in ENCHIA envision that this tool will ultimately be used in a comprehensive way by many city agencies in comprehensive planning, in plan and project review, and in agency-specific planning and budgeting. The Department of Public Health is committed to developing and maintaining this tool, supporting pilot applications in San Francisco, and monitoring community health indicators. The specific next steps for the project are outlined on the following page.

CONCLUSIONS

HIA represents more than a new method or technique in social policy; it reflects a value that policy-making should be an open process that accounts for a comprehensive set of impacts. Practitioners of HIA in urban planning must understand that significant political obstacles exist to achieving health objectives through city planning. Building supportive and trusting relationships both with community organizations as well as city planners has been critical for developing this practice in San Francisco. Our efforts in San Francisco suggest that HIA can influence urban land use policy in a way that advances equity and human health. Ensuring the sustainability and impact of this work will require continuing to work across institutional boundaries and working with non-traditional partners.

TABLE 1

Rapid Healthy Appraisal Approach for Land Use Projects, Plans and Policies

Screening	■ What is the problem or need that the project addresses? ■ Has the evaluation of the project considered significant potential pathways between the decision's outcomes and health outcomes? ■ Does public health evidence exist to support these pathways? ■ Do community /lay positions or concerns about the project relate to these pathways ■ Are the health impacts potentially of significant magnitude? ■ Can the project result in disparate effects to different social or economic groups? ■ Is the decision-making process open or closed? ■ Are decision-makers considering all feasible alternatives to address the problem or need?
Analysis	■ Document existing data on health outcomes logically related to the decision (e.g. baseline incidence of pedestrian injuries, asthma rates) ■ Document empirical peer-reviewed and "grey" literature relevant to the health impacts you have identified for analysis ■ Document existing environmental conditions in the project setting related to these health impacts (e.g. traffic volumes, noise measurements, unmet housing needs) ■ Apply existing environmental data to effect measures, where appropriate, to forecast health impacts
Informing the Decision	■ Summarize the background information, logic model, literature review, secondary data review, and forecasting in a report or letter to decision-makers or a comment letter on the EIR ■ Informally present findings to decision-makers, agency staff, and community stakeholders ■ Testify on the findings at a public hearing
Evaluation	■ Review response to comments on EIR, comments and questions by legislators ■ Document changes in the content of the EIR ■ Document changes in the final or proposed plan or action

TABLE 2

Health Determinants Potentially Affected by Land Use Planning in Urban Areas

Category	Examples of Health Determinants within Category
Housing	Housing adequacy and affordability Stable housing tenure Housing quality and safety
Livelihood	Security of employment Adequacy of wages, income, benefits, and leave Job hazards Job autonomy Economic diversity Locally owned businesses
Nutrition	Food cost Food quality and safety Proximity of retail food resources
Air Quality	Contaminants/pollutants in outdoor air Contaminants/pollutants in indoor air Exposure to environmental tobacco smoke
Water Quality	Contaminants or infectious agents in drinking water Safety of the recreational waters
Noise	Intensity and frequency of environmental noise
Safety	Rate of violent crime Rate of property crime Rate of structural fires Pedestrian hazards and injuries
Transportation	Access to jobs, goods, services, and educational resources Proportion of trips walking and bicycling Total miles traveled using personal vehicles
Education	Quality, proximity, and capacity of schools
Parks and Open Space	Quality, proximity, and capacity of parks
Private Goods	Quality and proximity of financial institutions Quality and proximity of childcare services Quality and proximity of health services
Public Services	Quality and proximity of health services Capacity of safety net resources for housing and welfare
Social Networks	Number and quality of contacts with friends and families Participation in voluntary organizations Quality of informal interactions
Social Inclusion	Population living in relative poverty Attitudes towards or stereotypes of minority racial, social, and ethnic groups Residential segregation by race, ethnicity, religion, or class Degree of inequality in income or wealth
Political Participation	Degree and quality of participation in public decision-making Responsiveness of government to popular needs

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Chapter 6

The Community Action Model in a Public Health Department Setting Case Study: Tobacco Divestment on College Campuses

Alma Avila, Alyonik Hrushow, Susana Hennessey Lavery, Mele Lau Smith, Diane Reed, and Melinda Moore

INTRODUCTION

Inequities in social systems – whether the political system, health care system, economic system or justice system - contribute to health inequities. However, public health solutions frequently focus on getting people to change their "unhealthy" behaviors or to make "healthier" lifestyle decisions. Unfortunately this approach places the onus on the individual and does not challenge the social structures that shape many of our "choices" and "decisions." Health status cannot be improved through individual behavior change alone - rather any solution to improve health must focus on changes in social systems. Socioeconomic status appears to be an indicator of health status such that there is mounting evidence that the gap between rich and poor contributes to health inequities between the "haves" and "have nots."[1] Because race and ethnicity are major determinants of socioeconomic status, communities of color are more likely to have poor health and to die early due to disparities in health.[2] Tobacco related illness is no exception as communities of color and low socioeconomic status groups have higher prevalence of tobacco use.[3] African Americans have the highest lung cancer incidence and mortality rates. American Indians and specific AAPI communities have the highest prevalence of tobacco use. Lung cancer is the leading cause of cancer deaths for Latinos.[4]

THE TOBACCO EPIDEMIC AS A SOCIAL JUSTICE ISSUE

In California's tobacco control program, the tobacco industry is seen as the vector of tobacco related diseases. The tobacco industry has a long history of deceit, deception, and duplicity in its pursuit of ever growing profits. Through manipulative and targeted advertising, disinformation campaigns refuting the health consequences of smoking, and political lobbying, the tobacco industry has grown and prospered over the years. And as the tobacco industry has prospered, the number of people who die due to tobacco related diseases has increased. Any discussion of addressing the disparities in tobacco related illnesses must analyze these disparities in the context of the market-based global economic structure and the tools that promote this structure such as privatization (turning public entities such as health care into private, for-profit entities), deregulation (eliminating laws and regulations that, often times, protect health and the environment), and free trade (the free movement of products and services across borders).

Utilizing these tools, the tobacco industry engages in aggressive marketing and promotion targeted at communities of color, women, youth, the Lesbian, Gay, Transgender (LGBT) community, and communities of low socio-economic status resulting in higher prevalence rates in these communities and subsequent disproportionate rates of tobacco related diseases.

A HEALTH DEPARTMENT TAKES A SOCIAL JUSTICE APPROACH

In response to these inequities, the San Francisco Tobacco Free Project (SFTFP) of the Community Health Promotion and Prevention section of the San Francisco Department of Public Health, has viewed the tobacco epidemic as a social injustice issue and has moved away from projects that focus solely on changing individual lifestyle and behavior (helping smokers quit or educating teens not to start) to projects that mobilize community members and agencies to change environmental factors such as tobacco advertising, promotion and tobacco product access for minors that promote health inequity.

As part of the comprehensive tobacco control plan for San Francisco, the SFTFP has funded community based agencies to implement the Community Action Model (CAM), a five-step model focused on environmental change through policy development or change in organizational practices rather than individual behavior change. The intent of the CAM is to work in collaboration with communities and provide a framework for community members to acquire the skills and resources to investigate the health of the place where they live and then plan, implement and evaluate actions that change the environment to promote health.

As part of the CAM process, SFTFP staff provide interactive trainings and technical assistance to community based organizations to facilitate a sharing of existing skills and community strengths so that the actions are community driven. It is the Tobacco Free Project's intention that community groups will find that these skills are transferable to community issues other than tobacco control, such as violence prevention, and are encouraged to integrate other community health issues into their work.

Between 1995 and 2004, the SFTFP funded thirty-seven projects to implement the Community Action Model. These community based organizations (CBOs) in San Francisco work with community advocates (community members) to implement the five steps of the CAM (see below). The CAM has successfully mobilized community members and agencies to change environmental factors that promote unhealthy behavior such as tobacco advertising, promotion and access for minors.

As part of funding the CAM process, SFDPH staff meets regularly with project staff and advocates to problem solve how to implement each step of the CAM process, to develop appropriate activities to use with advocates and come up with lists of potential "Actions" in each issue area. Additionally, SFDPH staff often provide guidance to project staff who often times do not get support from their agency due to lack of resources for staff development. The SFTFP also funds an evaluation contractor and sets aside funds for media consultants to provide assistance to the funded projects. This approach provides for collaboration and linkages between the CAM project's focus, tobacco control, and other issues of deep concern to the community such as immigrant rights, housing issues, environmental justice and food security. For example, one project concerned with food security issues in a low-income community of color in San Francisco is promoting a Good Neighbor corner store policy to promote inner city access to healthy food alternatives to tobacco subsidiary food products.

The CAM model draws from the long history of indigenous peoples struggles to overcome oppression and disparities through community organizing. The CAM provides a framework to fund environmental change projects at the community level; allowing health departments to partner with communities to make change. Central to this funding approach is a social justice analysis and a commitment to the community driven process as well as a commitment by DPH staff to work in partnership with the community and act as a resource for the community.

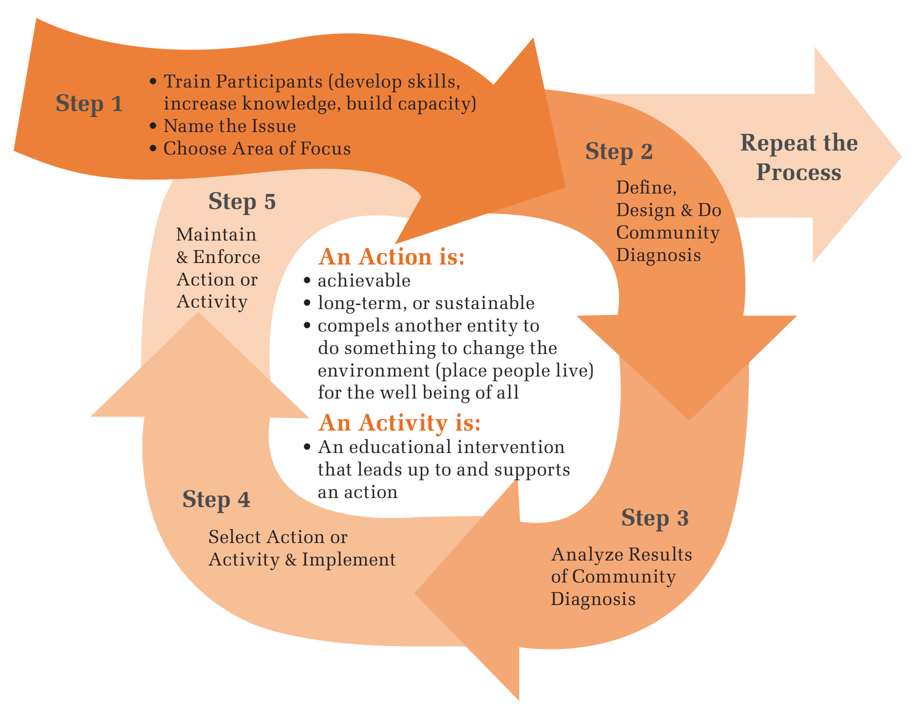
The Community Action Model is consistent with the public health model and provides a structured process for achieving sustainable outcomes. The CAM is designed to achieve this type of change through community capacity building rather than individual behavior change. By addressing the root causes of a problem, environmental change through the adoption of policies has a lasting impact and creates changes in social norms.

For example, having policies and laws that prohibit smoking in workplaces has had a lasting impact on reducing exposure to second hand smoke. Focusing only on educating the public about the hazards of second hand smoke would not have achieved the permanent reduction in exposure. The California Smoke Free Workplace law also changed the public's norms or view of what is socially acceptable as far as smoking in workplaces including restaurants and bars.

THE COMMUNITY ACTION MODEL

Based on the theory of Paulo Freire, the CAM is a five-step model focused on environmental change through policy development or change in organizational practices rather than individual behavior change. Freire, a Brazilian educationalist, who integrated educational practice and liberation, emphasized dialogue, praxis, situating education in the lived experience of the participants and 'consientizacion' or developing consciousness to have the power to transform reality, specifically with respect to addressing oppression. The CAM involves participatory action research approaches and is asset based (builds on the strengths of a community to create change from within). The goals of the CAM are twofold:

The Community Action Model
Creating Change by Building Community Capacity



1. Environmental Change: by moving away from projects that focus solely on changing individual lifestyle and behavior to mobilizing community members and agencies to change environmental factors that promote economic and environmental inequalities.
2. People Acquire the Skills to Do It Themselves: through asset based action research, the CAM provides a framework for community members to acquire the skills and resources to investigate the health of the place where they live and then plan, implement and evaluate actions that change the environment to promote and improve health.

The five-step process of the CAM : 1) skill based trainings where advocates choose an area of focus; 2) action research where advocates define, design and do a Community Diagnosis (action research); 3) analysis where advocates analyze the results of the diagnosis and prepare findings; 4) organizing where advocates select, plan and implement an "Action" for environmental change and educational "Activities" to support it; and 5) implementation where advocates ensure that the policy outcome is enforced and maintained. A curriculum has been developed in English, Spanish and Chinese to implement the model and includes specific curricula activities to assist advocates in implementing the steps. To further facilitate the transferability of the CAM to other health issues, a "facilitator guide" to accompany the CAM has been developed. The curriculum and facilitator guide can be found at http://sftfc.globalink.org/capacity.html.

HOW DID THE SFDPH OPERATIONALIZE IMPLEMENTATION OF THE CAM?

Most SFTFP CAM projects are funded at the $50K-100K/year level; however other CAM projects are funded from between $10-25K/year level. Aside from the budget requirements below, much of the same support goes into a $10K CAM as a $50K CAM.

- Funded a fiscal intermediary contractor - activist oriented CBOs tend to be fairly small often times making it difficult for them to meet the requirements for a city government contract, the SFTFP funded a fiscal intermediary organization with the infrastructure to meet the requirements for a city government contract. This enabled smaller CBOs to be a subcontractor on a larger contract. In addition, this structure allowed SFTFP staff to streamline the application process. The original application was lengthy and bureaucratic while more recent applications have been reduced to 4-6 pages.
- Funded CBOs as subcontracts to the fiscal intermediary contract to complete the 5-step CAM process with emphasis on selecting an "Action" (that meets the 3 criteria) and completion of an action plan to achieve it. This is a requirement for funding that is included in the MOU, work plan, deliverables etc. Provided technical assistance, training and consultation to ensure that the CBO will identify an "Action" and develop an action plan to achieve it.
- Identified three criteria to maximize a CBO's ability to successfully implement the CAM: 1) must be community based, 2) must demonstrate a history or interest in activism (not just service oriented), 3) must have infrastructure to support staff to implement a system change focused project. These criteria were integrated into the application and evaluation criteria. The application specifically stated that the funded CBO would be required to implement the CAM, choose an action meeting the criteria, and implement a community organizing action plan to work towards successful completion of the action.
- Included in the Request of Funding Application (RFA) a list of potential actions for applicants to respond to that gave them an idea of the types of projects that would be funded.
- Included non direct-service based CBOs in the outreach mailing lists for the release of the application.
- Developed simple work plans, budgets, budget revision and invoice processes to alleviate some of the administrative burden of implementing a CAM. Other guidelines required a minimum of .50 FTE project coordinator, funds for stipends for community advocates, and budgets for incentives for program participants. Projects could use their budget to purchase computers and pay for access to the Internet.

- Integrated an analysis of the root causes and solutions to the health issues into trainings in the case of tobacco, the role of the transnational tobacco companies, the elements of the corporate led global economy and related issues. Funded CAM projects partner with CBOs in countries with fewer resources, participate in "intercambio" exchange meetings and collaborate on joint environmental change actions.
- Provided a training for agencies funded to implement the CAM that addresses how to set up the necessary infrastructure, administrative support (budgets, work plans, staffing, computer, email), and methods to compensate advocates (stipends/pay/incentives) etc.
- Provided an orientation training for project staff and advocates to "walk" them through the five-step process of the CAM. Sample trainings are in the CAM curriculum.
- Coordinated regular meetings of all funded project staff to collectively brainstorm and collaborate as well as regular meetings between specific funded project staff and SFTFP staff to enhance on-going collaboration and the potential for success.
- Initiated regular meetings with agency staff to problem solve, brainstorm and share resources.
- Provided on-going, as-needed trainings for skill development at specific steps in the process.
- Funded an evaluation contractor to provided technical assistance and consultation in design of diagnosis, data analysis, and training in evaluation methodology. SFTFP staff and evaluators are not community based and may not have in-depth knowledge of a community's issues and concerns; thus ongoing collaboration is essential and must involve mutual information sharing and respect for the community driven aspect of the process. During the diagnosis (step 2) phase, the evaluator works closely with advocates as they define, design and implement the research.
- Provided funds to each funded project to identify a culturally competent media consultant to support advocacy efforts.

CASE STUDY: TOBACCO DIVESTMENT ON COLLEGE CAMPUSES

Since 1995 the SFTFP has committed to fund community based organizations to implement the CAM as part of its comprehensive tobacco control plan and budget. During the most recent three year plan (2001-2004), six CAM projects were funded from January 2002 through June 2004. Below follows a case study of one of those projects, the Latino Issues Forum (LIF). LIF was funded to implement the CAM at San Francisco State University (SFSU) and City College of San Francisco (CCSF).

Get Ready, Get Set, Go:

The Request for Application was released in October 2001 and the submitted proposals were reviewed by an independent review team who selected LIF as the successful applicant. There were six other projects funded at the same time. Once the projects were staffed and ready to go, the SFTFP provided a full-day training on the CAM. This training included interactive activities that moved training participants through the 5-steps of the CAM.

During the course of the 2.5 year project, SFTFP staff worked closely with the project coordinator through regular meetings, telephone calls, and review of project related documents as well as supporting the project by attending rallies, board of director meetings, and providing and coordinating trainings and presentations for the student advocates. The Project Coordinator was extremely organized and had the skills to successfully implement the project with technical assistance and consultation from SFTFP staff.

Step 1: Recruitment and Training and Selecting the Focus Area

At both campuses a core group of student advocates were recruited and trained to carry out and lead the tobacco-free education and policy advocacy campaign.

The student advocates researched tobacco-related issues and policies on each campus, educated the campus community, developed concrete, permanent tobacco control policies at each campus, and worked for their passage, implementation, and enforcement.

The advocates were expected to accomplish a variety of complex and demanding tasks:

- Research global issues of tobacco control;
- Conduct a diagnosis of campus and community tobacco policies and identify campus and community policy-making agencies;
- Research opinions and awareness of tobacco control issues and policies;
- Organize support for an educational campaign around tobacco control and passage of tobacco-free policies on both campuses;
- Implement a tobacco-free educational and media campaign to raise awareness of tobacco control issues;
- Advocate for the adoption of the chosen tobacco-free policy or policies by policymaking bodies; and
- Design a plan to enforce the policy after its passage.

To ensure that student advocates were prepared to meet the demands of the project, LIF provided extensive training during the first year of the project. The advocates learned about tobacco control issues and policy. They were given articles to read and were assigned additional research. The areas covered included: tobacco advertising; tobacco stock divestment; tobacco economics and profits; marketing to people of color, youth, and in foreign countries; environmental tobacco smoke; tobacco litigation; subsidiary products; tobacco and campaign finance; tobacco and individual health; tobacco and international trade/global economy; tobacco and agriculture/pesticides; and tobacco smuggling.

The student advocates on both campuses chose similar goals: permanently banning the sale of all tobacco products on campus and permanent divestment of all tobacco stocks owned by the Foundations on each campus. This case study will focus on the advocacy campaign related to divestment of tobacco stocks.

During the recruitment and training stage, SFTFP staff provided on going consultation via both telephone and in person including suggesting materials and activities for the training, reviewing training plans and offering suggestions and consultation on where, how and how many students to recruit and train. Recruited student advocates also participated in monthly SFTFP sponsored provider meetings to provided a time for information sharing and joint problem solving. The SFTFP staff established a collegial relationship with both the project coordinator and student advocates by being available and attending project sponsored events.

Step 2: Designing and Doing the Diagnosis

The first task for the advocates was to conduct a community diagnosis of the tobacco environment on their respective campuses. Each group documented the following information:

- Current tobacco-related campus policies;
- The decision-making bodies and process on each campus;
- The extent of tobacco availability on each campus;
- The extent of tobacco sponsorship at college events; and
- The extent of tobacco stock in the investment portfolios of each campus.

The advocates used key informant interviews and surveys to collect information gathered from each project site as part of the community diagnosis.

During this phase, the SFTFP staff and evaluator continued to be available to project staff and advocates to meet with them to discuss the design of the diagnosis – to review key informant interview questions and to brain storm how to complete the diagnosis.

Step 3: Analyzing Results of Community Diagnosis

SFSU advocates sent an initial informational letter about the campaign and its policy objectives on the campus to all SFSU Foundation Board members in late October to determine if SFSU had tobacco investments. There was some initial confusion about whether or not SFSU had tobacco holdings. The financial manager of the Foundation was “fairly certain” the Foundation did invest in some tobacco stocks, but was uncertain about how to go about checking on it. The advocates were later informed that investments are confidential and board members, even if they know about specific investments, are not permitted to share this information with the public. One of the board members told the advocates that SFSU did not have tobacco investments and agreed to work with the advocates to get a statement in writing and begin working towards a permanent moratorium on tobacco investment.

The CCSF advocates were initially told that the school itself had no tobacco investments and that CCSF faculty and employees are part of the San Francisco retirement fund that had already divested. However, the student advocates discovered that the Foundation had investments in mutual funds that might include tobacco stocks in their portfolios. No formal written policy existed that prohibited the CCSF Foundation from investing in tobacco stocks.

During this step, support from SFTFP staff and evaluator consisted of researching and providing information on divestment, brainstorming on ways to "compel" the college foundations to disclose their investment information, and participating in campus rallies to garner support for their advocacy campaigns.

Step 4: Designing and Implementing the Action Plan

The advocates describe the project approach as "influencing and educating people," "networking," and "being persistent" to accomplish their goals of tobacco divestment and banning on-campus sale of tobacco and subsidiary products. One student thought having students involved in a high profile way on campus made it easier to attract other students.

A large part of the work of the project entailed educating students, faculty, administrators, and policy makers about tobacco control issues, and organizing the campus community to rally around policy changes championed by the project. While few had prior community organizing experience, the student advocates on both campuses did form broad-based and effective coalitions to organize for those changes. The student advocates on each campus aggressively targeted campus policymaking bodies to advocate for policy changes to counter pro-tobacco influences.

On June 17, 2003, the SFSU Foundation Board of Directors unanimously updated the Foundation's list of restricted investments officially prohibiting the Foundation to invest in tobacco companies and, in September 2003, the CCSF Foundation Board agreed to pass a policy permanently prohibiting tobacco investments if it was determined that the Board had no tobacco holdings.

This is generally the most labor intensive part of the CAM process. During this step, support from SFTFP continued in the same manner – monthly meetings, on-going telephone conversations, participation in rallies and other support garnering events, attendance at hearings and review of materials, and strategy discussions. During this time, SFTFP staff met with student advocates to provide trainings on the global economy.

Step 5: Maintaining/Enforcing the Action

The Tobacco-Free College Campuses Project was successful in meeting most of its goals. The project educated the SFSU and CCSF campuses about the tobacco industry and its harmful practices, mobilized the campus community to support tobacco-free policies on both campuses, and successfully advocated for adoption of administrative policies to permanently end financial ties between both colleges and tobacco corporations.

- On June 17, 2003, after 8 months of advocacy by TACTIC, the SFSU Foundation Board of Directors unanimously passed a written policy updating its restricted investments to permanently prohibit investment in tobacco companies. The Board also passed an SRI policy that, while not specifically mentioning tobacco or other industries as prohibited investments, represented a step in the right direction. The student advocates were unsuccessful in convincing the Foundation's board to adopt a stronger SRI policy but were able to get the Associated Students (AS) to agree to incorporate tobacco as part of its agenda for the following year. The student advocates felt that incorporating the tobacco agenda into the larger Associated Students agenda that would provide the best chance to institutionalize ongoing tobacco prevention work at SFSU.

- City College advocates continued to work with the City College Foundation to divest the small amount of money it has invested in tobacco companies over a period of time and/or ensuring that all new funds are invested into a socially screened portfolio.
- NO BI advocated the successful passage of "Proposition A" on the April 2004 student trustee election ballot. Proposition A asked: "Does the student body recommend that the CCSF Foundation establish a Socially Responsible Investment mutual fund to invest their capital?" The measure passed with 64% of the vote.
- NO BI contacted other community colleges in California to build a coalition for a blanket Socially Responsible Investment policy among all community college foundations.

The original project coordinator left at the end of two years to purse educational opportunities and a new coordinator was hired for the last six-months of the project. Therefore technical assistance from SFTFP staff included overall orientation and review of the project's activities as well as technical assistance and consultation on current project activities. During this time, SFTFP staff arranged for a number of consultations with investment experts and attorneys to discuss possible avenues of interest to the student advocates. SFTFP acted as liaison for student advocates to set up meetings and get information from sources.

Beyond the CAM

The CAM is designed to have a lasting impact both in developing an individual and organization's capacity to continue social justice work by creating environmental change through policies. As the root of health disparities is social inequities in systems, empowering those members of the community most impacted to acquire the skills to change the social structures and inequities through environmental change will address health disparities. While the CAMs funded by the SFTFP are, by necessity, focused on tobacco related issues, the skills and capacities developed are transferable to other issues affecting the community and preventing them from being healthy.

The advocates felt a strong connection to the project and their work in large part because they were given leadership roles and liked having "a lot of say in what they were doing."

The student advocates also had opportunities to be involved in local, statewide, national, and global tobacco control events, which helped keep them, focused, stimulated, and aware of the connections between global tobacco control issues and their work on campus. Over the course of the project the advocates:

- Testified before the San Francisco Board of Supervisors in support of a citywide tobacco permit ordinance.
- Testified before the U.S. delegation to the Framework Convention on Tobacco Control (FCTC) in Nashville, Tennessee in September 2002 in support of stricter standards for worldwide tobacco marketing and advertising giving advocates an opportunity to practice their public speaking and presentation skills.

- Regularly attended meetings of the Global Action Task Force (GATF) and participated in GATF's November 2002 Intercambio in San Francisco that hosted tobacco control advocates from Africa, Latin America, and India.
- Traveled to the WTO meeting in Cancun in September 2003 and the FTAA meeting in Miami in November 2003 to protest liberal trade policies that put multinational corporate profits over public health.
- Traveled to Ecuador to hold an intercambio (educational exchange) with Ecuadorian high school and college students on tobacco control issues, share tools for policy advocacy, and work together in the growing youth-led tobacco control movement.

Most of the advocates saw the project as an opportunity to learn or improve their skills in research, communication, public speaking, writing, community organizing, and decision-making. The challenge of working on a long-term basis trying to convince high-level policymakers to change existing policies helped them to fine tune all of those skills and be constantly learning and challenged, even though some of the work involved doing things some weren't comfortable with, like public speaking. One advocate also mentioned that at times there was a lot of pressure trying to balance demanding extracurricular activities *and* schoolwork.

The project director fostered positive relationships and a family-like support system with the advocates through meetings, get-togethers, and special lunches and dinners. The project used other ways to foster positive interactions for the advocates that made the project less of a job and more of a student-run club or project where all members give equally of their time, commitment, and ideas. These included: providing lunch at events and meetings, keeping in constant email and phone contact, and setting aside time to celebrate successes and enjoy each other's company. The advocates also enjoyed the strong support they received from LIF and San Francisco Tobacco Free Project. "Without outside support it's difficult," said one advocate. "It's good to be able to lean on the wisdom of people coordinating the group."

CONCLUSIONS

The SFTFP began funding community-based organizations to implement the CAM process in 1995. By 2004, thirty-seven projects had been funded in six funding cycles. Thirty of these projects implemented an action plan towards the accomplishment of an "Action" (that meets the three criteria) and twenty-eight of them successfully accomplished the "Action" itself.

The CAM is designed to have a lasting impact both in developing an individual and organization's capacity to continue social justice work by creating environmental change through policies. Empowering those members of the community most impacted to acquire the skills to change the social structures and inequities through environmental change will address health inequities. The CAM is one concrete model for Departments of Public Health to draw from in funding environmental change projects. All it takes is the will and commitment.

NOTES

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2. M. Haan, G. A. Kaplan, and T. Camacho, "Poverty and Health: Prospective Evidence from the Alameda County Study," *American Journal of Epidemiology* 125 (1987): 989–998.
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4. Center for Disease Control and Prevention, *Tobacco Use among U.S. Racial/Ethnic Minority Groups—African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanics: A Report of the Surgeon General*. A Report of the Surgeon General (Washington, DC: US Dept of Health and Human Services, 1998).

Chapter 7

Tackling the Root Causes of Health Disparities Through Community Capacity Building

Anthony Iton

> *"The problems of poor neighborhoods are as much political as they are technical. That fact suggests the need for a new politics of community-building—one with explicit strategies for exerting pressure on the people and institutions who do not naturally serve the interests of disadvantaged people."*
>
> *- The Aspen Institute*

WHY WE HAVE HEALTH DISPARITIES IN AMERICA

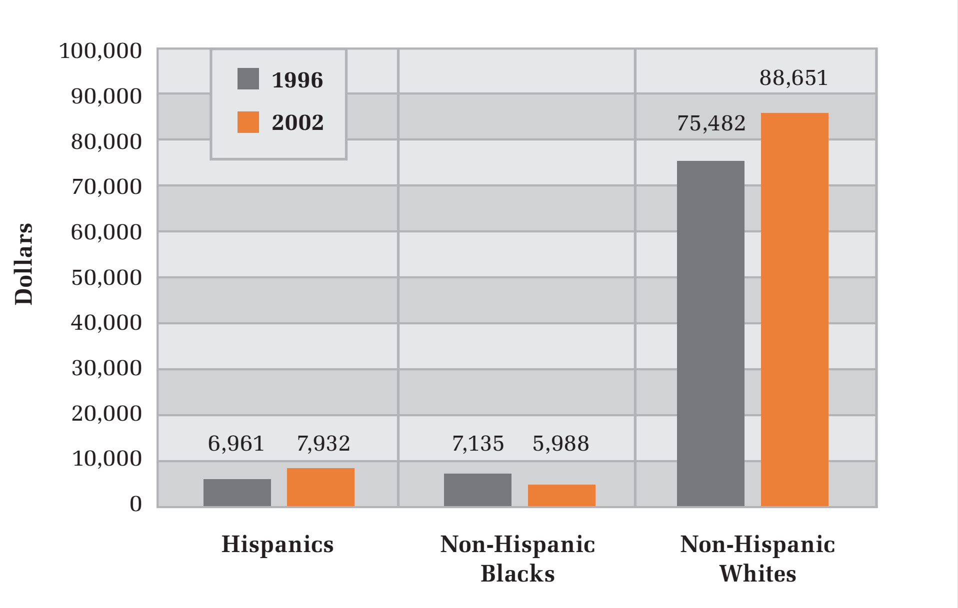
In the United States wealth is the strongest determinant of health. While this phenomenon is by no means unique to the U.S., the strength of this relationship in this country is profound and increasing. In America, wealth equals health.[1,2]

Wealth confers a number of important social benefits that are strongly associated with health outcomes. These benefits include access to a variety of social goods such as high quality education, employment, housing, childcare, recreational opportunities, nutrition, medical care, and safer and cleaner neighborhoods. While this general relationship has been demonstrated in many developed countries, the extent to which access to key social goods is controlled by wealth varies substantially across the developed world. Generally speaking, in countries where there is a well-developed social safety net, there are formal mechanisms designed to facilitate access to key social goods for all economic strata within the society. These mechanisms often include substantial government investments and subsidies for housing, childcare, education, vocational training, employment, medical care, and food access. A direct and intended consequence of these investments is the reduction of the powerful influence of wealth as a determinant of health as a result of conferring independent access to these critical social benefits.

In order to make investments in these critical social benefits, governments generally tax income and effectively redistribute it in the form of greater access to these benefits for lower income groups. As a consequence, in the countries where these investments are in place, there tends to be less inequality in the distribution of income. There is substantial evidence that life expectancy increases and other health indicators improve as the distribution of income and resources in developed countries becomes more egalitarian.[3,4]

In the U.S., wealth is the primary portal through which one accesses a variety of critical social benefits. Further complicating this issue in the U.S. is the enormous disparity in wealth between various racial and ethnic groups and the profound legacy of racial discrimination that is so inextricably embedded in this country's history and political practices, past and present. African-American and Latino households have less than ten cents for every dollar in wealth owned by White households. Approximately one-third of African-American households and one-quarter of Latino households have zero or negative net worth. Nationwide, the percentage of Whites who own their homes is about 75%, whereas homeownership rates for African-Americans and Latinos is about 47%.[5] These racialized patterns of wealth distribution are consistent from community to community across the United States. Furthermore, there is no evidence that this racial wealth disparity is narrowing; in fact, just the opposite appears to be occurring.

Median Net Worth of Households by Race and Ethnicity in 1996 and 2002 (2003 dollars)



Source: Pew Hispanic Center tabulations of SIPP data from the 1996 and 2001 panels.

So if in the American context wealth equals health and wealth is strongly correlated with race, then it naturally follows that there will be a strong relationship between health and race in America and that these large inequities in wealth will translate to large racial health disparities.

CONCENTRATIONS OF RACE AND POVERTY: NEIGHBORHOOD RESIDENTIAL SEGREGATION

In addition to racialized patterns of wealth distribution that lead to a relative concentration of poverty in certain racial groups, the spatial concentration of poverty has also increased sharply in America, creating a *de facto* American apartheid. Between 1970 and 1990, the percentage of urban poor Americans living in non-poor neighborhoods (defined as having poverty rates below 20%) declined from 45% to 31%, while the percentage living in poor neighborhoods (poverty rates between 20% and 40%) increased from 38% to 41% and the proportion living in very poor neighborhoods (over 40% poverty) grew from 17% to 28%. As a consequence, many American neighborhoods are becoming poorer and more segregated. In general in these neighborhoods, poor performing schools are abundant and school dropout rates are high. Additionally, access to transportation, quality affordable housing, adequate parks and recreational opportunities, and grocery stores is often very limited. In addition, these neighborhoods tend to be in closer proximity to sources of environmental pollution. It should then come as no surprise that the risk factors related to chronic disease tend to be found in greater concentration in these neighborhoods. Understanding and illuminating the social, economic and political policies that play a role in creating and reinforcing residential segregation in the U.S. is critical to designing solutions to eliminate health disparities.

NEGLECTED SCHOOLS IN STRUGGLING NEIGHBORHOODS

The majority of U.S. states provide fewer dollars per student to their highest-poverty school districts than to their lowest-poverty school districts. This educational funding disparity forms a consistent pattern across American communities despite the clear evidence that high-poverty schools need more resources to meet the same standards. This fact is even codified in the No Child Left Behind Act wherein Congress established a standard that states should provide districts with *additional funding* per low-income student equal to 40% of the average per student amount. Despite this awareness, these funding gaps between wealthy and poor districts within states remain, and have even increased in some states. In addition, most states also have a funding gap between schools with the most African-American and Latino students and those with the fewest.[6] Finally, there is also evidence of substantial within district funding disparities favoring wealthier white students at the expense of poorer African-American and Latino students within the same school district.[7]

The largest expense in a school's budget (typically 80-85%) is teacher salaries. Educational research has repeatedly documented that effective teaching is critical to student achievement, and low-income students and students of color are consistently assigned to the least qualified, and consequently lowest salaried teachers. It is thus not terribly surprising that based on these funding disparities alone, a substantial achievement gap should be expected to exist between wealthy and poor students, and between white students and African-Americans and Latino students. This achievement gap manifests itself through reduced standardized tests scores, promotion rates and high school graduation rates for African-Americans and Latino youth.

National Graduation Rates by Race and Gender[8]

by Race/Ethnicity	Nation	Female	Male
American Indian/AK Nat	51.1	51.4	47.0
Asian/Pacific Islander	76.8	80.0	72.6
Hispanic	53.2	58.5	48
Black	50.2	56.2	42.8
White	74.9	77	70.8
All Students	**68**	**72**	**64.1**

Nationally, only an estimated 68% of those who enter 9th grade graduate with a regular diploma in 12th grade. In 2001, only 50% of all black students, 51% of Native American students, and 53% of all Hispanic students graduated from high school. Black, Native American, and Hispanic males fare even worse: 43%, 47%, and 48% respectively.[8] Adults need a high school diploma in order to be able to compete effectively for jobs that pay a living wage. Neighborhoods where many residents are high school dropouts are more likely to have higher unemployment, poorer quality housing, poorer schools, and possibly less stable families. Middle and upper class families then point to low test scores and poor quality schools for their decision to move away from these neighborhoods in favor of better schools in the suburbs. Thus, the abysmally poor graduation rates being tolerated in the U.S. for poor African-American and Latino children are contributing greatly to maintaining an American status quo of economically-deprived, racially segregated and generally under-resourced neighborhoods mired in severe social dysfunction. This is the context in which health disparities are created.

PUBLIC HEALTH AS A SOCIAL JUSTICE ENTERPRISE

Public health practitioners that purport to be committed to "eliminating health disparities" cannot labor in ignorance of the persistent social, political and economic forces that create and reinforce such striking patterns of residential racial segregation, educational disparities and profound wealth gaps. Ultimately, when forced to examine how these rigid, apartheid-like patterns of societal organization are maintained, despite the successful elimination of legalized forms of racism following the civil rights movement, one cannot but conclude that at its very roots, the problem lies with a persistent inequity in the distribution of social, political and economic power among racial groups in the U.S. If one accepts this conclusion, then the relevant question for public health practitioners is how do we build social, political and economic power for low-income communities of color.

Public health practice as a social justice enterprise is a concept of public health that recognizes and targets root causes of social inequity. Social justice is a dynamic concept that takes on many different forms in different settings. Fundamentally though, the need for social justice efforts arises wherever significant power imbalances are found. In settings in which justice is in short supply, power will tend to concentrate according to lines of privilege. In this society, privilege primarily flows according to race, class, gender, and to some extent, immigration status. Consequently, many social, political and economic policies tend to favor whites, particularly wealthy white males. There are numerous specific examples of this including the GI Bill, red-lining practices, welfare policy, urban renewal policies, education funding policies and practices, drug use and incarceration policies, affordable housing policies and health insurance policies. One can easily describe these policies and practices collectively as affirmative action for whites. Cumulatively, these policies and practices have created and continue to reinforce America's unique form of apartheid. Any general strain on society whether it be economic recession, new drug epidemics such as crack cocaine, communicable disease epidemic such as influenza, or natural disaster such as Hurricane Katrina, will exact its greatest toll on low-income communities of color that are at the very bottom of the American privilege and power totem pole.

Justice has two key ingredients: truth and power. Without either one of these ingredients, there cannot be justice. Public health practitioners are experts at identifying truth. We have innumerable detailed studies published in peer-reviewed journals describing the clear relationship between various "social determinants of health" and health outcomes. In fact we have entire journals dedicated to these topics. Yet despite the truth being out there, we see relatively little evidence of progress in core health measures for our most socially, politically and economically marginalized populations. This is because public health has still largely ignored the issue of power and its skewed distribution throughout our society. Our work in communities tends to focus on individual-level behavioral change models, intensification of service delivery, and issue-specific community mobilization efforts. Rarely do public health agencies focus squarely on building upon indigenous social, political and economic power in low-income communities of color. What follows is a description of one county's approach.

THE SITUATION IN ALAMEDA COUNTY

Like many, if not most, American cities and counties, Alameda County faces profound and persistent racial health disparities. While significant health disparities can be found that afflict almost every racial and ethnic group, the magnitude of racial health disparities in Alameda County is most profound for African-Americans, Latinos, Pacific Islanders, and Native Americans. In Alameda County, African-Americans experience striking disparities in virtually all of the major health indicators, including coronary heart disease, diabetes, stroke, AIDS, cancer, asthma, infant mortality, low birth weight, and homicide. In fact, of the 19 key health indicators tracked longitudinally by the Alameda County Public Health Department, African-Americans have the worst outcomes in 16 of them.

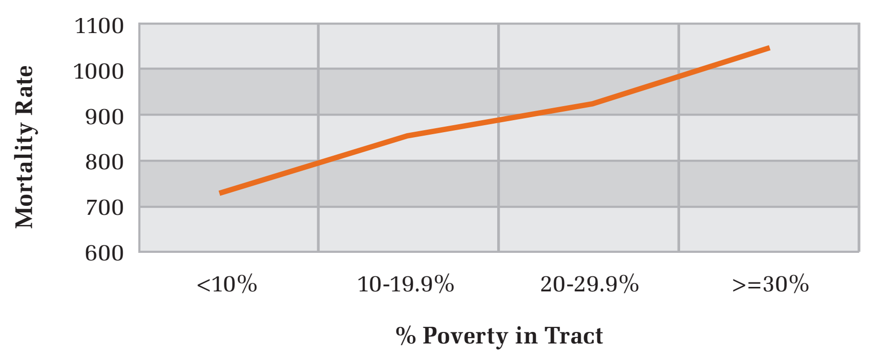
Tracking health indicators by race provides important information about the disparate outcomes of people within various racial categories and suggests the potentially powerful role that racism, both present and past, may play in determining health outcomes in this county. Understanding how race and racism may be mediating this powerful influence on health outcomes in Alameda County requires a better understanding of the complex interplay of a variety of social and economic factors and how their distribution across Alameda County may be strongly influenced by race.

WHY FOCUS ON NEIGHBORHOODS?

In Alameda County, higher rates of disease are observed in low-income neighborhoods independently of a wide range of demographic, behavioral, social, psychological, and health characteristics. Neighborhood of residence has been linked to all-cause mortality, cause-specific mortality, coronary heart disease, low birth weight, perceived health status and rates of violent crime. In Alameda County, the neighborhood in which one lives serves as a fairly good predictor of one's mortality rate. The graphic below demonstrates the strong association between the all-cause mortality rate and neighborhood poverty in Alameda County. Mortality steadily increases as percentage of neighborhood poverty increases. This so-called "social gradient" is strong suggestive evidence that the quality of the social environment itself may play an important role in determining health outcomes.

When one performs a similar analysis of the same overall mortality data now stratified by race (see figure below), two interesting phenomena appear. The first finding is that there is no evidence of a social gradient for Hispanics and Asians in Alameda County. In fact, one might even argue that the data reveals a slight reverse social gradient for Hispanics. That is that Hispanics living in wealthier neighborhoods actually have slightly higher mortality than those living in neighborhoods with high levels of poverty. The second interesting finding is that in neighborhoods where there is a high proportion of households living in poverty, white mortality rates exceed those of African-Americans.

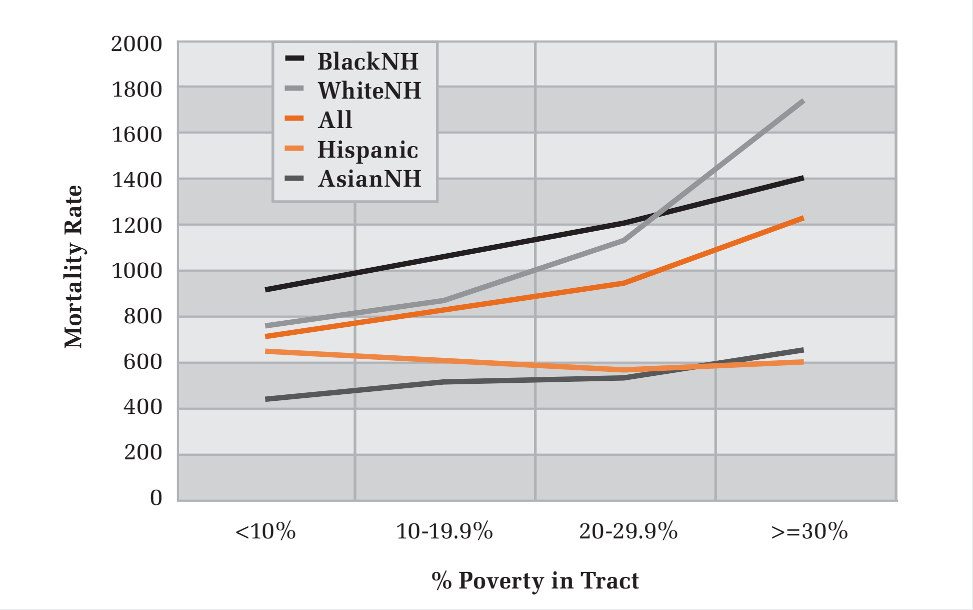
Understanding the underlying causes of these two phenomena may provide some useful insight into the design of public health interventions that can help reduce health


Mortality Rates in Alameda County Census Tracts Grouped by Poverty Rate: Social Gradient

disparities in Alameda County. Several hypotheses might explain the apparent paradox reflected in the lack of a significant social gradient for Latinos and Asians in Alameda County, including the so-called "healthy-migrant theory" which posits that the immigration process itself may select for a healthier sub-population. Additionally, Latino and Asian immigrants may also have health and social behaviors that are health protective, including healthier diets, greater inclination towards physical activity, and a greater cultural reliance on social and peer networks.[9,10] As immigrants acculturate, there is some evidence that they lose some of these protective health behaviors.[11] Public health interventions that attempt to strengthen and support these protective health and social behaviors may in fact lead to improved health outcomes among all Alameda County residents.

The second phenomenon of the cross-over between White and African-American mortality rates as neighborhood poverty increases above 20% is somewhat more complex. It should be noted that only 4% of Alameda County Whites live in census tracts where >20% of the households are in poverty. In stark contrast, over 40% of Alameda County African-Americans live in census tracts where >20% of households are in poverty. Thus African-Americans in Alameda County are 10 times more likely than Whites to live in neighborhoods where greater than 20% of the residents are poor. The few Whites that live in these high poverty neighborhoods have higher mortality rates then their African-American neighbors. A possible explanation for this phenomenon is the 4% of Alameda County Whites that live in neighborhoods with high poverty may suffer disproportionately from profound health and social burdens such as mental illness, alcohol and drug addiction, and severe family dysfunction. These factors, rather than factors related to race may explain their relatively poor health outcomes. Whereas *compared to* the small number of Whites living in poverty in Alameda County, African-Americans in poverty may be less burdened by alcoholism, mental illness, and severe

Mortality Rates in Alameda County Census Tracts by Race by Poverty Rate

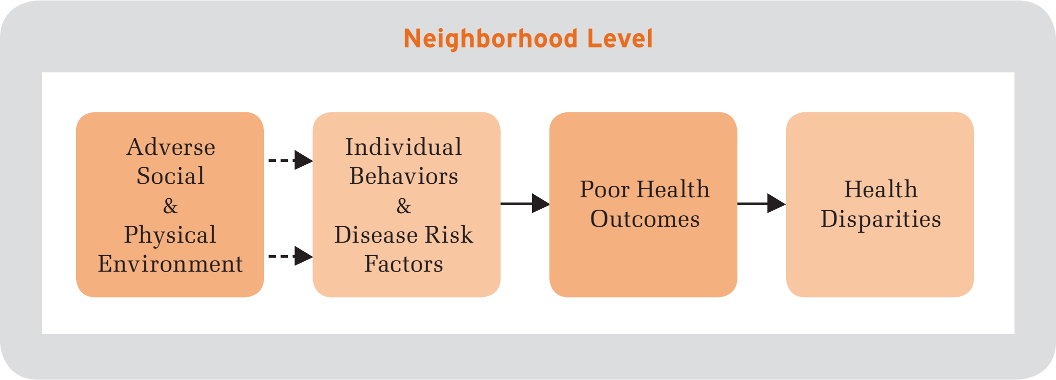


family dysfunction. In essence, Whites may be more often consigned to poverty due to severe social dysfunction and poor baseline health status, whereas African-Americans are to a larger extent consigned to poor neighborhoods due to the cumulative impact of racism, including social, political and economic policies that encourage neighborhood racial segregation.

According to standard measures of residential segregation, Alameda County has among the highest levels of residential segregation for African-Americans in the San Francisco Bay Area. Oakland, the county's largest city, ranks as the second most segregated city for African-Americans in California.

HOW DO UNHEALTHY NEIGHBORHOODS CAUSE UNHEALTHY PEOPLE?

Neighborhoods do not exist in a vacuum, however, for purposes of understanding some of the direct and potent mediators of health disparities, it is initially helpful to artificially isolate the neighborhood context and examine it independent of the larger societal context. What follows is a simplified analysis of the neighborhood-level mediators of health disparities. As stated above, it is clear that factors in the neighborhood social and physical environment are *associated with* disparities in health. However, the extent to which these factors are *causally related* to health disparities remains poorly understood. In order to better understand how these neighborhood-level factors in the social and physical environment may cause health disparities, it is important to delineate the pathways through which this effect may operate.



The above-simplified graphic should not be read to imply that these relationships are linear or unidirectional nor should it be interpreted to suggest that there is no role of genetics, access to medical services, quality of medical services, or individual choice. However, it does propose a possible pathway through which the neighborhood social and physical environment may produce health disparities.

- ***Shaping Individual Behaviors:*** Characteristics of the physical environment such as availability of parks, grocery stores, community centers, and public transportation, create the context in which individual behavioral choices are made concerning physical activity, nutrition, tobacco and alcohol use, and other health-related behaviors. In low-income communities, these neighborhood physical conditions may be operating in a manner that increases the likelihood that certain adverse risk behaviors will be adopted.
- ***Increasing Individual Risk Factors:*** Characteristics of the social environment may produce certain physiological changes in individuals that directly increase their risk of disease. A robust literature base has developed around several proposed theories to explain this including *Weathering, and Allostatic Load*.[12] These hypotheses generally propose a link between the cumulative impact of various social and environmental stressors and human physiological response. In this way, neighborhood-level poverty, racism, crime, lack of education, unemployment, and social isolation act synergistically to produce detrimental physiologic changes (hypertension, increased free radical activity, elevated cortisol, impaired immune system responsiveness, etc.).

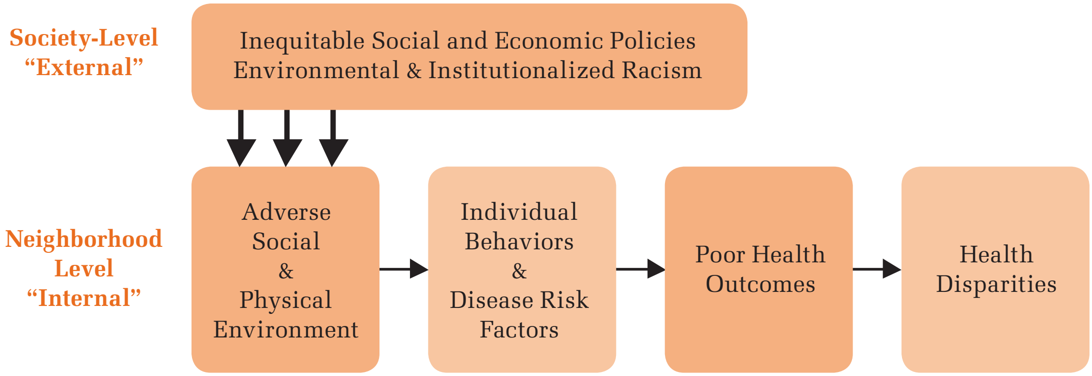
The existence of protective or resiliency factors in the social environment has also been proposed. These factors include high educational attainment, stable family relationships, positive youth-adult relationships, meaningful opportunities for civic participation, positive race/ethnic intergroup relations, timely access to appropriate health and social services, and high career/employment expectations. These factors are theorized to act as a buffer against poverty, crime, racism, etc. and reduce Weathering and the Allostatic Load, thus ultimately improving health outcomes. However, limiting one's focus solely to the *neighborhood level* risks missing the powerful influence of social, economic and political policy in creating impoverished, racially-segregated, and unhealthy neighborhoods.

HOW DOES INEQUITABLE SOCIAL POLICY CAUSE UNHEALTHY NEIGHBORHOODS?

In order to develop successful public health interventions to reduce health disparities one must thoroughly understand the forces that lead to the clustering of health disparities in low-income, minority neighborhoods. The social, political and economic forces that produce these discernible effects in low income communities are identifiable. They include longstanding and pervasive local, regional, state and federal policies that reinforce rigid patterns of social and material disparity between racial and economic groups in this country, ultimately leading to persistent health disparities. Over time these forces have taken many forms including racially-restrictive covenants on property, economic redlining in banking practices, school segregation, housing and urban renewal policies, disinvestment in public transportation, discriminatory zoning practices, law enforcement racial profiling, differential incarceration policies related to drug use and possession, and other deliberate governmental policies and practices. The cumulative impact of these discriminatory policies has created and maintained a well-structured racial and class apartheid in Alameda County and elsewhere in America. While some of these policies and practices have been successfully challenged and reversed, others remain intact. The legacy of decades of these discriminatory policies is indelibly stamped in the health disparities that we are faced with today.

A useful concept for understanding this legacy is that of "institutionalized racism" put forward by Dr. Camara Jones.[13] Jones defines institutionalized racism as "differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and often manifests as inherited disadvantage. It is structural, having been codified in our institutions of custom, practice, and law, so there need not be an identifiable perpetrator. Indeed, institutionalized racism is often evident as inaction in the face of need." Institutionalized racism *causes* unhealthy neighborhoods by systematically starving certain communities of access to key social goods, such as education, health care, adequate housing, recreational amenities, etc., thereby directly creating adverse social and physical environments within these communities.

Countering these powerful social and environmental forces is unquestionably a daunting task. Nevertheless, it is only by eliminating or counteracting these forces that health disparities can be eliminated. The question for local health departments is: What effective strategies can be employed to address these underlying forces that play such a powerful role in producing and perpetuating health disparities?



DESIGNING PUBLIC HEALTH APPROACHES TO TARGET HEALTH DISPARITIES

"Eliminating health disparities will also require new knowledge about the determinants of disease, causes of health disparities, and effective interventions for prevention and treatment. It will also require improving access to the benefits of society, including quality preventive and treatment services, as well as innovative ways of working in partnership with health care systems, State and local governments, tribal governments, academia, national and community-based organizations, and communities."

-CDC Office of Minority Health

Local public health interventions are generally focused at one of four levels: 1) individual, 2) group, 3) neighborhood/community, and 4) the larger society/policy arena. Individual and group-focused interventions frequently are heavily characterized by specific clinical and preventive services such as risk factor screening, immunization, and targeted educational campaigns. Individual and group level interventions dominate local public health practice in the U.S. in large part due to the programmatic requirements embedded in most of the major federal and state public health funding streams.

Public health interventions that focus on neighborhoods or other "places" are rarer despite the fact that many of the exposures to known social determinants of disease occur at the neighborhood level. It is particularly at the neighborhood level that the physical and social environments manifest their deleterious influence on low-income racial and ethnic communities in Alameda County and elsewhere. This is particularly true for young people living in low income communities for whom travel outside of their immediate neighborhood is often infrequent. Thus effective public health interventions to reduce and eliminate racial health disparities presumably must result in discernible neighborhood level change.

The rarest of all local public health interventions are those that are directed to the larger society and policy arena. However, it is in this arena where public health interventions probably hold their greatest potential. While there has been substantial support from public health leaders for social policies that have a direct and obvious impact on access to health services, such as universal health insurance, there has been relatively little organized public health efforts to support other equally health-beneficial policies such as universal pre-school access, improved public school funding, living wage efforts, affordable housing, land use planning reform, public transportation, immigration, incarceration and rehabilitation, and employment policy.

Despite a general effort by our national health leadership to acknowledge the role of "social determinants" in influencing health outcomes, the federal perspective on health disparities too often devolves into a discussion of disease-specific remedial strategies.[14,15,16] Many federal public health organizations frequently frame the issue of racial health disparities primarily from a medical perspective. As a result, the solutions proposed often focus primarily on the intensification of individual medical and case management services to the specific population most afflicted. In this framework, "determinants of health" are often limited to those that are perceived as amenable to individual behavior modification approaches such as tobacco cessation and drug treatment, counseling against high-risk sexual behaviors, and education regarding the consequences of poor nutrition and physical inactivity. However, efforts based on this "medical model" have demonstrated limited efficacy. Additionally, such approaches are generally resource-intensive and consequently unsustainable after the initial infusion of resources inevitably begins to dwindle.

Recently, there has been increasing acknowledgement by HHS, CDC, NIH, HRSA and other federal public health leadership bodies of the contribution to health disparities of factors such as housing and educational segregation, the location of sources of environmental pollution, selective marketing practices of alcohol, tobacco, and fast-food companies, access to transportation, and the availability of parks, open-space and other community amenities. Notably, however, discussions about the health consequences of social and economic policies that produce the inequitable distribution of income and resources across racial groups have been virtually non-existent at the federal level.

EXPANDING THE TRADITIONAL DISPARITIES FRAMEWORK

It is clear that effective public health interventions to reduce and eventually eliminate health disparities will need to be multi-faceted and long-term. In a recent speech in Oakland, former U.S. Surgeon General Dr. David Satcher laid out a useful framework for understanding how to intervene to eliminate racial health disparities. The Satcher framework calls for interventions that address the following five key domains: 1) access to and quality of medical care; 2) individual risk behaviors; 3) the physical environment; 4) the social environment; and 5) persistent discriminatory social policies and practices that serve to deprive many low income communities of the assets necessary to build healthy neighborhoods and result in a pervasive sense of hopelessness.

While there are many published health disparities interventions that focus on the first two domains in the Satcher framework, there are very few that focus on the latter three. It is within these latter three domains that the manifestations of the inequitable distribution of wealth and resources has its most acute impact on racial and ethnic minorities residing in low-income neighborhoods. Examination of the physical environment in these neighborhoods reveals neglected parks, abandoned cars, vacant lots, deteriorated housing, a proliferation of alcohol retail outlets and fast food franchises, a relative absence of grocery stores, and various sources of environmental pollution. The social environment reveals drug dealing, high unemployment, limited business investment, violence, street crime, public intoxication, and general litter. The cumulative effect of various discriminatory social policies and practices creates a spiritual environment that is characterized by hopelessness and a lack of a keen vision for the future, particularly among youth. This sense of *futurelessness* contributes to negative self images and short-term self-destructive behaviors and risk-taking.

WORKING INTERNALLY VS. EXTERNALLY: SOCIAL CAPITAL AND STRUCTURAL INEQUALITY

There is evidence that at the neighborhood-level these forces are operating both internally (low social cohesion, neighborhood disorganization, and lack of leadership) and externally (political, economic and social policies that lead to an inequitable distribution of important social goods such as employment, education and health care). While these internal and external contexts are closely inter-related, public health interventions designed to reduce health disparities that fail to address both simultaneously are much less likely to succeed. Some researchers have highlighted this internal/external dichotomy in critiquing public health approaches that focus exclusively on working within communities to build social capital. They argue that pure social capital building approaches present “a model of the social determinants of health that excludes any analysis of structural inequalities (e.g. class, gender, or racial/ethnic relations).”[17] Others are critical of approaches that focus primarily on legal efforts designed to dismantle specific policies and practices that have a racially discriminatory effect. Such approaches often fail to directly involve the affected community members and consequently do not lead to a sustained increase in community capacity.

The question can be simplistically stated as: Are health disparities due to something wrong within low-income minority neighborhoods, or are they due to something wrong with American society that concentrates health disparities in certain neighborhoods? Our contention is that this is not an either-or situation. Eliminating health disparities will require sophisticated public health interventions that simultaneously address both the internal neighborhood context (low social cohesion, neighborhood disorganization, and lack of leadership) and the external context (discriminatory political, economic and social policies).

Washing one’s hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral.

-Paulo Freire

THE INTERNAL NEIGHBORHOOD CONTEXT: BUILDING COMMUNITY CAPACITY

Not all poor communities suffer disproportionately bad health outcomes. In Alameda County, there is no better example of this phenomenon than the so-called Latino Health Paradox. As mentioned above, Alameda County's Latinos have lower overall age-adjusted mortality rates than Alameda County whites. This finding would seem to refute the conventional wisdom that health outcomes are inextricably tied to poverty level. At a minimum it would seem that other less well understood factors, in addition to poverty, have the potential to substantially influence the health outcomes of communities. What might these factors be, and how are they health protective? The Latino Health Paradox tells us that there may be certain health protective factors in the social milieu that can be identified and enhanced in a manner that would ensure to the benefit of the broader community. These factors are sometimes referred to as resiliency factors and may include strong social networks, meaningful employment opportunities, positive adult-youth relationships, and accessible venues for civic and political participation. Public health departments must become more adept at facilitating ongoing community-level processes that build upon these resiliency factors.

Alameda County Public Health Department has designed a community-led, multi-component public health intervention designed to build neighborhood-level community capacity. The goal of the intervention is to build political, social, and economic power within low-income communities of color within Alameda County. Our community capacity building approach borrows heavily from popular education principles expounded by Brazilian educator Paulo Freire and builds directly upon existing community assets and strengths. The approach focuses on identifying neighborhood assets, most specifically its leaders, and facilitating a coherent and supportive neighborhood social, economic and political infrastructure that will allow these leaders to enhance the natural resiliency of their communities and thereby improve long-term health outcomes.

BRIEF OVERVIEW OF THE COMMUNITY CAPACITY BUILDING STRATEGY

In conjunction with partners from county, city and community-based agencies and religious and neighborhood improvement organizations, Alameda County Public Health Department (ACPHD) has designed a multi-component, community-level intervention that is targeted at building community capacity in the low-income neighborhoods in Alameda County, thereby supporting and enhancing four key protective/resiliency factors: 1) positive adult-youth relationships, 2) meaningful opportunities for community participation, 3) high career/employment expectations for youth, and 4) improved race/ethnic inter-group relations. The approach is in part based on MAPP, a product of NACCHO, but substantially modified for application to the neighborhood level in a low-income, diverse urban community.

The intervention is three years in duration and has six core components:

1. Conducting a Baseline Door-To-Door Community Survey and Needs/Strengths Assessment (repeated three times during the course of the intervention)
2. Establishing a Resident Action Council
3. Instituting a Leadership Training Program
4. Establishing a Resident-To-Resident Grant-Making (Mini-Grant) Program
5. Establishing a Time Dollar/Neighbor-to-Neighbor Bartering Program
6. Facilitating Youth Economic Development Programs

The multiple components of the intervention are facilitated through the creation of a Resident Action Council (RAC) in the target neighborhoods. A Core Team in each neighborhood, comprised of representatives from local schools, churches, neighborhood associations, community-based associations and from city and county departments, supports the efforts of the respective neighborhood RAC. Meals, childcare, simultaneous translation services and incentives are provided for all intervention activities. Community meetings take place at locations identified by our community partners. What follows is a description of the community capacity building process in Sobrante Park, a low-income, diverse neighborhood of Oakland, California.

Component 1: Community Survey Needs/Strengths Assessment and Community Forum

The first step in the community capacity building process is conducting a survey that focuses on identifying neighborhood assets, needs and priorities. The standardized community survey is designed to measure neighborhood social capital based on existing validated instruments. In Sobrante Park, a youth and adult survey was performed by community residents and volunteers. These surveys served as the baseline assessment for the intervention. A total of 219 adult and 100 youth completed surveys in Sobrante Park. All respondents were asked if they wanted to participate in efforts to improve their community and were invited to provide their contact information (separate from the survey).

A follow-up activity was the hosting of an all-day Community Forum, attended by 61 residents, held in Sobrante Park in September 2004. Results of the community survey were presented and discussed, focusing on the neighborhood strengths and the areas for improvement that survey participants identified. Residents prioritized the top three areas for action from the list of neighborhood areas for improvement compiled from the survey results. They prioritized several physical and social characteristics of their neighborhood for change:

1. Improving the local park to provide safe, supervised recreation for youth;
2. Reducing drug use and dealing; and
3. Increasing positive youth activities.

Participants developed short- and long-term goals for addressing each of the priority issues, and agreed to join the Resident Action Council (RAC).

Component 2: Resident Action Council

The Resident Action Council (RAC) is the strategic planning and decision-making body where residents address issues related to neighborhood change on an on-going basis. This organized residential structure will remain in place after the completion of the intervention to insure sustainability of the neighborhood changes. Monthly 2.5-hour meetings provide an opportunity for residents to share ideas, bring suggestions, and form subcommittees to develop and implement action plans. Monthly minutes are distributed to the Core Team so that they can better support the resident-driven efforts.

The criteria for participation include living in the neighborhood, reflecting the diversity of the neighborhood, having a sincere interest in improving the neighborhood, and committing to participate for one year. All members participate in 2-3 days of initial leadership training and then receive additional training throughout their involvement in the RAC.

Due to successful recruiting, a total of 60 residents, of whom 40 are youth between the ages of 13 and 21, have joined the Sobrante Park RAC. The RACs will receive facilitation, administrative and technical support in their efforts from key staff of the Alameda County Public Health Department.

Component 3: Leadership Training

Leadership Training has been provided to the Sobrante Park RAC. This training will prepare local leaders to take a more active role in bringing about change in their community by developing their practical skills in the areas of community organizing, neighborhood problem-solving and political advocacy.

All RAC members participate in 16 hours of initial leadership training, for which the ACPHD has already piloted a curriculum. Additional training will be provided to the RAC on an on-going basis. Staff experienced in both youth- and adult-focused training will develop additional modules incorporating field-tested curriculum that will cover the following topics:

Community Organizing Skills

- Unlearning Oppression & Racism Training
- Conflict Mediation
- Recruitment Techniques
- Issue Identification and Prioritizing
- Action Planning
- Public Speaking
- Meeting Facilitation

Problem-Solving Skills

- Community Assessment
- Assessing and Using Data
- Asset Mapping
- Policy and Advocacy
- Campaign Management
- Media Advocacy
- Fund Raising and Grant Writing

Component 4: Community Mini-Grant Program

A committee of 10-12 youth and adults will be recruited from the RAC membership in each neighborhood intervention site to develop and implement the Mini-Grant Program for their respective neighborhood. The program provides mini-grants ranging from $250-$1000 that the resident-led committees award to fellow residents who have initiated community improvement projects.

The program will support the leadership development and social integration and cohesion of multiple levels of participants: committee members, grantees and project participants. The resident granting committees will help plan and implement the program and make all funding decisions. Committee members will benefit from in-depth leadership development opportunities, enhanced relationship-building and mentoring. Grantees will not only receive financial support for their projects—they will also be assisted in developing project ideas, writing proposals and implementing project activities. Community members who are reached through the granted projects will make new relationships and have further opportunities to get involved in their neighborhood. ACPHD staff who have experience implementing this program throughout Alameda County will provide training, technical assistance and mentorship to participants.

Component 5: "Neighbor to Neighbor" Time Dollar Exchange

A Time Dollar Exchange (TDE), the "Neighbor to Neighbor" program will be established in Sobrante Park. Time Dollars are a type of community currency that is earned by helping others and is spent by getting help from others. They can be exchanged for goods and services among a network of people and organizations. The TDE creates a reciprocal multi-ethnic, cross-generational network within the community where every member is respected and valued for their time and talents. Community members are able to trade their time, providing each other with valuable services such as care for the elderly, tutoring or home repair. In turn, community relationships and interdependency are enhanced.

In October 2004, co-founders of the Time Dollar Institute, Edgar Cahn and Chris Cahn, provided orientation and training to 25 participants who are working or living in Sobrante Park and other parts of Oakland. Our "Neighbor-to-Neighbor" program will be a member of the Time Dollar Institute, which nurtures the network of independent Time Dollar Initiatives throughout the world through its publications, annual conferences, ongoing trainings and evaluation services.

Component 6: Youth Employment & Career Development Strategy: Developing Skills, Experiences, Jobs, Career Paths and Enterprises

Unemployment, underemployment and the explosion of youth participation in underground economies are widely regarded as factors contributing to community deterioration. The Youth Economic Development Program, provided by our collaborating partner, Project YES!, is designed to address these issues by both preparing participants for jobs in the labor market and creating new jobs and internships. Beyond offering traditional vocational educational services, the program will address the severe shortage of viable economic development opportunities available to these communities by building social capital, creating jobs through the operation of innovative social enterprises, and actively partnering with the City of Oakland to leverage labor market attachment opportunities inherent in their community revitalization efforts. This program will be offered to all community residents who are under twenty-five years of age and who have completed the Leadership Development Training. The four interdependent components of the program are as follows:

JOB TRAINING AND SKILL DEVELOPMENT

Youth participants will be placed in the job training and skill development component, which will provide employment training, case management and coaching as the first step in facilitating their attachment to the labor market. Participants will receive training on time management, teamwork, conflict resolution, money management and job search skills. Participants will also receive customized training targeted to Alameda County's strongest labor market sectors, including health, food services, retail and professional services. Project YES! staff will provide on-going coaching for one year following placement through intensive case management.

INTERNSHIPS AND CAREER TRACKING: HEALTH FIELD

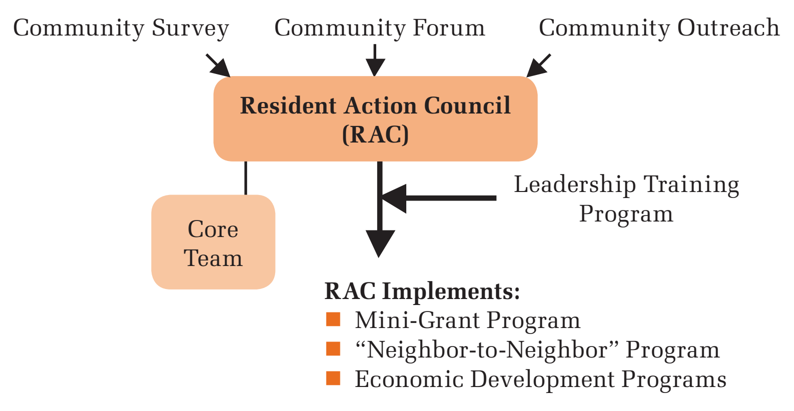
Youth interested in the health field will be enrolled in one of two health internships offered through the Project YES! Teen Clinic programs operated by Children's Hospital Oakland (CHO). Each year these programs will offer twenty paid health educator positions, one operated by Health Information For Youth (HIFY) and the other by CHO's nationally renowned Faces for the Future (FF) program. Youth participating in both programs will serve as paid peer health educators and will be supported in providing trainings and presentations in schools and community forums, as well as producing various public information campaigns using youth-appropriate social marketing health materials. In addition, the FF program places participants in a three-year internship program which introduces underrepresented minority high school students to health professions through "mini residencies" within the hospital and provides intense case management to facilitate movement into health professions.

JOB CREATION THROUGH ENTERPRISE DEVELOPMENT: COMMUNITY OWNED AND OPERATED BUSINESSES

Project YES! has committed to link job-ready participants to all four of its community owned and operated businesses, which include an Internet café, a graphic design business, a recording studio, and a social marketing company. These businesses, which will employ approximately fifty youth at any point in time, will exist as private not-for-profit entities that re-invest excess revenue in businesses expansion and the development of an employee base from within the two communities. Participants in all three enterprises will receive business-specific training, externships in related businesses, paid employment within the business, and support in pursuing continuing education in their fields through a network of relationships with colleges and advance trade institutions.

LABOR MARKET ATTACHMENT AND COACHING: LINKAGE TO EXISTING AND PLANNED REVITALIZATION PROJECTS

The City of Oakland has committed to partner with Project YES! to link our program participants actively to the employment opportunities created by the more than $3 billion in community revitalization efforts in the Council Districts encompassing Sobrante Park and other areas of Oakland. This represents hundreds of employment opportunities within the retail, construction, and professional services fields for the participants of the Youth Economic Development Program.



Schematic Overview of Neighborhood Level Community Capacity-Building Intervention

THE EXTERNAL CONTEXT: BUILDING SOCIAL, POLITICAL AND ECONOMIC POWER

Politics is the struggle over the allocation of scarce and precious social resources. Counteracting the forces that control the distribution of social goods and create the conditions in neighborhoods that lead to health inequities is a daunting task for local public health departments. This is particularly true when local public health agencies are confronted with the neighborhood level consequences of these broader societal and political forces. In addition, while many of the more potent discriminatory forces have been struck down in law, their long term legacy remains, for example, in profound residential racial segregation. While there is some evidence that residential racial segregation is improving for some groups, that improvement is very modest and gradual in pace. It is therefore often difficult to observe progress in undoing these effects in the timeframe of most public health interventions.

Nevertheless, there are many examples of disease-specific public health interventions that target the broader social, economic and political spheres such as tobacco control, and automotive safety efforts (e.g. changes in laws relating to seatbelts, motorcycle helmets, and drunk-driving). However, public health efforts that target broader determinants of health such as education, land-use planning, wages, benefits and employment, transportation, affordable housing, etc. are rarer. If one adopts the position that health disparities ultimately emanate from the fundamental power imbalances that are consciously maintained in our society, then one must conclude that efforts to build social, political and economic power within those communities that suffer most from health disparities is the only sustainable long-term solution.

Local public health agencies can provide considerable support to righting this power imbalance by striving to highlight the health implications of a variety of policy choices. Health agencies can legitimize grass-roots community-led efforts around living wage campaigns, environmental justice, and benefits for low-income workers such as janitors, nursing home aides, and hotel workers. Local health agencies can also become adept at conducting “health impact assessments” to make tangible the impacts of certain policy choices. Furthermore, local health departments can demand a role at the table in various local and regional policy-making tables such as those of land-use planning and transportation agencies, criminal justice and corrections boards, and boards of education.

One recent example was the Department’s efforts to support the cause of a group of low-income, elderly Chinese residents of rent stabilized housing in downtown Oakland. A wealthy real estate developer and generous political contributor had sought to interpret a ten year-old affordable housing agreement between his real estate company and the City of Oakland in a manner that permitted him to evict these elderly long-term renters from a building in order to convert it to market rate condominiums. In response to a request from neighborhood activists, ACPHD weighed in on the part of the elderly renters noting the well documented public health literature that illustrates the deleterious impact of the disruption of neighborhood social networks on the health outcomes of elderly communities of color. This testimony served to bolster and legitimize the position of neighborhood advocates who benefited from the credibility of the health department in what might otherwise have been perceived as a purely political struggle. Other examples include efforts to support the rights of striking nursing home workers and janitors, advocacy for improved grocery store presence in low income neighborhoods, supporting the closure and mitigation of environmental sources of pollution in communities of color, and support for litigation against regional transit agencies whose funding practices disadvantage disproportionately non-white bus ridership versus heavily white train ridership.

Public Health departments can also sustain efforts to address health inequities by building the capacity of community groups and residents to collect data, analyze, interpret, understand, and disseminate results so communities themselves can better advocate and represent their interests in the policy arena. An example of this is the support that ACPHD gave to a youth community group that had advocated for a free and reduced-price student bus pass that was threatened with elimination by the transportation commission. The youth were interested in surveying their peers to document how the increase in the student bus pass prices would affect the lives of area youth and to examine the local experience of being bus riders. They requested and received assistance from ACPHD to help develop a survey results database, including training in inputting surveys results and help conducting simple statistical analysis. The youth group administered surveys to over 1000 middle and high school transit riders. The findings of the survey were used to mobilize the broader community to successfully advocate for the continuation of the discounted student bus pass.

Alameda County Public Health Department has endeavored to assert the public health interests of our low-income residents of color in each of these venues when possible. Most often this is done in partnership with community-based organizations in order to maximally leverage our credibility. However, the vast array of different venues for protecting these interests makes this approach very challenging.

SUMMARY

In virtually every public health area of endeavor, be it immunizations, chronic disease, HIV/AIDS, STDs, obesity, or even disaster preparedness, local public health departments are confronted with the consequences of structural poverty, institutional racism and other forms of systemic injustice. Disproportionate amounts of public health resources are expended in neighborhoods where unhealthy social and physical environments reflect the cumulative impact of profound and unjust social, political and economic forces. By designing approaches that are specifically designed to identify existing assets and build social, political and economic power among residents of afflicted neighborhoods, local public health departments can begin to sustainably reduce and move towards eliminating health inequities in low-income communities of color. Additionally, local public health agencies must simultaneously seek opportunities to strategically partner with advocates for affordable housing, labor rights, education equity, environmental justice, transportation equity, prison reform, and other disciplines to change norms regarding the distribution of those critical social goods that have a powerful influence on health outcomes. Without such a focus, local health departments will most likely only succeed in tinkering around the edges of health disparities at a cost too great to justify.

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Chapter 8

Lessons from the Turning Point Initiative: Implications for Public Health Practice and Social Justice

Vincent Lafronza

OVERVIEW

Communities across America are struggling with increasing health inequities whose root causes are often beyond the scope of contemporary public health practice. This work presents unique challenges for public health practitioners. In this chapter, I have the privilege of sharing lessons learned by local public health agencies (LPHAs) about their vital roles in addressing health inequities from the upstream journeys of community partnerships that participated in the national initiative entitled, *Turning Point: Collaborating for a New Century in Public Health.*

Many LPHAs struggle with the notion that their programs should address issues of social justice. How could one agency tackle deep-rooted injustices related to racial and class discrimination, socioeconomic disadvantage, poor housing stock, and a myriad of other social forces that drive population health status? Shouldn't LPHAs just focus on their mission to provide everyday public health services such as preventing the spread of West Nile Virus, inspecting restaurants, family planning programs, immunizations, communicable disease surveillance, and so on? Won't inequities in health be addressed by providing access to services to all community residents?

These questions are understandable. History has shown that indeed one agency simply cannot address these issues, nor should one agency attempt to do so. However, given the clear case for the legitimate role of public health practice presented in Chapters One and Two, LPHAs can indeed significantly influence the scope of practice that a community undertakes and its impact on reducing the inequities in health status found in every community.

Turning Point's lessons can assist LPHAs to identify the roles and functions they can play in organizing a partnership to address social determinants of inequities in health. Much of this leadership role can be effectively achieved by expanding the scope of public health practice to address social issues that influence health outcomes. As discussed throughout this guidebook, this approach differs significantly from disease-based approaches that target illness after its onset. The lessons presented below can provide ideas from field-tested approaches to adopt a community-health model that engages the widest public audience possible in the interest of identifying causes – structural and otherwise – of poor health and developing a comprehensive framework to improve population health outcomes. Every community must develop approaches tailored to the unique issues and political contexts. The ideas and strategies presented herein can be readily adopted in other locales.[1]

TURNING POINT'S BACKGROUND: A DEMONSTRATION PROGRAM TO REVIVE PUBLIC HEALTH

The 20th century has brought major advancements in the health of the American public. People live approximately 30 years longer today than they did 100 years ago. Moreso than advances in medical treatment, this accomplishment is largely the result of improvements in our ability to improve health at a population-wide level through prevention and health promotion, the principal function of the public health system. Twenty-five of those 30 added years are due to public health successes, such as improvements in water and food quality, healthier living and working conditions, increased understanding of disease epidemiology, and greater public awareness about health concerns.[2] America's investment in creating an infrastructure for public health work made these and similar improvements in the population's health possible. In 1900, only a small number of cities had local health boards, and no county health agencies existed.[3]

At the turn of the 21st century, almost 3,000 public health agencies serve most of our states, regions, counties, territories, and cities, as well as a wide range of other governmental and private/non-profit organizations and community groups. While too often overlooked, a tribal health infrastructure exists, and serves 562 federally recognized tribes, and also includes Urban Indian programs in many cities.[4] This infrastructure helps to provide services to over 4.1 million American Indians and Alaska Natives.

As public health practitioners work to enhance their efforts and increase public support, the country has never needed a strong public health system more. The U.S. faces challenges related to the emergence of new diseases such as HIV/AIDS, and the re-emergence of old ones like tuberculosis, which is gaining new strength. Increasing numbers of toxicants pollute the environment. These and many other health threats exist in a social context brought on by such trends as increasing control of national economies; dramatic demographic shifts; uncontrolled urban sprawl; reduced federal and state revenues for investments in basic human needs and community infrastructure; and a new political climate hostile to publicly funded social services.

In the past few years, America was not ranked among the industrialized nations' top ten for protecting and promoting the public's health. Exemplifying this, recent data show the U.S. ranked 24th (down from 19th in 1989) among industrialized nations in infant mortality, the single most common public health indicator.[5] Overall, social and economic disparities have increased dramatically in the last 25 years, and highly correlate with increasing health disparities.[6] Most health inequalities are strongly related to cumulative factors sometimes viewed as outside the purview of public health's mission: wealth and income inequality, inequities in social and economic status, and social conditions associated with unsafe housing, poor education, turbulent labor markets, institutional racism, and unsafe working conditions.[7]

In recent years, public health practice has moved still further from its social roots through the gradual adoption of a more biomedical approach.[8] Reducing health inequity, and therefore reducing social and economic inequity, is shown to be directly related to health improvements not only for targeted population groups, but for the overall population as well.9 Hence, public health advocates must become advocates for social change related to improving social conditions. Systems improvement demands an honest look at how issues of race, class, and gender influence who is healthy and who is not, who is a partner in systems improvement and who is not, how the community defines health problems, who has decision-making power, and which communities/neighborhoods and organizations have resources, and taking action to change these realities.

TURNING POINT: MEANT TO REVIVE AND MODERNIZE GOVERNMENTAL PUBLIC HEALTH

In light of the aforementioned issues, and based on experience from previous foundation programming, W.K. Kellogg Foundation (WKKF) and The Robert Wood Johnson Foundation (RWJF) developed Turning Point: Collaborating for a New Century in Public Health. Inaugurated in 1996, Turning Point's goal was to transform and strengthen the current public health infrastructure so that states, tribes, communities, and their public health agencies may respond to the challenge to protect and improve the public's health. To achieve this mission, the developers attempted to create a safe learning environment for partners to work collaboratively on analyzing and addressing significant challenges pertaining to public health systems improvements.

Grants to community partnerships were small by design, and meant to supplement organizational and financial resources already within the community. Seventeen of 41 communities received up to $100,000 of additional support toward the continuation of innovative implementation activities through 2001. Due to the governance structure of governmental public health and considerable scope of work, two National Program Offices were established to provide program direction and technical support to partnerships. Funded by WKKF, NACCHO supported communities and tribes; RWJF funded the University of Washington School of Public Health and Community Medicine (UW) to support participating states (to view a list of all partnerships, visit www.turningpointprogram.org).

The national Turning Point effort sought to facilitate systems improvement by providing public health practitioners and their diverse array of partners with support to 1) consider innovative strategies for collaborating, and 2) transform and strengthen public and community health practice. In this light, partnerships are working to develop a more organized, collaboratively-based public health system. Effective partnership approaches transcended government-only models that vested sole or primary responsibility for public health within one or a few agencies. They also moved toward more broadly shared responsibility, engaging a variety of sectors and constituencies in communities, states, and tribes.

At the conclusion of the local planning and implementation process, local partnerships anticipated that they would have:

- defined key public health functions and services relevant to addressing current and future community needs and priorities;
- engaged and actively involved the entire community including those segments of the community with more severe problems in the identification of significant public health challenges;
- assessed changes needed to assure increased understanding and application of community-based public health principles for improving community health;
- agreed upon an appropriate array of health protection, health promotion, and preventative/primary health care services for the whole community, including uninsured, underserved and otherwise disadvantaged populations;
- developed and initiated a community health improvement plan to enhance policies and programs for advancing the public's health;
- established an effective public/private partnership to advocate for and sustain the necessary shifting and sharing of responsibilities for building a healthy community;
- promoted significant integration of the clinical health care and public health systems; and
- promoted significant integration of the pubic health systems with health-related activities in fields such as agriculture and environmental protection.

Public Health Practice: Context and Assumptions

The initiative was not designed specifically to address issues of social justice. But its premises, described below, and strong community component provided a unique opportunity to focus on the root causes of poor health status and quality of life. This approach presented opportunities to work with those most affected by poor health status to inform the changes needed in the public health and health care systems.

Addressing these issues from a social justice issues lens was challenging for many working in local government. The system did not readily reward this type of focus, and partnerships quickly learned addressing the root determinants of inequities in health requires upstream practice changes to address conditions that cause populations to become ill. These struggles are not new. The Institute of Medicine has argued that the public health system is highly fragmented and both inefficient and ineffective at community and state levels. Advocates for public health have argued that the fragmentation in service delivery was partly the result of uncoordinated funding streams and the absence of social and political support for assuring population-based health improvements. The Turning Point initiative, therefore, supported integrating all of the entities that play a role in improving health. This involved creating partnership *systems* that could better address root causes of inequities in population health status. But Turning Point participants learned that public health problems differentially affect disparate populations/constituencies, and often, the constituencies most adversely affected have little voice in policy making or service delivery. Turning Point sought to engage the broadest public participation in sharing responsibility for decisions that affect public health, making special efforts to engage those historically excluded from participating in planning and decision making.

Addressing fragmentation through partnership development required a comprehensive approach that integrated multiple processes and functions and coordinated decision making and health planning that reflect communities' perspectives. Turning Point sought to facilitate this *systems building* by providing public health practitioners and their partners with a learning environment to examine innovative strategies to reshape the future of public and community health practice. Effective partnership approaches transcended government models that vested sole or primary responsibility for public health within one or a few agencies, and moved toward more broadly shared responsibility engaging different institutional sectors, as well as all constituencies in communities and states. In the long run, these strategies made additional resources available and created much larger and diverse constituencies actively engaged in supporting public health.

Turning Point promoted the formation of new and innovative partnerships where partnerships were viewed as a means to improve public health. This approach was based on the following assumptions:

1. Groups with different histories, cultures, missions, authority and jurisdiction can best coordinate their efforts and investments in public health if they understand each other and can determine the most appropriate contribution for each group.
2. Experience working together contributes to increased trust, which is essential to confront inevitable and periodic conflict without undermining working relationships.
3. Identifying and influencing the social determinants of health, such as poverty, demands leveraging many resources across neighborhood, local/jurisdictional, state, tribal and national levels.
4. Effective improvements in health require enhanced integration of diverse fields to address a broad scope of public health activity.
5. Improving the health of a community necessitates the collective voices and efforts of its members.

Turning Point's view of an effective public health system is one that actively participates in collaborative decision making with various organizations and institutions about housing, transportation, crime, employment, agriculture and other vital realms of social life that affect the health of communities. This means that improving health transcends the traditional functions performed by public health authorities. In this light, an effective system extends to engaging a broader constituency of diverse fields to take anticipatory action to develop healthy communities, instead of responding to problems as they arise. Such an approach requires states and communities to anticipate and address inequitable distributions of social resources and differential impacts of plans and actions designed to improve health. Effective and sustainable solutions necessitate engaging multiple fields in activities to promote healthy communities, recognizing the health status implications of interlocking determinants of health, including but are not limited to culture, poverty, income, and education.

Critical to this process is a greater emphasis on community dialogue involving constituencies from diverse cultures, educational backgrounds and political affiliations. Participants from education, faith communities, housing and social services, business leaders, insurers, providers, payers, and others sectors were involved in the integrated planning process for community health improvement. The anticipated result of these interactions and planning processes is the creation of an efficient public-private system of strategic interventions that improve the health of the public. In this light, Turning Point seeks to create a process that moves beyond individual leaders, relationships and subsequent networks to a *system*, as reflected in operations, policies, practices and values.

HIGHLIGHTED LESSONS LEARNED ABOUT TRANSFORMING GOVERNMENTAL PUBLIC HEALTH PRACTICE

Among the many lessons learned, the following five areas capture important insight for LPHA leadership in addressing health inequities.

Stimulating Public Health Practice Innovation Requires a Safe Haven

The foundations and national program offices experimented with a number of learning approaches and technical assistance efforts to support the experimentation of grantees. We realized that the initiative's purpose was quite challenging, and that practitioners, many of whom worked in state and local governments, were forced to operate in fairly rigid systems that failed to encourage innovation. Moreover, successfully embracing the mission of Turning Point required working with organizations not directly responsible for health. It also required working with a broader public and building organized constituencies capable of working together on common issues that would impact health. These efforts require great leadership, skill, and risk taking. Not surprisingly, the foundations and national program offices often disagreed on what approaches would best support grantees. State- and community-level obstacles and tasks naturally differed. The following themes depict salient lessons learned about community partnership development and coordinated action to achieve Turning Point's mission.

Community Forums Are an Important Venue for Addressing Health Inequities

Building on the momentum from the Turning Point-affiliated Race, Class, and Health satellite teleconference, health inequities and the social determinants of health are now major focus areas for NACCHO. The 2001 NACCHO conference, *Confronting Disparities: Addressing the Social Determinants of Health*, was dedicated entirely to the subject. Further, NACCHO's role in assisting the New Orleans and Tri-County New Mexico

Turning Point partnerships in launching planning and action to address specifically health disparities and social conditions that impact health has led to greater insight on how to support communities in such efforts.

To advance this progress, NACCHO applied what was learned from the work of New Orleans and the Roswell area of New Mexico, as well as from the exemplary process of the Minnesota Health Improvement Partnership (an RWJF-funded Turning Point group), and sponsored a two-day pilot national workshop for a group of communities on creating a sustainable community movement and developing action plans to confront health inequities. NACCHO also worked closely with three rural health partnerships in Onslow (North Carolina), Cochise (Arizona), and Fort Peck (Montana) on the injustices associated with health inequities and the social determinants of health. This work focused on the following topics: a) What do we mean by health inequities, what does the research show, why do they exist, what are the main causes, and why are they bad for everyone? b) Why is it so difficult to address and discuss them in relation to policy and social change beyond educating individuals, and services to individuals? c) How can we reframe the way we look at inequities so others will understand what we mean? And d) What can we do to address them?

These three community workshops proposed a visioning exercise with the three partnerships that would enable them to work with their constituents to: a) explore what a socially just society looks like and what values it would express; b) identify public policy agendas and the type of social change necessary to realize a socially just society, and c) develop a useful strategy for getting there, however slowly, based on their goals and objectives. Questions included: a) what kind of society they could imagine assuming the power and resources to bring it about; b) the barriers to realizing what they imagine; c) public policies or other kinds of social change required to achieve a healthier and more desirable community and overcome the barriers; and d) the process and organizing strategy to get there, and the communications strategy, concepts, and language that will be needed to offer opportunities for insight, shift consciousness about what is desirable and possible, and about the ideas necessary to get there.

Many of us who participated in the initiative did not fully appreciate the challenges we would face with respect to forming and sustaining new partnerships. We frequently encountered philosophical challenges regarding public health's mission and scope. Many community partnerships were eager to embrace a wide spectrum of issues that impacted population health status, committing to focus on violence prevention and youth development, as examples. Some state and local health departments were challenged by the diversity of issues community partners raised. These lessons demonstrate the wide array of obstacles that must be addressed to work collaboratively on addressing health status, and in particular, health inequities. Addressing population health inequities requires adopting broad approaches and working with diverse partners outside the realm of state and local government. Governments provide services to citizens. Service delivery models are readily adaptable to disease-specific health problems, but can present challenges to community-wide interests to address larger social and economic causes of health problems triggered by social injustice. Partnerships that embraced and facilitated a broad scope of public health activity reported greater

New Orleans and Roswell Focus on Health Disparities

In New Orleans, the Healthy New Orleans Partnership led the discussion on a range of issues, particularly institutionalized racism, poverty, social and class inequality, health education, and low wages. As part of the suggested action plan, participants advocated for collecting and presenting more information on community health status, educating the community on the nature and effects of institutionalized racism, promoting knowledge of inequities in the mass media, and organizing community health councils to develop neighborhood action plans.

In Roswell, a city with considerable poverty and high mortality rates, participants discussed the impact of racism, violence, lack of resources, bureaucracy in the health and justice systems that create inequities, and the effects of economic disinvestments. Participants, led by the Tri-County Partnership, determined that improved public health services are needed in the city's poverty-stricken areas and that there is a strong need to invest in children, better enforce child support laws, provide equal protection and enforcement of laws, and provide resources to assist residents with the health and justice systems.

In both communities, the dialogue helped to strengthen alliances and draw attention to the systemic forces and decisions that make populations vulnerable to health inequalities. Participants at each workshop included health practitioners, public officials, community residents, educators, and representatives from faith-based groups, among others. Both dialogues explored the effects of economic development on community health.

success at engaging sustainable community involvement in problem identification and solution development.

In almost every Turning Point site, groups learned that *community participants* (those outside of the formal public health system) were eager to help identify root causes of poor health outcomes and reduced quality of life. Many individuals did not necessarily trust those working in government, but nonetheless were willing to participate in community action. The approach is important, and can significantly influence the success of participation. Often, an intermediary organization outside of a governmental entity (i.e., a faith-based organization or other CBO) was the most effective vehicle to engage participants and create a community dialogue on health and its improvement. By working with a wide array of partners, Turning Point partnerships quickly broadened the scope of public health practice available to the public, including but not limited to crime prevention and economic development. Participants described the importance of the process and experience, which created the opportunity for learning and perspective transformation. Many partnerships now have a productive relationship with the mass media. This takes great effort initially, but over time, media representatives also began to see the value in providing a voice for those whose living and working conditions created disproportionate levels of poor health outcomes.

These lessons are important for any public health practitioner. Delivery systems must be assessed continually and modified to meet the needs of impacted populations, and the organizations most trusted by those impacted can be valuable contributors. Almost all partnerships reported beneficial outcomes, and over time, a few Turning Point sites now report evidence of population health improvement resulting directly from their new collaborative capacities.

Organizational Policy Change Can Advance Community Development

Partnerships embarked upon efforts to increase the capacity of community-based groups that could participate in and contribute to public health practice. In light of NACCHO's audience, the Chicago Partnership for Public Health provides the most applicable example of how local government can develop policies and a structure to engage a broader public. The Chicago Partnership provided the following description of their work.

Chicago Partnership for Public Health

by Erica Salem

Under Chicago's Turning Point initiative, the Chicago Partnership for Public Health developed a plan to strengthen the local public health system. Key among the plan's recommended strategies were those designed to create a public health constituency and build the capacity of communities to participate in and affect the priorities and resources of public health and related systems. The Chicago Partnership envisioned that this would be achieved through the establishment of a linked network of community-based coalitions, supported by both the Chicago Partnership and the Chicago Department of Public Health (CDPH).

With Turning Point implementation funds, the Chicago Partnership piloted a model for community-based coalition development and planning. The early successes of this experience within a single Chicago neighborhood prompted the City's health commissioner to create an organizational division within the public health department: The Center for Community Partnerships (the Center). The Center actively engages communities as partners in health improvement and system change and in this way is working to shift the balance of power towards communities. Today the Center is supporting seven neighborhood partnerships across Chicago. The Center is staffed by three persons who provide technical and administrative support for these local partnerships to engage in community-based strategic planning. While each partnership follows a common planning framework, all decisions are determined locally.

The public health department recognizes that for coalitions to be effective they must have adequate resources and support. Thus, each coalition is provided with funding for a full-time community coordinator who is charged with identifying, recruiting and convening local residents, organizations and other members; facilitating meetings; providing staff support to the coalition and its committees; overseeing local data collection efforts; and conducting the work of the coalition between meetings. Coalition coordinators are accountable to their coalition steering committees. The department also provides financial support for residents to assist in local data collection activities, for office space, and other costs as needed.

The outcomes experienced at the community level have been encouraging. Some pertain directly to the locally-developed plans, such as increasing the availability of fresh produce in neighborhood stores and greater community participation in crime reduction efforts. Other outcomes have resulted more from the collaborative process, such as the forging of new partnerships between community organizations.

For the Chicago Department of Public Health (CDPH), the effects of this effort have been invaluable. These include new partners in public health, new opportunities for collaboration, and most importantly, a new way of doing business for the Department. Prior to Turning Point, CDPH's work with communities had largely involved a review of available data (often already existing within the agency's own walls) and then the development of programs. As a result of Turning Point, the flow of information has changed so that decision-making is based on information collected and analyzed by community partners and provided to CDPH. Programs are either designed solely by the community coalition or in collaboration with CDPH. It is the Department's job to support these programs.

Policy Change Can Promote Collaborative Public Health Practice across Jurisdictions

Currently, there are 569 Federally-recognized Tribes throughout the U.S. Under U.S. law, these Tribes operate as sovereign nations within the U.S. (a governance model often referred to a "sovereign within a sovereign"). Public health issues, however, transcend borders, and coordination among state, county, tribal, and federal governments is necessary.

Situated just outside Phoenix, the Gila River Indian Community (GRIC) participated in the Turning Point initiative. They focused their efforts on policy issues, especially as they relate to working with state and county governments. Wall and Worgess write: "Relationships between public health agencies and tribes range from non-existent to telephone contact throughout Arizona. These contacts occurred because many of the 19 reservations in the state may cover two or more counties, cross boundaries into other states, and in one case, straddle an international boundary. Also, because of the provision of many health care services to the tribes by the federal Indian Health Service, state and county public health departments often believe that Native Americans in their areas have adequate health care, and therefore do not require assistance from them. A lack of understanding between the two groups and the sovereignty of the tribes, requiring government to government relationships, have also contributed to this difficulty in developing working relationships between tribes and state/county public health agencies in the state. The Arizona Turning Point Project included a special section in its public health improvement plan that called for the strengthening of these relationships, with the goal of improving the health status of Native Americans in Arizona.[10]

Gila River's experience is a powerful example of how partnership activities can be successful. Gila River Indian community (GRIC) and the Arizona Department of Health

Arizona Health Officers Association Changes Policy to Include Tribal Health Directors

by Teresa Wall and Barbara Worgess

A second success was the first-ever coming together of the tribes and the county health departments at the Annual Retreat of the Arizona County Health Officers Association (ACHOA) in August of 2000. This meeting promulgated a needed change in ACHOA's by-laws to open up membership to tribal health directors. Subsequently, the bylaws were changed and the organization renamed the Arizona Local Health Officers Association (ALHOA). The overall purpose of the organization remains the same; however, the network includes both counties and tribes, and the focus encompasses the entire population of Arizona, including those residents living on Indian Reservations.

The Pinal County (AZ) Department of Public Health and the Gila River Indian Community Department of Public Health jointly prepared and submitted a proposal for collaborative planning to establish a shared data network to address issues of communicable disease control, service delivery, and to develop policy strategies between the two agencies. Their proposal was funded and the two agencies worked on activities that will allow data sharing, including procedures to share specific clinical information to facilitate follow-up and avoid duplication of services to individuals who seek care both on and off reservation.

Services (ADHS) signed a data-sharing agreement. This agreement made Arizona history, winning the "Project of the Year" award from the Arizona Rural Health Association and the Arizona Rural Health Office. Now GRIC receives the same data that the state provides to counties, enabling the Tribe to strengthen its own public health surveillance and response system.

Broadening Community Voice and Building Community Capacity

A critical Turning Point theme relates to reorganizing the roles, responsibilities, and relationships among organizations in order to share and maximize public health resources and decision making to engage the broader community. In many of these communities, an established governmental public health agency existed that sought to connect more meaningfully with community-based organizations and the public. Examples include:

- Further development of a system of community public health coalitions linking to county-level program and policy development (Cochise County, Arizona)
- Creation of a system of neighborhood/borough coalitions linked to city-level program and policy development (Chicago, New Orleans, Los Angeles, New York)
- Onslow County Community Health Improvement partnership leveraged Turning Point leadership to secure new housing for those economically disadvantaged residents through a Federal Community Development Block Grant (Onslow County CHIP, North Carolina)

- Development of an integrated system of public health policy setting, service delivery, and resource allocation with strong youth voice and leadership (Chautauqua County, New York)

These four examples demonstrate partnership efforts to engage a broader base of non-governmental participants interested in improving population health. Addressing inequities in population health status requires broad involvement of diverse groups who are often most impacted by inequities. This process naturally broadens the scope of public health practice and makes additional system capacity available to a community.

Several Turning Point communities sought to improve public health policy and strengthen the process of public health policy formulation. While not all policies address health inequities, some partnerships attempted to address determinants of inequities in health, not treatment of diseases, by focusing on policies and practices that govern the scope of public health practice and increase interaction and collaborative action with elected officials, regional groups, and non-governmental organizations. Highlights include:

- Initiation of state-level policy discussions related to local/regional public health authority models. Further forming and promoting regional policy agenda. Eventual decisions reached to establish new local health departments across the state (NCCCP, NE).
- Development of inter-town and state-region policies and processes to support authority and capacity at the regional level (CCNTR, NH).
- Development of a communications plan to guide establishment of working interactions with public elected officials. Preparing community members (including youth) to communicate with elected officials and producing training materials and press kits (Tri-County, NM).
- Collaboration with the private sector to create a work plan specifically to address engagement of the business community and the relationship of health and economic development. Examining related statues, regulations, policies, and procedures (Tulsa, OK).
- Development of tools for policy planning to aid the community in targeting policies for public review and action and working with elected officials. Additionally, the partnership formed an independent entity to work directly with the community, entitled the Center for Empowered Decision-making (New Orleans, LA).
- Successful development and approval of a new community ordinance that requires the removal of all soda machines in public schools in the Gila River Indian Community. Additionally, the Gila River partnership now collaborates with Pinal County officials on a myriad of cross-jurisdictional public health issues, including tribal-county emergency response planning. The momentum gained by Turning Point also enabled the statewide Arizona Local Health Officers' Association to alter its bylaws to include tribal entities (via tribal health directors). This group was able to leverage policy change at the state level, making Arizona the second state in the nation to provide funding directly to each tribe (20 across the state) for bioterrorism capac-

ity-building. This progress reflects significant policy achievements that will benefit population health (Gila River Indian Community, AZ).

Part of the Cochise County Turning Point initiative focused on health and social problems associated with the high number of illegal border crossings that take place in the county jurisdiction. This partnership participated in the NACCHO documentary entitled, *The Edge of America: Fighting for Health and Justice* (see www.naccho.org to order a copy of this resource). The partnership leveraged their participation in the documentary to conduct a study of the impact of border crossers on local services and economy.

Living On the Edge: The Effect of Federal Immigration Policy on Cochise County

by Cochise County Health Department & Toltec Evaluation & Educational Research Services

A tragic outcome of the federal government's policy on undocumented immigration from Mexico has resulted in Southern Arizona being home to one of the most serious human rights injustices in the United States. The number of undocumented immigrants who perish while attempting to enter the United States calls into question the federal government policy of channeling undocumented immigrants through the harsh desert environments found along the Arizona/Mexico border. Since federal policy has resulted in large numbers of undocumented immigrants crossing into Cochise County from Mexico, the citizens of Cochise County should not have to bear the expense associated with these undocumented immigrants. The partnership developed the *Turning Point Initiative Undocumented Immigration Cost Study* to answer three questions concerning undocumented immigration and its impact upon governmental agencies and private property owners in Cochise County: 1. Do law enforcement, hospitals, fire and rescue agencies, and Cochise County departments collect data on their interactions with undocumented immigrants? 2. What are the quantifiable costs to law enforcement, medical facilities, fire and rescue agencies, and Cochise County departments with regard to providing services to undocumented immigrants? 3. What are the out-of-pocket expenses to property owners— primarily ranchers, in the immediate border area? For a copy of the full report, see http://archive.naccho.org/Documents/Living-on-the-Edge.pdf.

The Cochise County example demonstrates that LPHAs can play crucial roles in shaping public policy and funding. The local government is not able to solve causes of illegal immigration, but by focusing on data collection of financial impacts to county, their efforts raised public awareness and increased pressure on the federal government to provide increased assistance to the border-crossing problems.

Taken together, these examples illustrate partnerships' experimentation with broadening the scope of public health services, where collaboration better enabled partnerships to address determinants of health and not just disease. Working with a multitude of community partners enabled the public health system to address inequities in health at a strategic level not necessarily driven by health indicators but by social and economic concerns (which are often determinants) expressed by community partners. These strategies can be very effective since community health status data become available only after the onset of disease. Further, disease reporting processes typically do not shed light on the determinants of poor health or health inequities.

NEW DIRECTIONS FOR PUBLIC HEALTH PRACTICE

While the lessons learned across all 41 Turning Point communities are too numerous to describe herein, the five themes presented reflect similar patterns across many sites. Close examination of Turning Point activity supports the need to focus on social determinants of inequities that create population health or ill health, as health is a creation of society, not merely a reaction to disease.

The U.S. public health system is a complex arrangement of many systems that work together to protect and improve the health status of those living within U.S. borders. The U.S. remains the only industrialized nation that does not produce a national report on the social health of the nation. This is clearly not sound public policy. Balancing economic development, increasing pressure from health care market forces supporting healthy land use policies, and safe and affordable housing with population health continues to present enormous challenges to those interested in reducing inequities in the distribution of disease and illness. Continued under-investment in tribal communities is also of grave concern, as life expectancy rates for American Indians/Alaska Natives trail behind non-Indian communities by at least six years, and in many communities, the disparities are staggering.

In the U.S., public health functions, while largely carried out by public agencies, also require substantial contributions from private organizations such as hospitals, private school systems and businesses, and a significant number of community, tribal, state and national non-profit organizations whose missions are to protect and improve the public's health and well-being. Generally, public health practice does not include the direct provision of primary, secondary or tertiary medical care services, although in many communities, both public and private organizations work together to provide medical services to people who otherwise would not have access to affordable medical care. But as of this writing, estimates of uninsured in the U.S. exceed 44 million. The relative separation of public health and medical care in the U.S. is likely one of the most significant differences in organization and function with respect to the systems that operate in many European countries.

European communities are experimenting with investment strategies that produce population health while the U.S. has shifted its national attention to anticipate bioterrorism events and war. "Historically, our public health culture championed a scientific approach to emerging threats and supported the principals of social justice and improved health and health care for all. That culture has shifted in a post-September 11, 2001, world."[11] Meanwhile, U.S. life expectancy rates are slipping behind other nations, and the most significant threats to health remain outside the direct purview of medicine and public health practice. But partnerships can make enormous differences in communities despite these challenges.

Clearly, new approaches to addressing health inequities are needed. Lessons learned from national demonstration initiatives like Turning Point raise important questions about the structure of population health services and activities with respect to eliminating health inequities. Moreover, the examples of and themes within Turning Point activity discussed herein point to new directions on health systems evolution. Such evolution is inevitable, though the signs that shed light on future directions are understandably easily missed in the everyday work environs in which we function. In research and curriculum, schools of Public Health and Public Administration promote partnership approaches, but too often do so absent a research agenda closely aligned with practice. Federal and state governments follow suit and promote partnership approaches absent specific financial and personnel systems required to provide necessary incentive and basic support. This approach often rewards grant writers to exercise maximum creativity in the application phase, but absent support structures, program leaders struggle to operationalize the scope of work. Over time, many partnerships fade out slowly and some collapse immediately after the funding cycle ends. Others learn how to continue their work, but usually with great adaptation. What are the alternatives to partnerships? Are the current structures incapable of supporting sustained and effective partnership activity?

Reducing Health Inequities: What Can Your LPHA Do?

Turning Point Partnerships experimented with a variety of approaches to address social determinants of inequities in population health. The following activities offer examples of specific actions LPHAs can take to provide community leadership in addressing health inequities:

1. Provide ongoing mechanisms and venues for public forums that give community voice and work with those groups most impacted by social and economic inequalities to mobilize communities to action. Support this with policy and provide staff training to ensure sustainability.
2. Develop strategic alliances with CBOs and other groups that are working to improve housing, economic development, living wages, and other conditions that influence health status.
3. Support the development of community-based partnerships with sustainable capacity to address issues such as inadequate housing, lack of access to mass transit, and unemployment that traditionally fall outside of the health arena.
4. Collaborate with the state health department offices of workforce training, minority health, universities, public health institutes, and other state and local organizations to develop workforce recruitment and training programs that emphasize health and social justice competencies.
5. Implement a performance management system that specifically targets closing gaps in population health status.

6. Produce (on an annual or bi-annual basis) a community social indicators report or publication that includes multiple determinants of inequities in health, communicates progress, and engages public opinion.
7. Assess and revise your LPHA practice model (e.g., ten essential services or other model) to ensure that addressing health inequities is clearly defined, included in staff orientation programs, program development and performance monitoring activities.
8. Launch your own Turning Point process in your jurisdiction to engage individuals and organizations in a community-wide dialogue and strategic planning process focused on population health status.
9. Include a special focus on addressing health inequities and provide resources on your LPHA Web site.
10. Develop a succession planning process to ensure that the future LPHA workforce will continue to address health inequities.
11. Work with the local board of health (or other similar governance body) to engage them in dialogue and planning related to addressing health inequities in your service delivery areas.
12. If your community is near any American Indian or Alaska Native tribes, explore opportunities to support their public health efforts and invite representatives to meetings, SACCHOs and other events (resources are available at www.nihb.org or www.ihs.gov)
13. Develop new "essential services" frameworks to support an expanded scope of public health practice.
14. Explore governance models that better address an expanded scope of public health practice.

The power of collaboration enables a community to achieve goals and realize visions that transcend achievements within the reach of an individual organization. Partnerships reflective of a given community can play a critical role in health protection and improvement in rural areas where it is not fiscally prudent to establish a fully functioning governmental local public health agency. These partnerships can collaborate effectively with state or other regional public health entities that may be responsible for an entire territory but may not have any meaningful understanding of community life in the service delivery areas. Turning Point also demonstrates that public health practice in the U.S. is much more than mere service delivery; it is a social enterprise that weaves art and science, and requires leadership, commitment, flexibility and perseverance.

Community-based partnerships can also play a critical translation role, as population health data often do not shed light on the root causes of disease or changes in rate patterns. Community-based partnerships can augment governmental public health agency capacity by identifying problems, developing and implementing long-term strategies, and achieving advancements in population health and well-being in areas that traditionally would fall outside of the purview of governmental public health practice focused on disease rates. Many community partners are naturally inclined to address root causes of health inequities such as promoting living wage policies or improved land use planning efforts, whereas governmental public health practice in the U.S. primarily emphasizes the prevention of disease outbreaks. Sustaining these efforts is challenging.

Community partnerships can provide a unique catalyst function to promote social change needed to "produce" a healthier society, which requires moving beyond services that address disease to taking action that measures and actively produces health. Partnerships can play an intermediary role for issues that may present challenging political situations for state or local governments. Partnerships may also bring credibility to policy agendas and may garner additional and critical support beyond the traditional purview of community health programming.

National demonstration programs also illustrate weaknesses in partnership approaches. Turning Point participants also learned about the many challenges associated with sustaining partnership activity. When grant funding and external technical support end, it is exceedingly difficult to sustain coordinated effort among a group of individuals placed in different working environs. Often, these environs (with timeline pressures, policies, etc.) do not provide sufficient incentive for employees to maintain their involvement in partnership activity. Additionally, leadership turnover can immediately impact the extent of support for continued engagement. This caused many Turning Point partnerships to lose momentum, and where priorities were shifted to address those introduced by new leadership, other partners ceased their support.

Turning Point also teaches us that in the current definitions of organizational arrangements, partnerships are not substitutes for public health agencies nor are public health agencies by themselves sufficient components of a public health infrastructure. What do these lessons learned suggest about current infrastructure models? Are partnership approaches sufficient models to address health inequities? As stated previously, in 1900 no county public health agencies existed. Perhaps we find ourselves on a new precipice of public administration, and to make the next advancements, new community structures need to evolve.

The past century has brought great advancements in health. But the U.S., with chronic disease as our most significant threat, struggles to create solutions. Moreover, government's role in combating infectious disease has evolved into a fairly standard practice. But this is clearly not the case for chronic disease, as the extent of government influence over the conditions in which chronic disease has increased remains quite limited. Public health agencies are struggling to organize comprehensive action to reduce chronic disease, and the nation is on the brink of exploring the potential value of accreditation for local public health practice. Now is the time to ask challenging questions that may lead to even greater health improvements for the 21st century. How might we structure an arrangement of public and private organizations to advance health equity? What types of agencies (in terms of institutions and advocacy roles) are needed to achieve this? Turning Point's lessons clearly show the need to build broader, more integrated systems to address the sources of health inequities which lie beyond the scope of any one profession, and that doing so is both challenging and valuable, and perhaps the natural direction for health systems evolution.

NOTES

1. Much of the basis for this chapter – including some actual text in the background section below – was taken from NACCHO's 2001 publication entitled, *Advancing Community Public Health Systems in the 21st Century: Emerging Strategies and Innovations from the Turning Point Experience. [Interested readers can order copies of this text and a number of other products by visiting www.naccho.org. Additional state-focused publications and products can be found at www.turningpointprogram.org.]*
2. Centers for Disease Control and Prevention, "Ten Great Public Health Achievements – United States, 1900-1999." *Morbidity and Mortality Weekly Report* 48(12) (April 2, 1999): 241-243.
3. A. R. Hinman, "1889 to 1989: A Century of Health and Disease," *Public Health Reports* 105(4) (1990): 374-380.
4. See Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).
5. World Health Organization, *World Health Statistics Annual*, 1997-99 Edition (Geneva: WHO, 1999).
6. See Robert Beaglehole and Ruth Bonita, Public Health at the Crossroads (Cambridge: Cambridge University Press, 1997); Bruce Kennedy, Ichiro Kawachi, David Williams, David Blane, et al., *Health and Social Organization: Towards a Health Policy for the 21st Century* (New York: Routledge, 1996).
7. See the introduction and articles in part one of Ichiro Kawachi, Bruce P. Kennedy, and Richard Wilkonson, eds., *The Society and Population Health Reader: Income Inequality and Health* (New York: The New Press, 1999); N. Moss and Nancy Krieger, "Report on the Conference of the National Institutes of Health," Public Health Reports 110 (1995): 302-305; Beaglehole and Bonita, Chapter 3; John W. Lynch et al., "Income Inequity and Mortality in Metropolitan Areas of the United States," *American Journal of Public Health* 88 (May, 2000): 690.
8. Elizabeth Fee and Theodore M. Brown, "The Past and Future of Public Health Practice," *American Journal of Public Health* (May, 2000): 690.
9. For more discussion, see Institute of Medicine, *The Future of Public Health* (Washington, D.C.: National Academy Press, 1988).
10. T. Wall and B. J. Worgess, "Advancing Statewide Collaborative Partnerships Between County and Tribal Health Programs," *NACCHO Exchange* V1(2) (Summer 2002).
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Chapter 9

Using Living Wage Campaigns to Benefit Public Health

David Reynolds

INTRODUCTION

In December 1994, Baltimore became the first city to link contract funds to public standards when the mayor signed into law Council Bill 716 requiring city contractors to pay service workers at least $6.10 an hour. The first of its kind in the nation, the new living wage ordinance followed a year-long grassroots campaign led by the American Federation of State, County and Municipal Employees (AFSCME) and a group of 50 multi-denominational churches called Baltimoreans United in Leadership Development (BUILD). Since this time, the living wage has become a nationwide grassroots movement. By the summer of 2005, at least 140 municipalities had passed living wage ordinances—with at least another seventy campaigns underway.

Living wage laws are based on a simple principle. If private companies benefit from public dollars they should be expected to follow community-supporting standards in how they treat their employees. Certainly, public funds should not be used to replace jobs that support families with those that do not. When Ann Arbor, Michigan, for example, privatized work at the city parking structures attendants went from family-supporting union wage plus benefits to $6.50 an hour with no benefits provided by the non-union contractor. Living wage laws require companies receiving public funds to pay workers employed through such funds a living wage—typically above the federal poverty for a family of three or four (the later being $18,850 or $9.42 an hour full time in 2004). Ordinances often require a higher wage if the employer does not provide health care. Some laws have required paid vacation and sick days. Others have encouraged local hiring. While nearly all living wage ordinances apply to contractors, many also cover companies who lease public property or who receive tax abatements or other forms of financial assistance.

LIVING WAGES AND THE PUBLIC'S HEALTH

The research on the relationship between income and health documents clearly that those with lower income typically have poor health outcomes, although the connection is not a simple one of cause and effect. Living wage campaigns link to the work of local public health agencies at three levels: improving the health of workers and their families, partnering with community organizations, and encouraging a broader public conception of public health issues and the role of local health agencies. We explore the former below and the latter two at the end of this chapter.

In 2001, officials at the San Francisco Department of Public Health estimated the public health impact of a proposed San Francisco living wage ordinance.[1] They predicted that the $11 an hour wage requirement on city contractors and property leaseholders would effect approximately 30,600 full-time and 11,500 part-time workers. The likely wage gains varied between $2,668 for part-time workers to $4,822 for full-time. With three-quarters of the workers living in families of two or more the financial impact was likely to prove significant. Indeed, one-third lived in families earning less than $25,000 a year.

Drawing on the work of over a dozen peer-reviewed studies on income effects on health, Bhatia and Katz were able to estimate the following public health impacts:

- Mortality reductions among both men and women
- A nearly 2% decrease in the CES-Depression scale for full-time workers
- A 5.8% reduction in sick days for full-time workers
- An increase in the chances of completing high school among children of covered workers.
- Among girls of covered workers a reduction in the risk of childbirth outside of marriage.

In a more recent working paper on the impact of a citywide minimum wage in San Francisco, Irene H. Yen and Rajiv Bhatia found that income is one of the strongest and most consistent predictors of health and disease in the public health research literature.[2] The findings included:

- A recent national study that found that people with average family incomes of $15-20,000 were three times as likely to die prematurely than those with family incomes greater than $70,000.
- The strong relationship between income and health was not limited to a single illness or disease; people with lower incomes had higher risks than people with higher incomes for giving birth to low birth weight babies, for suffering injuries or violence, for getting most cancers, and for getting most chronic conditions.
- Low incomes isolated people socially through a combination of working multiple jobs and the inability to afford socializing opportunities that cost money. This isolation feeds into increased chronic stress.
- Improved income supports eating nutritious food, being physically active, enjoying friendships, and participating meaningfully and productively in society.
- A synthesis of five large-scale studies on the effects of 11 different employment-based welfare and antipoverty programs found that "programs that included earn-

> ings supplements, all of which increased both parental employment and income, had positive effects on elementary-school-aged children."[3] Specifically, these programs led to higher school achievement, a reduction in behavior problems, increased positive social behavior, and/or improved overall health. Other research confirmed that, in general, family economic conditions in early and middle childhood appear to be important for shaping ability and achievement.[4]

Raising wages for the working poor also addresses other factors that undermine health. Low wages encourage poor nutrition as families purchase cheap, low-nutrition foods. Low-wage workers are often forced to live in substandard housing. To support a family, workers earning below a living wage commonly work multiple jobs. Most living wage laws also address the common lack of health insurance among low-wage workers. When the uninsured do not get care and then are compelled to use emergency wards, this increases costs to our health system.

By contrast, living wages offer workers better support for their families. Higher wages reduce employee turnover and encourage employers to invest in greater worker training and other employee developments.[5] Responsible Wealth, a national network of businesspeople, investors and affluent Americans, maintains a living wage covenant signed by over 100 business people (www.responsiblewealth.org).

To determine the minimum income needs to support a healthy family, the Michigan League for Human Service conducts regular market basket studies in which researchers use actual existing costs for basic items such as food, shelter, clothing, health care, transportation, and so forth. In 2001, the Michigan League for Human Services estimated the minimum self-sufficiency income needed by families in the state. In this relatively low cost part of the country, a family of three needed $34,367 (or $16.52 an hour at one full time job) to not be dependent on some form of public assistance or subsidy. Yet fully one quarter of the state's working families fell below this minimal level.[6]

Although living wage laws apply only to that portion of the working poor whose employment is directly connected to public funds, living wage campaigns raise a basic debate about income and community well-being more generally. For example, once securing a basic living wage law, coalitions have sought to broaden coverage by expanding the categories of public supported employers covered. They have raised wages of city employees. Religious and non-profit employers have reconsidered their own private employment practices. Most recently, San Francisco, Santa Fe, and Madison, Wisconsin have enacted citywide minimum wage laws—opening a new avenue for organizing, depending upon state laws. Ballot and legislative campaigns by labor and community allies have also raised state minimum wage laws in Oregon, Washington, California, Massachusetts, and Vermont. In November 2004, 70 percent of Florida voters chose to raise the state's minimum wage to a dollar above the federal level. A minimum wage initiative also passed in Nevada.

WHAT HAPPENS IN A LIVING WAGE CAMPAIGN

While no two campaigns are the same, most living wage efforts involve some minimally common elements. They have to build a coalition between key local labor, religious, and community groups. The list of endorsers can often grow to impressive numbers. One hundred organizations or more for a mid-to-large city is not unknown. Obviously, the core of active allies is much tighter. For example, the Chicago living wage campaign's steering committee included Service Employees International Union 880, AFSCME, Teamsters, United Food and Commercial Workers, ACORN, Chicago Coalition for the Homeless, an organization of neighborhood groups, and key religious networks.

Chicago's 1997 Living Wage Coalition
78 Groups

ACORN
AFGE Local 1395
AFSCME Council 3
Amalgamated Transit Union Local 308
Americans for Democratic Action
Association House
Bakery, Confectionery and Tobacco Workers, Local 1
Bickerdike Redevelopment Corporation
Black Elected Officials of Illinois
Center for Economic Policy Analysis
Center for Neighborhood Technology
Chicago Coalition for the Homeless
Chicago Federation of Labor
Chicago Institute on Urban Poverty, Headland Alliance
Chicago Jobs Council
Chicago Jobs with Justice
Chicago New Party
Coalition of Labor Union Women
Committee for New Priorities
Community Renewal Society
Congressman Bobby Rush
Congressman Danny Davis
Congressman Jesse Jackson Jr.
Congressman Luis Gutierrez
Cook County Clerk David Orr
Council of Religious Leaders
Democratic Socialists of America
Eighth Day Center for Justice
Fireman and Oilers Local 7, SEIU
Homeless on the Move for Equality
Humbolt Park Empowerment Partnership
IBEW Local 134

IBEW Local 1031
IVI-IPO
Illinois Center for Youth Advocacy
Illinois Nurses Association
Illinois Public Action
Illinois State Council of Senior Citizens
United Steelworkers Local 1010
Institute for Economic Justice
Interfaith Committee on Worker Issues
Italian American Labor Council
Jeffrey Manor Community Revitalization Court
Jewish Council on Urban Affairs
Jewish Labor Committee
Kenwood Oakland Community Organization
Labor Coalition on Public Utilities
Lawndale Christian Development Corporation
League of Women Voters
Logan Square Neighborhood Association
Midwest Center for Labor Research
Network 49
Northwest Neighborhood Federation
ONE
Our Lady Gate of Heaven Church
PSEU Local 45
Redmond People Full Gospel Church
Rogers Park Community Action Network
SEIU Local 1
SEIU Local 236
SEIU Local 25
SEIU Local 73
SEIU Local 880
St. Benedict Peace and Justice Committee
State Senator Alice Palmer
State Senator Jesus Garcia
Teamster Joint Council No. 25
Teamster Local 705
Teamster Local 726
Teamster Local 733
Teamster Local 743
UAW Region 4
UE District Council Number 11
UFCW Local 100A
UFCW Local 881
UNITE Chicago and Central State Joint Board
UNITE Midwest Region
Uptown People’s Development Corporation

Coalitions are most powerful when they reach beyond the "usual suspects" among religious leaders and community groups. Opponents have attempted to use building trades and public sector unions against living wage efforts. However, the parallel of the living wage with prevailing wage laws among the building trades and the direct interest of public sector unions in combating privatization to low-wage, non-union contractors provides a strong basis for avoiding such conflicts and bringing such unions in as official supporters and even active advocates. Campaigns also benefit by outreach to non-profit and for-profit employers so that the opposition cannot paint the issue as one of the living wage versus "struggling non-profits" or "Business."

The coalition must cultivate some champion within local elected government. Regardless of their political affiliation, most local governments are saturated by a better business climate ideology that sees the best role for government in creating a passive low-tax, low-regulation environment for business investment.

Ironically, depending on the proposed law's specific reach, employers covered by the legislation are not always, or even typically, the main opposition. Rather the local chambers of commerce will lead an opposition supported by business people ideologically opposed to public participation in economic decisions. Nationally, the Employment Policies Institute, a think-tank funded by the restaurant and retail industry, provides a clearinghouse for anti-living wage materials. To date, the opposition has offered no concrete evidence to back their claims that living wage laws produce job losses, tax increases, or a poisoned business investment climate. Indeed, over two dozen academic studies and internal city reviews have found that paying living wages costs relatively little money, has long-term cost savings and quality benefits for employers, and has produced few jobs losses.[7]

Although over 120 communities have living wage laws, coalitions typically have to push for each new ordinance in a context whereby elected officials fear going into the "unknown." For this reason, campaigns must demonstrate that the living wage is a popular cause. At a minimum, organizers need to fill local council chambers with vocal living wage supporters. Once the ordinance has been passed, the battle is not always over as opponents may try to weaken the law either through amendments or various ways of undermining enforcement. Indeed, enforcement is the weakest link in the living wage movement.

Almost all campaigns have seen activists mobilize impressive turnouts of concerned citizens demanding a living wage at council hearings. The more elaborate campaigns have also mounted street parades and rallies, prolonged and intense grassroots lobbying, and memorable media events. In Los Angeles, for example, living wage supporters sent over 1,000 decorated thanksgiving paper plates to city hall to dramatize people's struggle to survive on poverty wages. An actor playing the ghost of Jacob Marley joined up with several dozen clergy to pay a visit to city hall to protest the mayor's scrooge-like opposition to the living wage. The city council passed the ordinance over the mayor's veto in 1997.

ROLES FOR LOCAL PUBLIC HEALTH AGENCIES

Public health officials can make a valuable and unique contribution to living wage organizing in two ways.

Presenting the Facts

All campaigns need some documentation of the problems of poverty and low wages in their community. Professionals, such as public health officials, familiar with using government data can provide valuable basic information—typically without much work. Furthermore, most campaigns do not even think of, let alone have ready access to basic information, specifically linking a living wage requirement with improvements to public health.

All campaigns require people who can offer expert testimony before elected officials and with the media. Public health testimony would be an especially useful contribution that would go beyond the typical comments from progressive academics. Public health agencies can also help identify those links between wages and health that could be readily quantified, such as loss of work days, mortality rates, childhood well-being, and illness risks. Contacts with university-based health economists could then help provide a more comprehensive analysis.

Public health agencies can also provide helpful general information about employers. Because many of them regulate restaurants they can provide data on the number of opening, closing, and continuing restaurants before and after a living wage or minimum wage law. In San Francisco, such information from the city's public health department showed that the restaurant industry in the city continued to grow as living wage and new minimum wage laws went into effect despite claims made by the opposition that the contrary would prove true.

Outreach to Non-profits

Since public health officials have contacts with many local non-profits they are well situated to play a facilitating role in avoiding an unnecessary controversy over how a proposed living wage law would apply to non-profit employers. By spreading misleading information and drawing on a few more corporate-oriented non-profit staff, living wage opponents have used non-profit organizations as front groups to hide the real sources of their opposition to a living wage ordinance. For example, a November 1998 article in the Detroit press exclaimed: "One Hundred Thousand Families Won't Receive Thanksgiving Turkeys Due to Living Wage." This alarm came from an inaccurate claim made by the head of the local Salvation Army that the new Detroit living wage ordinance was going to cost the organization millions of dollars. In fact, since the law applied only to two Detroit facilities funded by the city—and not the entire statewide organization—the actual impact proved minimal. Because supporters learned from this experience and did extensive outreach in neighboring Washtenaw County, no non-profit organizations, including the local Salvation Army, publicly opposed the living wage ordinance. Instead fifteen non-profits officially endorsed the campaign.

To avoid such conflicts some living wage campaigns have restricted or waived coverage of non-profit employers. However, such employers are often a chief source of publicly funded poverty-wage jobs. A survey by researchers at Wayne State University of non-profit organizations covered by Detroit's living wage law found that claims of mass ruination were simply inaccurate. A year and a half after its passage by voters, most non-profits had been able to comply with the new law's $8.35 an hour wage with benefits or $10.44 without. However, a small minority of such organizations did face financial obstacles. While the overall cost of the wage increase was relatively small, some non-profits dependent on outside grants had little room for maneuver. And a handful had become dependent on paying a majority of their employees poverty-wages. The report recommended policies to target additional funds to non-profit employers most in need. The total estimated costs of such a program came below one percent of the funds currently flowing to non-profits through the city administration.[8]

The key to avoiding controversy is to bring together covered non-profit employers early in the campaign to discuss what the proposed law is and is not, and to seek their input on how the living wage effort can be structured best to meet their needs. The Detroit study found that twice as many non-profit administrators supported the city's living wage law as opposed it. And many of the opposing opinions came from misunderstandings about how the law actually operated. The Ann Arbor living wage campaign surveyed the 26 covered non-profits about the potential impact of the proposed ordinance. The findings showed only a couple with any financial concerns. Meanwhile, a retired head of Catholic Social Services worked through the countywide non-profit network to hold a meeting with non-profit heads to discuss the living wage law and possible concerns. As a result the campaign wrote into the ordinance a three-year phase-in exemption that non-profits could request from the city council on an individual basis. This outreach removed non-profit coverage as a controversial issue and led twelve non-profits to formally endorse the campaign. Other campaigns have joined forces with non-profit employers to lobby local and state governments for additional funds to raise the wages of workers doing public social and health work. Non-profits forced to pay low wages due to shrinking government funds often realize the virtues of paying a living wage for retaining good staff and encouraging quality work.

Like the retired head of Catholic Social Services, many public health officials have an understanding of the local non-profit sector that most members of the coalition will lack. Furthermore, they are in position to play a neutral facilitating role for developing a conversation between living wage advocates and non-profit staff.

FOSTERING LONG TERM OPPORTUNITIES FOR PUBLIC HEALTH

In addition to addressing one direct connection between public money, wages, and community well-being, living wage campaigns can provide an opportunity to build connections with community groups and to broaden the public perception of public health work.

Cultivating Allies

Many of the groups involved in living wage campaigns are attracted by the opportunity to develop relationships with other groups. Many can be helpful partners for future public health work. For example:

- Unions: Occupational health and safety marks a core union concern. In addition to preventing accidents, ergonomic injuries, and toxic exposure, unions are also concerned with job stress and promoting meaningful work. Their attention to workers' general wellness connects to a wide range of community health concerns just as much as the more traditional concerns for the neighborhood impact of workplace pollutants. In addition to their many workplace-specific groups, many area labor movements also either have, or have people who would be interested in, some form of active COSH (Committee on Occupational Safety and Health) organization.
- ACORN & low-income neighborhood organizations: ACORN (Association of Community Organizations for Reform Now) has been a major promoter of living wage campaigns. ACORN and other low-income groups also work on affordable quality housing, predatory lending, and environmental racism issues as part of their central mission.
- Religious Community: People of faith are attracted to living wage campaigns from moral concerns about worker and community well-being. Several living wage campaigns helped produce ongoing religious networks focused on worker issues.
- Anti-Poverty Work: Living wage campaigns can bring together partners for further anti-poverty work. The Boston area campaigns, for example, built an alliance between ACORN and the Massachusetts AFL-CIO that subsequently joined forces to win increases in the state's minimum wage and Earned Income Tax Credit. Several partners from Chicago's campaign lobbied the Illinois legislature for funds to increase the wages of home healthcare providers.
- Rethinking Local Economic Development Policy: Living wage campaigns raise fundamental issues about the role of government in basic economic decisions. For the past thirty years government policy has been increasingly reactive—focusing on creating conditions for a "better business climate." Living wage advocates are taking one step toward placing questions of job quality and its subsequent impact on wages, families, and overall community health back on the table. Local economic development policies should be driven by broad standards of community welfare, not simply the all-too-frequently vague promises of "jobs." Ironically, while poor people typically have to wade through a mountain of forms and monitoring to qualify for meager forms of public assistance, in most states companies can receive millions of dollars in tax funds for local governments simply by asking. Little or no paperwork is required. In Los Angeles many of the key players in the living wage campaign subsequently worked together on efforts to secure community benefits agreements with the developers of major projects that included affordable housing, living wage jobs, childcare, community infrastructure, and other binding commitments. They have also sought institutionalized community impact reviews as part of the normal public development approval process. Economic development initiatives offer rich ground in which to raise questions related to public health.

Broadening the Definition of Public Health

Just as living wage campaigns attempt to redefine the role of government in regional economic development, the participation of local public health agencies can also help shift public perceptions of health issues and the role of public authorities. Traditionally, public health is often seen narrowly as primarily dealing with access to health care, promoting vaccines and preventive medicine, and educating the public on good nutrition. While all valuable work, such foci maintain a perception of public health as emphasizing individual concerns and actions. By contrast, linking wages to health points to societal-level concerns and greater collective action. Promoting public health is not simply an issue of what individuals do, but rather how communities are built and organized. Are the land-use, employment, social spending, and economic development patterns, policies, and actions pursued by government, business, unions and community groups promoting a healthy living environment or are they ultimately undermining health? Defining public health in broad collective terms helps pave they way to new constituencies and new ways to involve public health officials in decision-making that will determine the future of communities.

APPENDIX: WHERE TO GO FOR MORE INFORMATION AND HELP

ACORN's national Living Wage Resource Center provides a clearing house for questions, help, and further contacts about living wage campaigns. Contact Jen Kern at 617-740-9500, natacorncam@acorn.org, or visit their web site at livingwagecampaign.org. Working with ACORN, the Labor Studies Center at Wayne State University, Detroit has produced a 225-page guide on how to organize a living wage campaign and beyond. A pdf file of the main text—without 80 pages of documents—can be downloaded for free at www.laborstudies.wayne.edu. Click on living wage. The report on Detroit non-profits is also available on this site. Spiral bound copies of the full guide can be ordered by sending a check or money order for $15 (payable to ACORN) to Denise Johnson at ACORN: 739 8th St. SE; Washington, DC 20003. Responsible Wealth's Living Wage Covenant, as well as their pamphlet documenting small business success through living wages, can be found at www.responsiblewealth.org. For what comes after the passage of the living wage ordinance see the above guide as well as Stephanie Luce's detailed examination of enforcement effort in *Fighting for a Living Wage* (Cornell University Press, 2004).

NOTES

1. Rajiv Bhatia and Mitchell Katz, "Estimation of Health Benefits From a Local Living Wage Ordinance," *American Journal of Public Health* 91(9) (September 2001): 1398-1402
2. Irene H. Yen and Rajiv Bhatia, "How Increasing the Minimum Wage Might Affect the Health Status of San Francisco Residents: A Discussion of the Links between Income and Health," Working Paper (February 27, 2002).

3. P. A. Morris, A. C. Huston, G. J. Duncan, D. A. Crosby, and J. M. Bos, "How Welfare and Work Policies Affect Children: A Synthesis of Research," Manpower Development Research Corporation, January 2001.
4. G. J. Duncan, W. J. Yeung, J. Brooks-Gunn, and J. R. Smith, "How Much Does Childhood Poverty Affect the Life Chances of Children?" *American Sociological Review* 63 (1998): 406-423.
5. In the words of Don Walker, President of the Pinkerton security agency:
   "Studies and surveys of business that pay self-sufficiency wages report real business advantages as the result. They...attract more qualified employees, and those employees have higher morale, are more productive and require less supervision. They also report that higher wages reduce employee turnover and absenteeism and result in improvements in the quality of products and services delivered to customers....Pinketon is proud to be in the forefront of seeking to achieve higher standards and more than a living wage for America's security officers. We believe that this is a basic right for the men and women who protect America's business assets." Don Walker "A Living Wage! Fair Wages for Security Officers Benefit Clients," in *Pinkerton Solutions*, Issue1, 2001.
6. Michigan League for Human Services, "A Living Wage: The Least We Can Do," (2001).
7. See David Reynolds, *Living Wage Campaigns: An Activists Guide to Building the Movement for Economic Justice* (ACORN: 2003) Chapter VII.
8. David Reynolds and Jean Vortkamp, "The Impact of Detroit's Living Wage Law on Non-Profit Organizations" (2000). Available from the Economic Policies Institute or www.laborstudies.wayne.edu.

Tackling Social Injustice

- Focus on Social Determinants of Inequities in Health
- Move Beyond Programs and Services to Addressing Conditions and Policies that Create Inequity
- Rethink Essential Services Rather than Transform Them
- Attend to Power Imbalances and Emerging Social Trends
- Support Public Health Agencies as Change Agents
- Develop Connections with Social Movements
- Change Statutory Mandates to Include Health Equity

Chapter 10

From Neurons to King County Neighborhoods: Partnering to Promote Policies Based on the Science of Early Childhood Development

Kathryn Horsley and Sandra J. Ciske

The early years of life are an important time of active development and foundation building for later-life successes and good health.[1] A recent Institute of Medicine report, *From Neurons to Neighborhoods*,[2] identified 2 essential conditions that shape the well being of young children and their developmental trajectory into adolescence and adulthood: "First is the need for stable and loving relationships with a limited number of adults who provide responsive and reciprocal interaction, protection from harm, encouragement for exploration and learning, and transmission of cultural values. Second is the need for a safe and predictable environment that provides a range of growth-promoting experiences to promote cognitive, linguistic, social, emotional, and moral development."[2(p413)]

Socioeconomic status is a strong predictor of children's health and development.[3–6] Children with a low socioeconomic status are usually more vulnerable to health and developmental problems than are children from families of higher socioeconomic status. However, these differences in health and development by socioeconomic status can be seen at all points on the continuum, not just in the poorest groups.[3,7] Data from 3 national US studies[8–10] of developmental differentials in childhood and adolescent wellbeing reveal that such gradients exist along the entire income spectrum.[11]

These results suggest the need to improve all children's neighborhood environments, not only those traditionally considered "high risk" because of high poverty levels.[12]

Several current models suggest social or ecological determinants of health—the interaction between social, economic, and physical environments and individual biological factors and behaviors.[13–16] Two of these models explicitly include a lifecourse dimension, suggesting that early life experiences affect later health and social wellbeing.[13,16] The Institute of Medicine framework[16] calls for a multilevel approach to understand and intervene at both upstream (social and economic policies, institutions, neighborhoods and communities, living conditions, social relationships) and downstream (individual risk factors, genetic/constitutional factors, pathophysiological pathways) points of reference. Hertzman[13] offered a useful framework for understanding the role of social forces on human development and the social determinants of health. Forces shaping human development are drawn as 3 concentric circles representing the determinants of health and well-being at 3 levels of social organization. The most immediate and interpersonal level shows social network factors associated with social support and nurturing. The next level shows community factors that can either buffer or increase the daily stresses, such as quality child care and safe, family friendly neighborhoods. The broadest level shows social and economic environments usually determined by public policy—employment benefits, taxation, national wealth, income distribution, and so forth. Hertzman summarized the model as follows: "The picture that emerges is of a lifelong interaction between the cognitive and socioemotional capabilities of the developing individual and social, economic and psychosocial conditions as they present themselves" at these 3 levels.[13(p31)] From this ecological perspective, policy analysis and advocacy has the potential to influence the middle and outer levels of the social determinants of early childhood development.[12, 17–21] Figure 1, an adaptation of Hertzman's framework, shows this influence. Public health agencies are well positioned to educate and advocate about how to change policies that promote optimal environments for young children.[22]

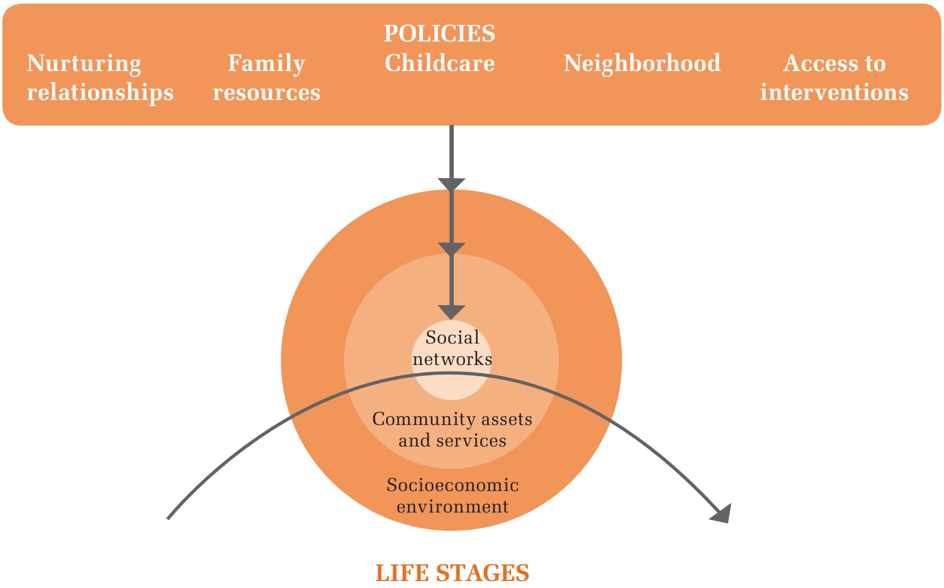
Public Health—Seattle & King County (PHSKC) designed a policy-oriented intervention to focus explicitly on social and economic environmental factors to complement existing efforts focused on the family and individual. The organization's goal is to strengthen early childhood environments across King County, Washington, by (1) developing a partnership with early childhood development stakeholders, (2) building a common knowledge base, (3) developing a local policy agenda informed by science, and widely disseminating the policy agenda, (4) organizing support at the community level, and (5) monitoring the policy environment. Through a coordinated policy agenda and strengthened advocacy, stakeholders who work with parents and young children or who are concerned with optimal early childhood development are focusing on building public will to address social and economic environmental factors shaping young children. The ultimate goal is "universal access" to environments that support healthy development, school readiness, and success in school.[13]

PARTNERSHIP DEVELOPMENT

Early childhood policies and practices are deeply imbedded in the fabric of communities and thus require wide and diverse community participation to change them. PHSKC's initial challenge was to engage scientists, advocacy organizations, elected officials, educators, and service providers to build a partnership. The organization brought together a multisector, multidisciplinary group of stakeholders who work with parents and young children or are concerned with optimal early childhood development and asked them to participate in all aspects of project planning and execution, especially in working toward consensus on the policy agenda.

Framework for human development and the social determinants of health that can be influenced by public and private policies.

FIGURE 1



Source: Adapted from Figure 2.2 in Hertzman.[13(p30)]

Among the academic partners was a public policy expert at the Evans School of Public Policy, University of Washington, Seattle, who worked with partnership leaders to formulate policy prioritization criteria and later facilitated prioritizing exercises to finalize the policy agenda. Other partners included local and state government representatives from departments of parks and recreation, human services, "neighborhoods," mental health, public health, and child care and a citizen commission appointed by the King County Executive. Education sector partners included school districts, the Puget Sound Educational Service District, Head Start/ Early Childhood Education and Assistance Program, and child care organizations. Family and child advocates contributed expertise particularly useful in developing policy recommendations concerning moving families out of poverty and ensuring family friendly work environments. The overall goal of strengthening social and economic environments depended initially on increasing the partnership's collective capacity to develop policies affecting such environments. The partnership first built a common knowledge base (see next section) and then applied individual knowledge and experience to local circumstances to identify needed policy changes.

BUILDING A COMMON KNOWLEDGE BASE

The early stage of this King County project included an extensive review of the literature on early childhood development that had already been compiled by The National Research Council and the Institute of Medicine in the 2000 Institute of Medicine report *From Neurons to Neighborhoods: The Science of Early Childhood Development*.[2] This 500-page review is extensive, multidisciplinary, and complex and is a credible source for establishing a common knowledge base about early childhood environments. PHSKC produced a 75-page summary of *From Neurons to Neighborhoods* to provide an accessible summary of "what we know." This product was the primary resource provided to partners to inform them about social and economic environmental factors considered crucial for normal childhood development. All 60 stakeholder partners were asked to read the summary before coming together to generate policy recommendations for each of 5 early development environments: nurturing relationships, family resources, child care, neighborhoods, and access to early interventions.

DEVELOPING THE POLICY AGENDA

This collaborative work, initiated and convened by PHSKC, resulted in a policy agenda comprising 15 recommendations (Table 1). Over a period of 18 months, 50 to 60 community stakeholders took part in 3 half-day meetings and 10 small task force working meetings. At the second stakeholder meeting, PHSKC summarized the main findings from *From Neurons to Neighborhoods*[2] and presented a model policy framework to promote optimal early childhood development. Policy experts were invited to compare existing policies at the city, county, and state levels with model policies for each of the 5 environments. Partners used the following criteria to develop and prioritize policy recommendations: robustness (reaches many children), equity (lifts poor children up), feasibility (has public support), and effectiveness (it works). The partnership held additional small group work meetings with the stakeholders to develop 4 to 5 specific policy recommendations for each early childhood environment. At a third large stakeholder meeting, the stakeholder group finalized the policy agenda, selected priority policies (7 of the 15 recommendations), and made commitments to promote these policies. The product resulting from this work was a brief 5-panel leaflet that summarized "what we know" (science) and "what we propose" (policies) for each environment, the latter shown in Table1.

ORGANIZING SUPPORT AT THE COMMUNITY LEVEL

PHSKC reached out to communities within King County through face-to-face presentations of the policy agenda to 2 types of local groups: (1) Families and Children Early Support, a consortium of community members and early childhood educators, providers, agencies, funders, school staff, and advocates who supported early childhood education and school-readiness efforts in each of 4 regions of the county and (2) United

Way Human Services Councils in the same 4 regions. The organization had additional presentations and discussions with child care task forces representing diverse ethnic communities. PHSKC also provided regional level data on early childhood indicators relevant to the 5 environments, so that community members and leaders would have baseline data to help them set local goals and choose strategies to improve these environments. The King County Early Childhood and School Readiness Action Agenda used the policy agenda as a framework for creating more detailed action strategies for each of 4 regions.[23] Regional Families and Children Early Support groups committed themselves to work on the policy recommendations, specifically improving the quality of child care through teacher credentialing and compensation and helping parents through training and support. Collaboration and alignment issues will be a key focus for annual policy updates with stakeholders.

MONITORING POLICY CHANGES AND CHILD OUTCOMES

As the convening partner, PHSKC committed to annual monitoring and reporting to all partners the progress, or lack of progress, on the 15 policies in the agenda. The current evaluation question is "How have the 7 prioritized policies of the From Neurons to King County Neighborhoods early childhood development policy agenda fared in King County from fall 2002 through spring 2004?" Specifically, what changes have occurred and what are the current opportunities for advancing the goals of the policy agenda? PHSKC administered key interviews with persons knowledgeable in each of the policy areas. Key data will help us identify opportunities for action as well as policies needing more coordinated partner and community support. PHSKC will use feedback from individuals, organizations, and interest groups, combined with an update on the status of local, state, and federal policies to determine future directions of the partnership work and to refine the original policy agenda.

In addition to monitoring the progress made with the policy agenda, PHSKC also initiated a public health–public school collaboration in partnership with United Way of King County to assess community-level school readiness. Both the policy and action agendas identified school readiness as a significant and relatively concrete outcome. School readiness refers to a child's ability both to cope with the challenges of starting kindergarten and to benefit from the academic and social opportunities at school. Readiness encompasses social, emotional, linguistic, and cognitive competencies.[23] School-readiness has been linked to children's later academic performance, adolescent dropout patterns, and behavior and coping skills.[24] Children who are "not ready to learn" when they start school are more likely to repeat a grade, need special education services, and leave school before graduation.[25–27]

The objective of the assessment is to identify gaps in readiness and to engage communities in deciding how to narrow the gaps through program and policy changes. The Early Development Instrument, a psychometrically validated instrument focused at the population level, is being used to monitor changes over time.[28] A population-based assessment of school-readiness in King County kindergarten children will be piloted in

From Neurons to King County Neighborhoods: Policy Agenda for Early Childhood Development in King County, Washington, 2002 – 2004[23]

TABLE 1

Nurturing Relationships	Family Resources	Child Care
Goal: Every parent/caregiver has the mental health and knowledge to build and sustain nurturing relationships with the children in his/her care.	**Goal:** Every parent/caregiver has the time and financial resources to provide safe, nurturing, and stimulating environments for her/his children.	**Goal:** Every child has quality child care.
Policy Recommendations: 1. Promote strategies to help parents and caregivers establish and maintain nurturing relationships with children:[a] ■ Offer education for first-time parents through programs that emphasize the emotional exchanges between parents and children and that focus on normal behavioral and emotional development (e.g ., Parents as Teachers, Birth to Three, The Preventive Ounce, The Temperament Program, Touchpoints) ■ Provide incentives for parents to attend quality parent education during pregnancy or through the early years of child rearing 2. Ensure comprehensive system of identifying and treating emotional, behavioral, and substance abuse problems in children and their parents and caregivers: ■ Mental health services for parents and other caregivers ■ Information and training for parents and other caregivers to recognize signs of emotional, regulatory, and health problems in young children ■ Links for families between child care and therapeutic services to meet those needs noted by early identification ■ Education of primary health care providers (pediatricians, family doctors, nurses) to improve linkages between primary health care providers and therapeutic services ■ Education of mental health professionals to intervene with young children ■ Mental health system changes to meet criteria for services and service delivery	**Policy Recommendations:** 1. Move people out of poverty:[a] ■ Provide income assistance by enrolling all eligible families in Earned Income Tax Credit/ TANF/Social Security benefits ■ Provide poor families with in-kind support: nutrition, housing health care ■ Ensure adequate family earning capacity through flexible, client-centered job training, career progression, ESL, GED, ABE, and conversational English programs ■ Assist in building financial assets through Individual Development Accounts, home ownership, microenterprise, etc. 2. Ensure family-friendly work environments: ■ Paid parental leave during child's first year ■ Flexible work schedules parents ■ Health insurance for family members ■ Sick leave policies	**Policy Recommendations:** 1. Increase provider knowledge about early childhood development and reduce provider turnover through[a] ■ Increased salaries and benefits ■ Career path incentives and opportunities (TEACH, Career and Wage Support Study) 2. Improve licensing standards, modeled after nationally recognized, research-based standards:[a] ■ Strengthen • Ratio of provider/child • Staff education • Group size • Assessment of provider–child interaction • Parent involvement • Health and nutrition • Control of pesticide and toxic substance use [Show Seattle as example of tiered rating (1–3) system] ■ Increase child care program accountability by ensuring adequate number of licensers and health surveyors ■ Provide supports and incentives for program quality (through mini grants, increased DSHS reimbursement, on-site training and technical support) 3. Expand access to quality early care and education through financial aid.[a] Increase for rates of reimbursement to providers. 4. Provide more flexibility and wider eligibility for higher-income families: ■ Enrichment for children not in child care or in care by family, friends, and neighbors ■ Increased supports and incentives for offering preschool more universally (not within K–12 system)

Note: TANF = Temporary Assistance for Needy Families; ESL = English as a second language; GED = general equivalency diploma; ABE = adult basic education; TEACH = Teacher Education and Compensation Helps; DSHS = Department of Social Health Services; ECEAP = Early Childhood Education and Assistance Programs. aPolicies were prioritized for local action.

TABLE 1

From Neurons to King County Neighborhoods: Policy Agenda for Early Childhood Development in King County, Washington, 2002 – 2004[23]

Neighborhood/Community	Access to Early Interventions
Goal: Every neighborhood is safe and cohesive and supports families and children. **Policy Recommendations:** 1. Reduce concentrated poverty and residential segregation through neighborhood economic and housing development: ■ Increase housing subsidies and ensure affordable housing wherever people want/need to live (rent control, rent tied to income, assistance with loans for housing ownership) ■ Improve and stabilize neighborhood-level economic development by increasing opportunities for microenterprises, community development corporations, small business development, “mainstreet” improvements, empowerment and enterprise zones, and support for community partnerships 2. Develop and enforce codes and standards for home and community safety, addressing toxics, contaminants, family and community violence, and safe streets. 3. Build neighborhood connections and strengthen social fabric and informal supports: ■ Support safe and accessible places for gathering and common activities—community centers, parks, libraries, schools open for community use ■ Provide resources for organizing mutual assistance groups like child care and house maintenance co-ops 4. Build civil society at the neighborhood level. In partnership with communities, strengthen and integrate formal institutions that are inclusive of and responsive to residents’ priorities: ■ Create and strengthen mediating structures within organizations to reach out to residents who are isolated or alienated ■ Develop local leadership through opportunities for leadership training and mentoring	**Goal:** Regardless of income and cultural background, every parent has access to the support, information, and effective services needed to identify and respond to the developmental needs of the child. **Policy Recommendations:** 1. Ensure a comprehensive system of assessment and care that provides[a] ■ Universal early developmental screening beginning at age 3 in all school districts ■ Multiple entry points for assessment and care that are linked across services and yield a coordinated plan of care ■ Interventions with timing, intensity, and duration that are based on intervention-specific best practices ■ Family-centered, community-based, and culturally reinforcing services 2. Provide family literacy programs to all who need them. 3. Provide Head Start, Early Head Start, and ECEAP to all who are eligible.[a]

2 school districts and eventually administered in all 19 districts in the county. Resulting data will support 2 important functions: serving as a springboard for mobilizing community action and, over time, providing quantitative feedback on whether the policy agenda and advocacy are changing social environments to benefit the youngest children.

The Early Development Instrument is a relatively short, easy-to administer checklist completed by kindergarten teachers to evaluate age-appropriate performance in 5 major developmental domains: physical health and well-being, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge.[28] Results can be aggregated for schools, neighborhood clusters, and school district levels. This makes it possible and desirable to link school readiness results with other population and community data shown in maps based on the same geographical boundaries.

CONCLUSIONS

In recognition of the crucial role of social and economic environments in shaping early childhood development and determining the health of young children, PHSKC partnered with early childhood development stakeholders to design a From Neurons to King County Neighborhoods policy initiative based on science and community knowledge. A number off actors shaped the direction of this project. The community understands the importance of the early years, not only for health outcomes but also for overall well-being, success in school, and adult achievements. The veritable explosion of scientific knowledge about human development, from early brain development to the influence of social determinants of health and development, has added excitement to the policy arena. This new knowledge is increasingly acknowledged by educators, social service providers, and child advocates—the professionals who are PHSKC's partners.

The process of developing the policy agenda spanned 1.5 years, and it was a challenge to keep partners engaged long enough to reach a "common knowledge base" in order to be fully informed participants in building the policy agenda. Partners found it challenging to focus on the level of social and economic environments instead of the level of providing services to individual parents, children, or families. The tendency to focus on immediately needed services rather than the social and economic contextual factors that led to the need for services, required reorienting the group to prioritizing policy recommendations. Partners struggled with how to take incremental steps toward making structural changes in the environment to address such things as access to affordable housing, adequate food, healthcare, childcare, and other financial resources needed to support young children. "Moving people out of poverty" is a goal that all can agree on, but the changes required to truly increase family resources seem daunting and distant, especially to partners who typically plan specific service delivery programs.

Although the momentum and high level of activity directed toward healthy early development was evident during this project, enhanced collaboration of organizations to address prioritized policies remains a challenge. Identified impediments to coordinated efforts fell into several key areas: the need for better collaboration among groups to align their respective policy agendas to address specific policy priorities of the partnerships, the need for stronger leadership and commitment to prioritized policies, and the need for protection of existing funding for early childhood services and programs.

The Institute of Medicine's report *The Future of Public Health in the 21st Century*[22] recommends that "every public health agency exercise its responsibility to serve the public interest in the development of comprehensive public health policies by promoting use of the scientific knowledge base in decision making about public health and by leading in developing public health policy."[22 (p412)] Professionals and communities need both time and concerted effort to use evidence and best practice to advance a policy agenda addressing optimal early childhood development. The public and public officials may recognize the importance of the early years without acknowledging the underlying structural forces in the social, economic, built, and political environments that shape development in those early years. Achieving universal access to conditions for all children to be healthy and ready to learn will require ongoing commitment of many sectors and multidisciplinary partners over time to move political will and mobilize for change.

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Chapter 11

The Evolution of the Health Determinants, Planning and Evaluation Division: The Region of Waterloo Public Health Department

Theresa Schumilas

Arguably, public health practice remains almost exclusively focused on "downstream" strategies and issues and diverted from addressing broader determinants of health. For many years, traditional public health approaches have focused on disease risk factor and behavior change as a means to attain health. Research accumulating over the last ten years illustrates that broader social, economic and environmental "risk conditions" determine the choices that individuals can make, and have more influence on health than lifestyle factors per se. Since 1999, Region of Waterloo Public Health (RoWPH—Ontario, Canada) has been working to increase the capacity of staff and citizens to develop policies and programs which address these underlying social, economic and environmental conditions that affect health.[1] This article summarizes the evolution of a division to advance this agenda within RoWPH. First, it describes establishing the Health Determinants, Planning and Evaluation (HDPE) division and the framework underpinning the work. It offers several examples of activities to further illuminate the framework. Finally, it describes outstanding issues and the challenges and opportunities that lie ahead.

ESTABLISHING THE HEALTH DETERMINANTS, PLANNING AND EVALUATION DIVISION

In the months that preceded the formal creation of the "Health Determinants, Planning and Evaluation" Division, the Department Leadership Team (DLT) at the Region of Waterloo Public Health Department began to shift from relying on conventional strategic planning approaches to a strategic thinking approach. Environmental scanning and opportunity identification became a primary focus. Within this culture, the DLT saw an opportunity to advance multiple program objectives by shifting resources toward advocacy and policy work related to underlying social, economic and environmental conditions that affect health.

In Ontario, provincial legislation sets forth a set of minimum public health standards to guide programming of local official health agencies (public health departments).[2] The RoWPH leadership team noted that these guidelines (unintentionally) seemed to encourage public health programs to evolve independently of each other. Clearly, however, any activities designed to develop "determinants of health" strategies could not be isolated into a "unit" within the Department. Therefore the new division was positioned as a cross-functional team with other health department programs.

In determining the mandate for the new team, the DLT understood that two quite different types of work needed to "co-evolve." First, resources were needed to coordinate better research, evaluation and planning activities for departmental programs and to build a strong evidence-based culture. Always basing policy and program development on the best available evidence was critical. Second, it was important to strengthen the department's capacity and the community's capacity to undertake healthy public policy initiatives. These two lines of work would mutually inform each other. Effective action on healthy public policy issues required a strong evidence base combined with the voices of an active and effective citizenry.

With that broad guidance, in November 1999, the Health Determinants, Planning and Evaluation Division was established with 20 positions and a budget of $1.7 million. Its goal was "To increase the collective capacity of staff and citizens to develop policies and programs which address the social, economic and environmental conditions that affect public health." This goal was to be accomplished with three inter-related teams: Planning and Evaluation, Epidemiology and Data Management, and Healthy Communities and Policy.

CREATING A FRAMEWORK TO GUIDE THE DIVISION'S WORK

Two complementary frameworks integrated to guide the division's development, planning and priority setting. An indicators document (also referred to as the Healthy Communities Model) developed by Hancock, Labonte, and Edwards illustrated the destinations and outcomes to aim toward.[3] It answered the question, "What are the healthy public policy areas we need to modify in order to impact on public health outcomes?" In addition, division staff adapted the Ottawa Charter on Health Promotion to guide strategy development in answer to the question "How should we allocate our resources?"[4]

The Healthy Public Policy Areas

The overlapping spheres in the Healthy Communities Framework depict what are often called the "upstream" policy areas, which have the widest influence on health inequalities and health status.[5] The indicators described are the desired outcomes of healthy public policy action. Two qualities distinguish these policy areas from more focused health policy work.

First, they are broad in their effect. Change within these areas affects more than one health status or health behavior goal. Policy changes in any one of these areas would therefore advance more than one goal, as described in Ontario's mandatory public health programs. Second, they are intersectoral. Upstream policy activity is supportive of health even when the policy makers fail to consider their work in that context. These policies derive from vastly different perspectives, such as land use planning, agricultural economics, community policing, engineering, and transportation planning.

The Change Strategies—Adapted from to the Ottawa Charter for Health Promotion

Early on, staff realized that facilitating policy advocacy would need to be a central strategy. Division staff has evolved some adaptations, which sharpen the charter's strategies to this end. Whereas the Ottawa Charter portrays "healthy public policy" work as a separate strategy, it is clear that building an environment that supports policy work, building policy advocacy skills of staff and community change agents, and engaging citizens in policy advocacy, when taken together, are the pillars of the policy advocacy process. HDPE staff has modified the Ottawa Charter for Health Promotion as outlined below.

Creating a Supportive Environment within Public Health

One of the key divisional strategies has been to build organizational systems and processes, which are supportive of work related to healthy public policy. This is seen as foundational work upon which subsequent policy advocacy initiatives can be built. An organizational culture that values evidence-based and cross-disciplinary practice is essential to advancing healthy public policy. A supportive environment within public health is one that mentors diverse research and planning activities and builds the support systems and internal policy environment for such work to proceed.

Building Policy Advocacy Skills of Change Agents

The Ottawa Charter for Health Promotion describes "building personal skills" as a key health promotion strategy. In practice, however, this can be interpreted broadly to mean everything from teaching about safe food handling to training community leaders in using data effectively. Considering the goal of changing social, economic and environmental conditions that affect health, the focus needs to shift to more specific skills and competencies that enable public health staff and selected citizen change agents to work collectively on diverse issues across different professions, work cultures, models and frameworks.

Increasing Citizen and Community Engagement

"Strengthen community action" (as described in the Ottawa Charter for Health Promotion) does not distinguish between such activities as starting a smokers anonymous group and supporting a healthy communities process. Effective policy advocacy requires a sharper focus. HDPE staff finds "citizen engagement" to be a more precise term which describes the process of investing in alliances with citizens and citizen groups who want to have an impact on public policy. This perspective has assisted the division in selecting from dozens of community groups and networks requesting involvement and support for a myriad of public health issues.

SUMMARY OF HDPE'S DEMONSTRATION AREAS

The Health Determinants, Planning and Evaluation division has evolved over the past five years to deliver six inter-related "programs." These are outlined below. Three of these are "consulting" areas where HDPE division staff responds to requests from other department staff and community groups for assistance. The other three are proactive demonstration areas, where division staff initiate, plan and implement policy-focused work.

The 3 Consulting Areas

HDPE staff consults broadly with all programs in the department as well as with citizen groups and community agencies in order to increase capacity to manage and use health data and information effectively (Epidemiology and Data Management), increase evidence-based planning and integrated program planning (Planning and Evaluation), and increase capacity for citizen engagement and policy advocacy (Citizen and Community Engagement).

Planning and Evaluation

Staff in this unit coordinates and integrates planning and research activities by providing training, consultation and development of resources to support effective planning, research and evaluation practices across the department. Staff has been active in creating an environment which mentors research and planning. For example, all of the department's business plans are described and results monitored through a management information system developed by HDPE staff. The team also develops and maintains policies that guide research and evaluation projects. This includes an ethics review policy and an electronic monitoring and approval process for research projects, which streamlines communication, monitors and enhances research quality and improves reporting and use of results. Staff in this team often consults to ensure effective citizen involvement in community consultations and research studies by advancing participatory approaches.

Epidemiology and Data Management

Staff from the epidemiology and data unit provides assistance to RoWPH staff and community groups regarding health-related data requests and analysis, survey methodology, statistical methods, health information management and related quality assurance issues. Program staff consults and produces short data-based reports called "Public Health Perspectives" which focus on current public health issues in the region. Recent topics have included: Child Health Status, Health Status of Immigrants, Food Access, and so on. Widely distributing these highly readable reports, coupled with geographic mapping of data, facilitates citizen involvement in healthy public policy processes.

Citizen and Community Engagement

Within this consulting area, staff is building an internal environment supportive of citizen engagement through the development of written policy advocacy guidelines which outline various ways in which RoWPH staff implements its mandate of health protection and promotion through policy development. In an innovative program called "Reaching In," staff collaborates with Wilfred Laurier University to offer an eight-week citizen capacity building program which helps community lay leaders develop an effective voice in municipal and regional government to advocate for community level change.

The Three Demonstration Areas

In addition to the more responsive consulting work, staff in the division has evolved three well-established demonstration areas. After a year of exploring different directions, the HDPE division decided to concentrate resources on three broad policy areas: sustainability—with focus on local food systems; equity—with focus on employment and employability of immigrants; and livability—with focus on land use planning and chronic disease prevention.[6]

These particular goal areas were chosen because their links to mandatory public health standards and programs are relatively clear. For example, walkable communities and accessible food are well established as prerequisites to obesity prevention and chronic disease prevention and they hold legitimacy in terms of public health involvement. Further, in Ontario, one of the mandatory program standards for public health embraces equity and access, and gives a clear mandate for work related to vulnerable populations.[7]

Access and Equity

The focus on access and equity solidified in 2002 with a review of all RoWPH programs and services. As a result of the review, staff is adapting and modifying programs and services to improve access for all community members. Poverty prevention, immigrant employability and employment have emerged as central themes in this work. Staff has worked with community consortia to publish fact sheets on local poverty, and a series on immigrants, health and employment. This work has evolved into advocacy regarding the recognition of foreign trained professionals. A labor market scan completed in 2002 revealed significant discrepancy between the local needs for skilled labor and the number of foreign-trained professionals whose skills haven't been optimally used. A "Voices for Change" forum has culminated in a call for change that provides specific recommendations to the regulatory, provincial and federal authorities. An Immigrant Skills Summit was prepared for 2005, with a goal of assisting in the formation of a regional immigrant employment council, a multi-sectoral body to continue policy advocacy in this regard.

Sustainable Community Food Systems

Since 2002 staff has focused on building sustainable community food systems as a broad policy area. As an early step, staff initiated the incorporation of an autonomous food policy organization with whom to partner. Foodlink Waterloo Region is now an independent organization that promotes a local, sustainable food system. With appropriate advocacy partners in place, staff then completed several inter-related research studies to gain broad understanding of the local food system and to provide advocates with required data and information. A local economic impact study found that food production, processing, distribution and retail generate $2.7 billion in annual sales and support over 26,000 jobs in the local economy.[8] Local food buying research indicated that a majority of citizens want to buy local food and make efforts to do so, but despite the size of local food economy, availability of local supply remains a significant barrier to sustainability. Staff has conducted food affordability and availability studies, as well as studies quantifying links between eating practices and diet-related diseases.

Livability—Health and the Built Environment

Between 2004 and 2006, HDPE staff, in concert with an inter-disciplinary team from across the Regional Municipality of Waterloo, is conducting a series of research and planning projects to inform the Region's Growth Management Strategy and the Regional Official Policies Plan. These projects are about a broad range of livability issues affected by population growth and demographic changes expected over the next 20 years. Among other projects, a comparative study contrasts the health of residents living in six neighborhoods characterized by differing urban design features. It examines food practices, physical activity patterns, obesity and various chronic diseases related to different design elements such as density, public transit choice and mixed use elements. Another study concerns policy supports and barriers for farms selling food locally in order to develop plans for increasing local food production, processing and consumption. The cross-functional team engaged in the above research hosts interactive "lunch and learn" sessions with other disciplines and sectors. The purpose is to become more familiar with new and specialized vocabulary and different professional literature, and identify other policy initiatives underway that can be leveraged from within a public health framework. Taken together these initiatives will help inform and shape the Regional Official Policies Plan, and suggest policy mechanisms to enhance the natural environment, build vibrant urban spaces, provide greater transportation choice and protect the countryside within the Region of Waterloo.

CHALLENGES AND OPPORTUNITIES

The policy areas related to the social, economic and environmental conditions which most affect health have not been the recent purview of public health. (Hence the observation that health is to a large degree created outside the health sector.) The Ottawa Charter for Health Promotion speaks to the need to reorient health services by opening channels "between the health sector and the broader social, political, economic and physical environment components." This shift implies moving beyond clinical, curative and prevention programs to working at a systems level and engaging in policy work. In making this shift at RoWPH, several challenges and associated opportunities have been observed, and are described below.

Complexity of Both Process and Content

In the context of public health, staff is familiar with multidisciplinary teams that include the conventional public health disciplines and focused health policy issues such as tobacco use, communicable disease control, fluoridation, and so on. In this new context of policy action on determinants of health, the range of professions in the alliances is significantly broadened to include, for example, agricultural economists, land use planners, social policy analysts, and environmentalists. The range of work cultures, models and frameworks used, and work styles also broaden making the process of building effective partnerships more complex and somewhat foreign. In addition to this need to build alliances and partnerships with new players, there is a parallel need to communicate about these new policy issues. For each issue, public health professionals need to learn specialized new vocabulary, identify and study its professional and academic literature, build trusting relationships with the associated informal leaders and citizen groups, and identify existing policy advocacy underway at all levels of government.

This challenge also offers significant opportunity to document our experiences in this regard in ways that will make a contribution to the literature on policy advocacy and assist others in replicating successes. Joining up advocacy efforts across local, provincial, federal and global boundaries is necessary. Otherwise, local level policy change can be rendered ineffective by action at other levels.

Accountability Structures

As governmental bodies, public health agencies are mandated to achieve certain outcomes. These mandates are usually translated into organizational structures that hold individual managers responsible for the accomplishment of specific goals. However, the “upstream” policy areas (equity, livability, sustainability, etc.) have wide influence on health inequalities and health status, requiring structures and processes which place greater value on collective accountability.

Further, building the necessary alliances for policy change is both time and labor intensive. It can take years to build a constituency within an organization, at a community level, and politically to address determinants of health issues. Yet government requires that impacts need to be measured through short-term program objectives with one or two-year time horizons for change.

Channeling Energy

One final challenge of policy change associated with determinants of health relates to the type of people who are drawn to social change work as a career choice. Interest in policy advocacy seems to manifest itself in a staff group with a strong commitment to egalitarian practice and empowerment. This same group of staff can feel restricted and frustrated by the political and sometimes cautious nature of systemic change work within a governmental organization. Energy and enthusiasm are positive qualities to be harnessed and focused toward the policy change agenda. At the same time, staff working on these issues need to balance enthusiasm with an understanding of the dynamics of the organization's decision points and processes and comprehend its complex organizational and political realities.

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Chapter 12

Establishing a Center for Health Equity and Social Justice in a Local Health Department

Adewale Troutman

Beginning in the winter of 2006, the Metro Louisville Health Department established the first Center for Health Equity as an independent division within a local health department. This chapter presents briefly the historical, demographic context and rudimentary outline of its formation. When fully operational, it will combine community-based research, education, advocacy, services, staff training, and communication strategies toward the elimination of health inequity within a social justice perspective.

INTRODUCTION: THE HISTORICAL CONTEXT

The awareness of the existence of inequities in health, health status and health outcomes between racial and ethnic groups in America is as old as the nation itself. The two-volume Pulitzer Prize nominated work of Michael Byrd and Linda Clayton, *An American Health Dilemma*, which focuses on the health of African Americans, documents this fact with scientific clarity and prolific references. W.E.B. DeBois in his work *The Philadelphia Negro*, published at the turn of the 20th century, reaffirms the existence of dramatic differences in health based on race in his examination of the health of blacks and whites at that time in history. Booker T. Washington led a movement before 1920 to create a Negro Health Week which led to the creation of a federal office of Negro Health Work that existed until the 1950's, when it is reported that the government believed it was no longer needed because all racial issues had been solved.

Of course the dramatic era known as "the Sixties" to some and "the Movement" to others had a focus on the heath of the nation's people of color and the poor. It led to the passage of Title 19 of the Social Security Act, the creation of Medicaid, the creation of the Community Health Center

Movement and the Civil Rights Acts of 1964 and 1968. If we examine closely the Title 330 centers, we see evidence of a thought process demonstrating that dealing with the health of populations was a multidisciplinary effort and needed to address housing, employment and education—a truly revolutionary concept.

With the publication of the 1985 Task Force Report on Black and Minority Health, the nation's attention was drawn to the inescapable fact that these historic inequities now prevalent in the fabric of this nation could no longer be ignored. That report documented the existence of 60,000 excess deaths per year among the nation's federally recognized minorities from six primary causes and set the stage for the examination of the role of access, financing, underepresentation of health professionals from specific racial and ethnic groups and the need for culturally competent health education. With this backdrop, along with the overarching goal of eliminating health disparities by the year 2010 delineated in the nation's health plan, we approach the creation of the Louisville Metro Health Department's Center for Health Equity.

LOUISVILLE'S HISTORICAL LEGACY

The city of Louisville is by far the largest metropolitan area in the state of Kentucky. In this state of greater than four million people, over 700,000 call Louisville home. Of that number, approximately 19% are African American with about 5% Latino and other. It sits on the banks of the Ohio River and boasts of its history as the starting point of the Lewis and Clark expedition, which included an enslaved giant of a man known as York. His statue (designed by a local African American artist) sits in a prominent place at river's edge. It is the home of Muhammad Ali and the recently completed Ali Center for Peace and Justice. The bulk of downtown development is reflected in the shining new condominiums and loft apartments and the buzz over the prospect of a new downtown arena to house the University of Louisville Cardinals basketball team. It is also the home of the Kentucky Derby; the state theme song until recently still sang the words that "it's summer, the darkies are gay." Under the newly merged government it is the 16th largest city in the nation. However, this growing city by the river is in fact two cities—one East, white, prosperous and healthy; one West, economically deprived, African American and a poster child for negative outcomes on measures of the social determinants on health.

Upon arrival in Louisville after six years as Director of the Fulton County Health Department in Atlanta, Georgia, an initial nonscientific analysis of that city led me to believe that all the conditions existed that would demonstrate a significant degree of inequities in health, access to healthcare and health outcomes that I have seen in other major cities across the nation: under-education, poverty, poor housing stock, residential segregation, dramatic inequities in economic development and a history of racism.

I arrived in Louisville coincident with the development and release of the Mayor's new strategic plan. My arrival was too late to place language appropriate to the importance of health in the city's future, but I was able to insert a focus on eliminating health disparities, a pragmatic phrase here, in the language of the city's philosophical governing document that would provide legitimacy to the future work that my department would undertake. The Mayor, a supporter of a healthy city, accepted this language, which was consistent with discussions held during my recruitment. Those conversations led me to believe that the city administration was willing to address these issues and that all that was needed was leadership.

The language of health inequities was foreign to much of the Louisville community and the language of health equity was unheard of. In addition to this focus on inequities, I made the clear and strong case for a data-driven health department. This principle was supported by recognition that local public health departments had three core functions: assessment, assurance and policy development. The most relevant here was our commitment to the assessment of health status. In order to move ahead, much needed to be done. We needed to develop funding for efforts aimed at establishing a viable database to document the existence of health inequities and then create a funding stream for the creation of a response to that data—namely the Center for Health Equity. The data and the language of equity had to be familiar to the department, the Metro Council, the Mayor and even the community.

RESEARCH AND PLANNING IN THE LOCAL HEALTH DEPARTMENT

To that end, our departmental strategic planning process resulted in the development of seven strategic goals. The first mirrored the overarching goals of Healthy People 2010. It simply stated that the health department would improve the health and wellness of the Louisville community. The second, however, stated that the department would create *Health Equity through Social Justice* in Louisville. A departmental committee was then formed to attend to each strategic goal; the entire document was presented in focus groups to every employee of the Louisville Metro Health Department for discussion and eventual support.

Reorganization efforts within my department led to the creation of the Office of Policy Planning and Evaluation. With this move, a locus of activity to meet the needs of community assessment and policy development was now a reality. I made clear to the Metro Council the need to appropriate funds to accomplish this task. My first budget request focused on the funding of a comprehensive Community Health Status Assessment Report. I made the case to the council and the Mayor that since a core function of the health department was assessment, we needed those funds to bring our assessment efforts up to national standards. The results of the funded report were presented to the Council, the Mayor and the Board of Health as well as the press. These results made it painfully evident to all that there were in fact two Louisvilles. Those dedicated budgeted funds led to the identification of the following sample data:

1. The age adjusted death rate from all causes for African Americans was 1209.5/100,000 compared to 941.3/100,000 for whites
2. African Americans had higher death rates for four of the six leading causes of death in Louisville

3. Age adjusted death rates for diseases of the heart for African Americans was 357.6 compared to 297.4 for whites
4. The diabetes death rate for African Americans was 74% higher than for whites
5. The infant mortality rate was twice the rate for African American babies as compared to whites
6. The homicide rate for African Americans was six times the rate of homicides among whites
7. African Americans demonstrated significantly higher rates for HIV/AIDS, syphilis, gonorrhea and chlamydia
8. 82% of African American children in the public school system come from single parent households
9. Disproportionate rates of uninsured amongst African Americans and Latinos
10. Age adjusted death rates from cancer among African Americans was almost twice the rate of whites at 92.8/100,000 vs. 55.9/100,000
11. African American men in Louisville, in a state with the highest smoking rate in the nation, had the highest smoking rate in Louisville

The release of the report raised significant interest in many segments of the community and the process of community education swung into high gear. Presentations at churches, political meetings, civic groups, and policy maker gatherings all focused on the presentation and discussions of the data and the condition of the African American community in particular. The language of health equity and the association of inequity with the absence of social justice were being spread throughout Louisville. The following definition of health inequities has become the foundation of the departmental and community conversation on this issue.

Health Inequities are systemic, avoidable, unfair and unjust differences in health status and mortality rates and in the distribution of disease and illness across population groups. They are sustained over time and generations and beyond the control of individuals.

Equity then is understood in relation to a process where fairness, justice and an attention and commitment to the rights of individuals and peoples are at the core.

These definitions necessitate placing the issue of human rights, social justice and the right to health in the forefront of any discussion of the health status of population groups whose health status is measurably worse than that of the more privileged groups in the U.S., or for that matter in the world.

Armed with the funded Community Health Status Report with its inescapable conclusions and the strategic plan of the Mayor and the second strategic goal of the department, we implemented mandatory staff training in Creating Health Equity through Social Justice, the second strategic goal of the department. As such, it will be a major focus of the department in all its dealings. It will influence all the work we do as an agency. Our strategic goals are discussed in leadership team meetings and are a focus of our project management methodology of leadership. Its placement therefore allows us to cut across traditional silos and recognize the multidisciplinary nature of this work. Each section of our organization gets to see its connection and its place in this work. We recognize that old habits die hard but they do die, allowing for the establishment of more progressive and healthy ways of organizational and community living.

THE CENTER FOR HEALTH EQUITY

The methodology of the department's second strategic goal called for the creation of a Center for Health Equity appropriately placed in our table of organization and adequately funded. The next budget cycle provided the opportunity to make the Center a reality. With the data collected and presented with budgeted funds, the second-year budget called for the funding of the desired Center, which is not a grant-funded operation. With the passage of the budget, my request for $250,000 to found the Center was a reality. The positions, as well as the operational dollars included in the budget, are permanent. The language of health equity had been introduced, the department staff had been trained, and the strategic planning process of both the Mayor and the department called for its creation.

The structure of the Center and its relationship to the rest of the department will be a critical determinant of its success. Metro government is based on a cabinet arrangement of departments. As such, Metro Health is linked with Human Services, Workforce Development, Community Action and the Family Health Centers (an FQHC with multiple sites). These departments serve the population around many of the social determinants critical to creating health equity. The structure represents an opportunity to integrate the theory and practice of health equity across multiple departments. For example, we recently raised the issue of tying job development consistently to health insurance, an issue not previously considered. Within the metro health department, the Center Director's position has been established at the level of administrator. That places it just below the Deputy Director's level in the table of organization. The Center's Director thus reports directly to the Department Director. In a specific effort to break down traditional silos in public health practice, all administrators will be integrated into an administrative team. These seven high-level staffers will meet to coordinate their activities and apply the principles of health equity to all the work of the department. Every aspect of the work of the department will be evaluated in relationship to its incorporation of the principles of health equity. Departmental performance measures are being developed to measure this integration of equity principles and practice into our work. For instance, we are preparing for a pandemic Flu summit. The Center will play a key role in insuring that issues of vulnerable populations are at the center of our planning efforts. Working with the training officer, they will facilitate ongoing training in these principles for the entire workforce of the department.

Distinctions in its make-up and mission differentiate the Center from other similar endeavors. It has been created and lives at a local health department. It is not a university-based academically focused facility, although the University of Louisville School of Public Health has committed to contribute to its funding in year two. I'm sure that my position as an Associate Professor in the School of Public Health and Information Sciences has had a positive influence on that decision. That speaks to the utility of this new and evolving model of local public health leadership.

GOALS

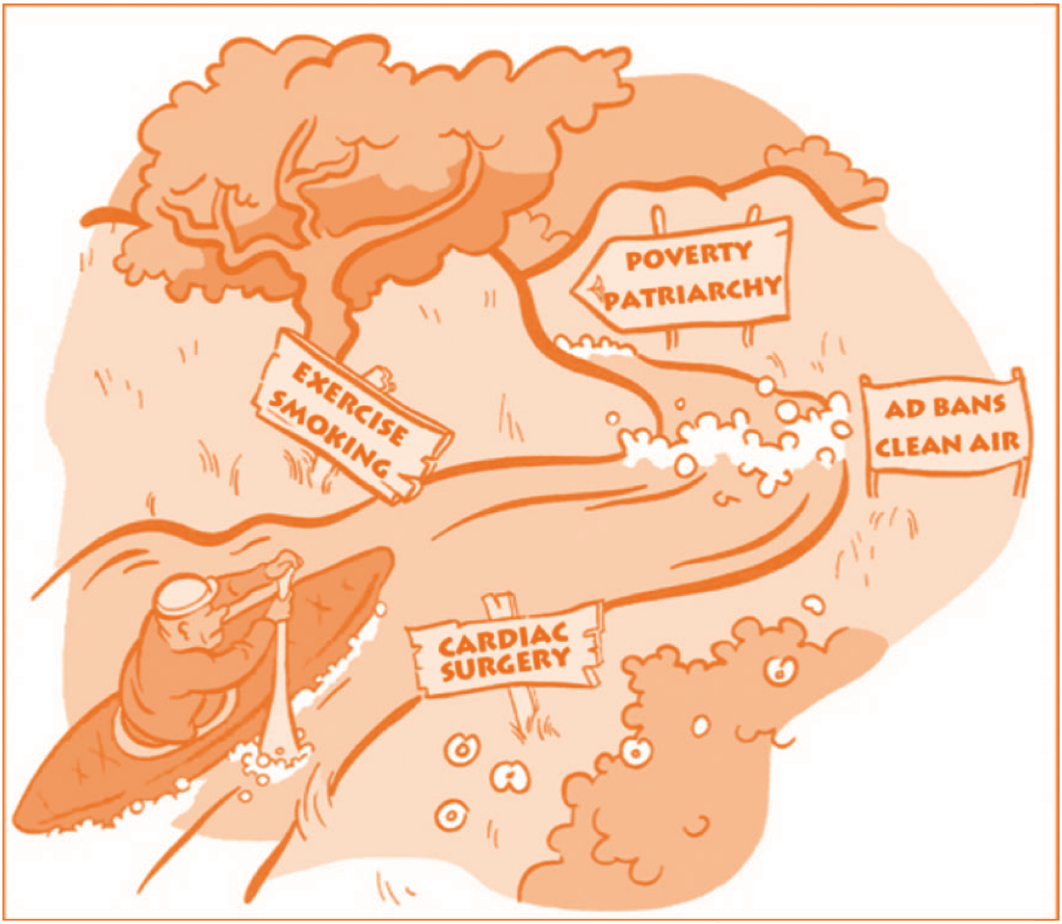
The Center will accomplish several things. Primarily a service institution, it will strive to change the paradigm of health in Louisville to focus on rights, equity, social determinants and justice as foundations of health. In addition, the Center will partner with the University to develop research proposals—but only proposals that fit the model of Community Based Participatory Research and Applied Research principles. The Center has reached out to the Morehouse School of Medicine and is developing a Memorandum of Understanding with them. Morehouse School of Medicine has a Prevention Research Center and an NIH-funded Export Center for Health Disparities Research. This research effort will focus on defining the local causes of health inequities and develop true community partnerships in generating those research initiatives and defining benefits to be derived by the communities targeted for that research.

The Center will expand general and specific community awareness of the existence of inequities and their negative effect on Metro Louisville. It will serve as a vehicle for expanding our knowledge of specific communities through targeted health status reporting, including the use of focus groups and epidemiologic data. The center will lead the way in applying best practices from across the nation in reducing and eventually eliminating health inequities in Metro Louisville.

The Center will also forge new partnerships and coalitions with agencies and organizations not traditionally associated with public/community health efforts, such as human rights organizations and groups traditionally seen as social justice advocates. In recognition of the importance of social marketing, the Center will develop and launch a unique campaign using the tools of marketing to move the community to action and participating in a paradigm shift that recognizes the principles of health as a human right and sees the creation of heath equity as a basic social necessity. In that light, a new University of Louisville initiative will focus on “Creating Human Equity in the West End” with a focus on health, economic development, education and human services. Our work at the health department and our examination of health equity has been a major influence on that decision. This systems change approach will dramatically expand our ability to see health in a holistic view and expand community support for the mission of public health. The center will also provide a primary source of education for metro staff and training for health professions students and policy makers regarding the dynamics of health and health inequities. Our intent is to influence curriculum change at our academic institutions—undergraduate, graduate and professional—as it relates to health, equity and social justice. This includes an understanding of the role of health in economic development. An undergraduate course, “Health Issues in the African American Community,” has been developed based entirely on the principles of health equity and social justice and focusing on the work of established national authorities in this field. All aspects of the Center’s work will be documented for general consumption and for potential replication across the nation.

The Center has been placed in a community location in the West End, and its first initiative is just beginning. In its organizational stages, it will start by exploring the health of the region’s youth in partnership with one of the 1960’s icons of social justice, 1968 Olympian gold medallist and world record holder Tommie Smith, who along with John Carlos made an international comment on the status of African Americans with their raised black gloved fist, black socks and lowered heads on the Olympic medal stand. The Center has already become a place for policy makers to seek advice and direction on related issues. To date, two state legislators have requested our assistance in crafting legislation around the health of the state's populations of color; we are advising them on the inclusion of principles and language of health equity and social justice. We have also received funding to create a model for the policy education of local public health departments. This will be another source of education and influence on these vital themes. Plans are under way for our first conference on equity, social justice, social determinants and health.

We have made substantial progress in our effort to bring principles of social justice and practice to the work of public health. There have also been obstacles. However it is reasonable to assume that by the end of this first year (2006) the Center will be firmly established in the Louisville community with our many stakeholders, our governing structure and the primary funders of health-related activity in this city. The entire staff will be grounded in these principles and the Center for Health Equity will be a locus of activity around the interactions between health, social justice, community education and action. Hopefully, the work we do will serve as a model for other local health departments across the country to develop a different and in my opinion a more relevant paradigm to eliminate inequities in health.



Refocusing Upstream[1]

[1] Refocusing upstream is a key theme of this report and of public health generally. It was popularized in the 1970s by Professor John McKinlay, the New Zealand medical sociologist who established the New England Research Institute in Boston. It refers to the idea that the practice of medicine is equivalent to people who are constantly finding more efficient ways of pulling drowning people from a river. They are so engaged with improving their methods and technologies for doing this that they have no time to look upstream to see who it is that is pushing the people into the river in the first place (in other words the social, economic and political forces causing ill-health).

Graphic courtesy of New England Research Institute, Boston; adapted by Paul Blackburn, Division of Public Health, University of Liverpool.

Source Reprint: Politics of Health Group, UK Health Watch, *The Experience of Health in an Unequal Society* (2005).

APPENDICES

Appendix A

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Appendix B

Measuring Social Determinants of Health Inequities: The Connecticut Initiative

Baker Salsbury, Jennifer Kertanis, David Carroll, and Elaine O'Keefe

INTRODUCTION

Connecticut is the most affluent state in the nation, yet profound health inequities exist in our population that belie this material wealth. For all the attention paid to health disparities as a salient public health issue, the remedies directed at the "problem" do not address the underlying causes. Our continuing failure to confront root causes simply means that we abandon our core mission in public health of promoting optimal conditions that support good health for all.

As a discipline dedicated to the prevention of disease, public health must look beyond traditional behavior change interventions and engage in efforts to eliminate social injustices that are the root causes of inequities in health status. Nonetheless, many health professionals find it more comfortable to act on symptoms or consequences. In the words of one epidemiologist, "Modern epidemiology is oriented to explaining and quantifying the bobbing of corks on the surface waters, while largely disregarding the stronger undercurrents that determine where, on average, the cluster of corks ends up along the shoreline of risk."[1] These undercurrents, and not the characteristics of individuals, must become the focus of public health today.

In 2003 the Connecticut Association of Directors of Health, Inc. (CADH) came together with The National Association of County & City Health Officials (NACCHO) and a diverse group of stakeholders to launch an initiative aimed at incorporating the principles of health equity through social justice into public health practice. The Universal Health Care Foundation of Connecticut provided the seed money to support the planning phase. Under the acronym HEAT (Health Equity Action Team), the coalition set out to achieve two fundamental tasks that would lay the groundwork for future action:

1. Surveying the views of local public health directors on public health's purported role in achieving health equity through social justice; and
2. Inquiring what health directors perceived their health departments could do to address root causes of inequities, including: institutional racism and other forms of discrimination; unequal distribution of resources; environmental injustice; and unequal educational opportunities, among others.

We recognized from the outset that the HEAT initiative would fail if local health directors did not embrace the concept of health equity through social justice. Through a survey and subsequent focus groups, it became clear that the vast majority of local health directors not only believed that public health should engage in efforts to address the root causes of health inequities but also believed it was their particular responsibility as public health practitioners. The survey demonstrated a consensus among health directors that public health does, indeed, have a role to play with respect to health equity and social justice—a leadership role and, at times, a supporting role with other community partners. The findings indicated that public health has a responsibility to address the root causes of ill health as both advocate and activist for the re-engineering of environmental, economic, and social policies. While survey respondents acknowledged multiple barriers associated with this work, they also identified many strategies and actions that should be employed to assist local health practitioners move more decisively into the social justice milieu. Moreover, they expressed a desire to receive some guidance about what to do to achieve health equity, with most recognizing that the work should begin with an effort to cultivate a greater understanding and awareness of the issues related to health and social inequalities among their own department staff.

Another theme to emerge was the need for data that would illuminate the underlying conditions that perpetuate health inequities at the community level. In order to affect change, health directors generally agree that such data, provided or acquired in a timely manner, are important to illustrate social and economic conditions that lead to health inequities in our communities. Thus the notion of producing a tool to generate data to profile health inequities at the local level was born and ultimately became the new focus of the HEAT initiative. The tool is called the Social Determinants of Health Equity Index.

SOCIAL DETERMINANTS OF HEALTH EQUITY INDEX (SDHEI)

The SDHEI will serve several purposes:

1. Provide a portrait of social, economic and environmental conditions related to inequities in health and an instrument to measure inequities.
2. Assist local health departments to engage in community dialogue regarding health disparities, focusing on root causes, not individual behaviors.
3. Facilitate community discourse/actions related to health inequities framed in social, economic and environmental conditions.

The Index will examine the essential characteristics and conditions of a community associated with inequities in health, for example: employment, adequacy of housing, poverty rates, etc., and seek to establish correlations with critical health outcomes, for example: infant mortality, excessive morbidity, rates of disease, etc. It will also provide a way to communicate a concept of health equity that can inspire people to action. While traditional risk factor profiles based on individual level determinants are often the foundation of public health interventions, focusing on the underlying social, environmental and economic factors will produce more wide-ranging health benefits for communities as a whole.

IMPORTANT CONSIDERATIONS IN CONCEPTUALIZING AND CONSTRUCTING THE INDEX

Several important assumptions underlie the construction of the Index. Foremost is the premise that social conditions are major determinant influences on health status. These influences, such as income, education and occupation, help determine individual biology, risk behaviors, environmental exposures and access to resources that promote health. Larger institutional forces affect these determinants, forces that include discrimination based on race, class, gender and age; segregation; lack of political control and access to decision making structures; and public and corporate policies that affect labor markets, trade, taxes, wages, land use and regulations.

The Social Determinants of Health Equity Index (SDHEI) was thus conceived as an instrument with the capacity for locating, quantifying and measuring the social determinants that lead to health disparities between different population groups, not as a tool to measure the usual health outcome data that are commonly employed in community health assessments. To construct an instrument capable of fulfilling this function, it was necessary to address several important considerations:

1. The significance of common meanings for the critical concepts associated with health inequity. The terms "disparity," "inequity" and "inequality" have been used interchangeably by practitioners, policy analysts and researchers as they refer to differences in health between different groups. As a result, disagreements have surfaced over the definition and use of these. As Carter-Pokras and Bouquet have stated, "These conflicting views have implications for resource allocation and reflect differing political ideologies."[2]

Consequently, CADH decided early on that clear definitions were critical when discussing the SDHEI's purpose and its implications, especially the distinction between "inequalities" and "inequities." Virtually all health status, whether individually or among populations, is "unequal." That's to be expected. Our genetic makeup, our ethnicity or race, our environmental beginnings, our social construct, our personal behaviors—all contribute to differing, unequal health status, even among like individuals. But within that universe of inequality, our health status is more particularly defined and made discrete by the emergence of a "moral dimension" —as for example, when our health status is impacted by circumstances and forces that are unjust, unfair, unavoidable, and not attributable to individual choice or behavior. These are health *inequities*.

Thus, our efforts to devise a SDHEI are prompted by a moral premise; that disparities in health status that arise from unfair circumstances, beyond our choice or control, and avoidable, reflect inequities in health status, and must be challenged and ultimately changed if we are to be true to the fundamental moral precepts of our society.

2. The need for a systematic methodology. The credibility and ultimate effectiveness of any measurement tool is inextricably tied to the soundness of its methodology. CADH conducted a thorough examination of existing indices and methodologies, both national and international, to ascertain their premises and review their research methodologies. Based on this analysis, CADH decided that the SDHEI framework should consist of the following elements:

- A Set of Social Determinants
- Indicator Selection Criteria
- Indicator Definitions and a Rationale for their Usage
- Data Sources
- Reference Points and Measurement Scales
- Methods of Calculating and Scoring the Index

Further, a decision to pre-test the SDHEI in two target communities was seen as critical to refining the instrument prior to its utilization in pilot communities.

3. The importance of taking a holistic perspective on the social determinants of health inequity. From the outset we viewed social determinants as representing the context in which people live their lives—their living and working situation. The interplay between social determinants such as income, wealth and assets, availability of affordable housing, quality of schools, school readiness and educational experience, and adequate housing, altogether construct the social conditions that affect the health of population groups.

Given the overall importance of their impact, we determined that the initial selection of social determinants should be as encompassing as possible, including the various influences that shape an individual's social, economic and physical environments, recognizing that limitations would inevitably arise, such as the lack of data to support certain determinants.

4. The challenge of developing effective and responsive measures of disparities. The SDHEI's usefulness will be based on its capacity to quantify the size and magnitude of inequities. This capability is largely dependent on quality of indicators used. However, the identification of effective indicators is problematic. A number of considerations come into play that have major implications for what measures can and cannot be used.

Decisions therefore had to be made at the outset regarding the selection of indicators, including:

- Types of indicators that should be used, i.e. input, process, outcome
- Qualities that indicators should possess, i.e. reliability, validity, sensitivity
- Integration of qualitative measures into a quantitative framework
- Level of disaggregation that indicators should be capable of, i.e. geographic, demographic, social group
- Use of proxy indicators
- Availability of adequate data sources

5. The significance of addressing "up-stream" issues. We assumed that the social conditions that influence health inequities require a multi-level perspective. This assumption was based on the growing body of literature that explores the relationship between health outcomes and social-institutional forces such as discrimination, political access and power, and social and corporate policies. It was therefore essential that the SDHEI incorporate an "upstream" consideration of these broad forces and their impact on the social determinants of health inequity.

Within a multi-level framework, the SDHEI has to function as a bridge between the social-institutional forces and social determinants on one end of the spectrum and community action and structural change at the other end. This posed a major challenge from a design perspective.

6. The need for utility at the neighborhood level. Ultimately the SDHEI's value rests on its capacity to stimulate community action and prompt structural changes that reflect local needs. The SDHEI has to represent a process through which the community could measure health inequities at the neighborhood level and give voice to its concerns. Further the SDHEI must be an instrument whose measurement and analysis is sufficiently credible to support meaningful structural change as it involves equity-driven policies, priorities, resource allocation and governance. The SDHEI must be scientific enough in its construction to pass the tests of reliability and validity, but not so scientific as to be seen as an irrelevant academic exercise by community advocates.

THE SDHEI FRAMEWORK—HOW IT'S CONSTRUCTED AND HOW IT WORKS

There are four levels to the SDHEI: Social Determinants, Components, Indicators and Data Sources.

Social Determinants of Health.

These represent the processes or critical pathways whose collective interaction creates the social conditions that affect the health of population groups. The interplay between determinants gives rise to circumstances that can lead to low income, unemployment, underemployment, lack of a preschool experience, poor nutrition, crowded housing, unsanitary conditions, social stress and no primary care physician.

A set of ten social determinants was chosen for the SDHEI.

- Economic Security and Financial Resources
- Livelihood Security and Employment Opportunity
- School Readiness and Educational Attainment
- Environmental Quality
- Availability and Utilization of Quality Medical Care
- Health Status
- Adequate, Affordable and Safe Housing
- Community Safety and Security
- Transportation

Components. Within each Determinant, Components serve as the operational definition of the Social Determinants by specifying the composite elements that comprise them. For example, the Adequate, Affordable and Safe Housing Determinant consists of the following Components: Condition, Ownership, Values, and Affordability.

The Components are not intended to be all-inclusive. They are primarily determined by their capacity for measurability. In other words, are they quantifiable, supported by consistent data sources and able to be disaggregated to the city or neighborhood level?

Indicators. Within each Component, Indicators are the measurements used to describe the condition of a population group on a specific characteristic or event. For example, Housing Affordability consists of the following Indicators: rental vacancy rate; percent of households paying more than 30% of their household income for housing; difference between median annual household income and fair market rent; difference between median annual household income and median sales price of existing homes; and number of subsidized housing units.

A set of selection criteria was designed to guide decisions on the choice of indicators to be included in the SDHEI. Among the criteria used were:

- ***Availability*** – is available, accessible and affordable
- ***Reliability*** – is based on consistently collected, compiled and calculated data
- ***Validity*** – measures what it purports to measure
- ***Measurability*** – is easily quantifiable and lends itself to numeric scaling
- ***Capacity to be Disaggregated*** – can be disaggregated into target groups of interest based on race/ethnicity, gender, age and place of residence
- ***Sensitivity*** – is able to monitor changes over time
- ***Compelling and Interesting*** – lends itself to understanding and has the capability to resonate with the public, media and decision-makers.

The SDHEI utilizes three types of Indicators: Core, Complementary, and Identifying.

a) ***Core Indicators*** fully meet the selection criteria and answer two questions. "What is the size or magnitude of the inequities?" "Where do the inequities exist?" Core Indicators underpin the SDHEI's basic function since they have reference points and measurement scales that will be used to calculate scoring.

b) ***Complementary Indicators*** are measures that can be used by communities to support further, in-depth analysis of the issues raised by the SDHEI. They help to answer the question, "Why is this an inequity?" As such, Complementary Indicators move the analysis "upstream" by placing greater focus on the source of a disparity. Complementary Indicators have been developed in nine areas:

- Urban Environment/ Sanitation
- Nutrition/ Life Style
- Natural Environment
- Political Access and Power
- Social Cohesion
- Stress

- Community Organization
- Work Environment
- Public Transit

c) ***Identifying Indicators*** specify the population groups most affected by disparities from demographic and health outcomes perspectives. They answer two fundamental questions. "Who is most affected by the inequities?" "How are they affected in terms of health status and health outcomes?" Identifying Indicators enable communities to examine existing disparities by race/ethnicity, gender, age, place of residence and class, as well the incidence or prevalence for certain diseases and morbidity rates.

FROM TOOL TO ACTION: THE NEXT STEPS

As described, the SDHEI transcends a mere measurement instrument. Properly applied, it is an inherently political tool that will provoke action to change unacceptable conditions in communities. And it may threaten some that choose to engage, for the process will intentionally shine the light on fundamental inequities that underlie disparate health outcomes for segments of the population. Such exposure must occur if public health is to heed seriously the edict of the Institute of Medicine (IOM) years ago when they asserted that a principal role of public health was "to assure the conditions in which people may be healthy." This is a profoundly political statement that departs from the traditional preoccupation with changing health status by changing people, in favor of a position where public health departments strive to alter conditions that allow health inequities to thrive. In essence, the IOM report beckoned us to move upstream to refocus on the root causes of differentials in health status and to acknowledge that these differences are largely based on circumstances that are unjust, avoidable, and unfair. The SDHEI will give us the framework to begin this important paradigm shift in the practice of local public health in Connecticut and the nation.

If the SDHEI is to serve as a catalyst for structural and policy change in local communities it is apparent that the process will require a large measure of collaboration and investment on the part of diverse segments of those cities and towns that heed the call to action. This "community engagement" dimension of the SDHEI is the next major challenge to be tackled by the HEAT team as they continue to construct and refine the index. In the years ahead several Connecticut towns or cities with different demographic profiles will be enlisted to attempt to implement the SDHEI process in their areas as a "pre-test." This pre-test will serve to gauge local reactions to the relevance and utility of the SDHEI, as it evolves, and help to shape the "final" product. Simultaneously, a different pre-test will be conducted by the HEAT researchers to ascertain the availability of data sources that are required to undertake the quantitative component of the SDHEI.

If successfully planned, the tool that emerges from the pre-test process then will be piloted in three or more demonstration sites with considerable guidance on how to orchestrate and sustain the endeavor with ample input from community stakeholders. The demonstration site projects will be lead by local health departments that are selected based on criteria established by HEAT in the early stages of the Connecticut initiative. Though not fully articulated, these criteria will likely include demonstrated collaboration with various constituencies and partners in the health department's jurisdiction; letters of support from key individuals (including a local official such as the mayor) that express a genuine commitment to explore and confront issues of health equity; a demonstrated prior investment in addressing the needs of socially and economically disadvantaged populations and multicultural health issues; and the infrastructure needed to support the SDHEI process.

A fundamental component of the SDHEI demonstration project experience will entail cultivating understanding and support on the part of staff that work in the lead health departments. This endeavor is itself a major undertaking. In addition to providing awareness training to the public health workforce, it is essential that our work environments encourage and support the adoption of a newly defined philosophy of public health practice incorporating a social justice perspective.

Fortuitously, this workforce development goal complements another NACCHO supported initiative that was conceived to bolster local health departments that wish to begin the process of incorporating health equity and social justice principles in their daily public health practice. The locus of this vanguard initiative is the Ingham County Health Department in Michigan. In 2004-05, Ingham County public health leaders have embarked on a journey to institutionalize health equity principles and practices into the culture of their organization through a dialogue process that was carefully designed to involve a diversity of staff members. Their experience will eventually be extended to other local health departments to enable them to undertake a similar dialogue process in their organizations. The Connecticut SDHEI demonstration sites would be a natural setting in which to replicate this dialogue process as the way toward transforming internal and external practices in order to address the root causes of health inequities, and as prelude to implementing the SDHEI with other community partners.

NOTES

1. Anthony McMichael, "The Health of Persons, Populations, and Planets: Epidemiology Comes Full Circle," Epidemiology 6 (1995): 633.
2. Olivia Carter-Pokras and Claudia Bouquet, "What is a Health Disparity?" Public Health Reports 117 (September-October, 2002): 426-34.

Appendix C: Communications Strategies

1. Talking about Public Health: Developing America's "Second Language"

Lawrence Wallack and Regina Lawrence

In their classic analysis of American culture, *Habits of the Heart*, Robert Bellah and his colleagues[1] argued that the first "language" of American life is individualism. This is a language centered on the values of freedom, self-determination, selfdiscipline, personal responsibility, and limited government. The language of individualism is easy for most Americans to use, because it taps into values reinforced by dominant societal myths endlessly repeated in the popular culture. But although it may be this country's first language, individualism is not a sufficient language for advancing public health.

Bellah and his colleagues also identified a second language in US culture—a language of interconnectedness. This is a language of egalitarian and humanitarian values, of interdependence and community. We have drawn on literature from the fields of sociology and political science as well as from public health to suggest how that second language could be more clearly articulated in order to talk more effectively to the general public, journalists, and policymakers about public health. By *public health* we refer in a broad sense to the question of how a society balances considerations of personal responsibility and social accountability in public policies that impact health. *Public health* focuses on the *health of populations*. But despite wide agreement among public health professionals on that general approach, what it *means* to focus on the health of populations is not necessarily well defined.

A substantial body of theoretical and empirical work shows that the state of the public's health unavoidably reflects systemic forces as well as individual behaviors. Indeed, "a key class of determinants of health is the full set of macrosocioeconomic and cultural factors that operate at the societal level,"[2 (p233)] necessitating interventions that span the many levels of the society in which any given health problem exists.[3,4] Ironically, many professionals in the field of public health believe in the importance of social determinants of health yet routinely rely on strategies that largely ignore social determinants in favor of individual, behavioral approaches to improving health. Although this disconnect between public health theory and practice has several sources, including the structural and philosophical limitations of conventional public health,[5] a significant cause is the fact that a language to properly express the unique public health approach has not been adequately developed.

The lack of a well-developed language for talking about public health has serious consequences that extend beyond how public health professionals spend their working hours. Public policies that reflect the disciplinary theory of public health remain difficult to enact in the United States. Egalitarianism, humanitarianism, and social responsibility—values that lie at the core of a social justice orientation to public health[6,7] —often seem inadequate to respond effectively to the moral resonance of individualism. Yet in a culture preoccupied with personal responsibility and suspicious of governmental power, it is imperative for the public health profession to tap into these countervailing values in order to become more effective advocates for the public health approach to the nation's many health challenges.

VALUES AND PUBLIC HEALTH IN THE UNITED STATES

Although it is useful to analyze cultures in terms of their dominant beliefs, cultures of developed societies typically exhibit multiple value systems, with various subgroups weighting those values differently.[8] Despite the well-documented prominence of individualism in US culture,[9–11] equality, compassion, community, and social responsibility have, throughout US history, motivated people, particularly marginalized groups, to act collectively to address social problems.[12,13] Although support for egalitarian values is more limited in the United States than in many other Western democracies, and the term *welfare* is highly unpopular,[14] many Americans nevertheless believe that government and society have a responsibility to ensure that the opportunities to build a successful life be enjoyed roughly equally by all—beliefs that, research shows, are rooted in humanitarian values.[15–17]

Empirical research also suggests, however, that most Americans do not articulate these values nearly as easily as they use the language of individualism. For example, when researchers asked members of the public to explain their support for or opposition to social welfare policies, they found that those who opposed such policies did so in terms of abstract principles like personal responsibility and limited government. But the abstract principles of equality, fairness, and compassion that underlie social welfare policies were not readily articulated even by supporters of those policies.[18] In other words, these people knew that they supported these policies, but they couldn't easily explain why.

And therein lies the rub: these values of equality, fairness, and compassion are closely associated with public health. One of most visible definitions of public health is "the process of assuring the conditions in which people can be healthy."[19] In the context of public health, each element of that definition—process, assuring, conditions—evokes values beyond individualism. Yet the predominance of the first language of individualism makes the mission of public health often seem somewhat alien to the general public, as well as policymakers, journalists, and other elites.

For example, public health focuses on "conditions" that make *populations* more or less healthy, which shifts both the causal explanation of public health problems and their potential solutions away from a sole focus on individual choice. These are relatively complicated explanations compared with the simple ones generated by the more reductionist language of individualism. Take the example of obesity: it is much simpler to believe that people are obese because they eat too much and don't exercise enough. News coverage has framed the issue predominantly in terms of personal responsibility, the frame also favored by those who oppose policy changes such as eliminating junk food from schools and requiring better food labeling. Although the balance of public discourse now seems to be shifting, until recently most news coverage did not convey the idea that people are also obese because our society is organized in a way that encourages overconsumption of fat laden, high-calorie food (through advertising, marketing, and an economic system requiring 2 wage earners) and limits outlets for physical activity (for example, by elimination of physical education in schools and heavy reliance on automobiles).[20] In the first language, the point that people need more self-discipline simply needs to be asserted and its assumptions (e.g., personal responsibility) are intuitively grasped and expected conclusions reached. In the second language, the point that society needs to be organized in a healthier way must be explained, because the assumptions (e.g., social accountability, shared responsibility) are not easily grasped and the conclusion needs to be argued.

As cognitive linguist George Lakoff has revealed, the metaphors underlying the language of individualism form a coherent and compelling package rooted in widely accepted moral values.[21] The political virtues of limited government and personal responsibility correspond, at a subconscious level, with many Americans' mental model of personal morality in which self-reliance is a moral obligation. Government policies that interfere with the mechanisms of personal responsibility and self-discipline are therefore seen, in a sense, as immoral. Thus, a predominant belief is that "people should accept the consequences of their own irresponsibility or lack of self-discipline, since they will never become responsible and self-disciplined if they don't have to face those consequences."[21(p97)] When seen through this lens, many social welfare and public health policies look like wrong headed efforts to "protect people from themselves," thus (immorally) undermining self-discipline.

Consequently, the language of public health seems foreign ("Sounds like central planning—didn't they fail at that in the old Soviet Union?"), and its paternalistic objectives and methods for protecting the health of populations (government as national nanny) can be difficult to support. Even the public health data amassed over the years that demonstrate empirically the relation between social inequality and health inequality[22–25] can be hard for the public to understand, in part because the predominant moral framework makes it easier for people to imagine what one person might or might not do to be healthy compared with what society might collectively do to ensure health for the population. Thus, individualism, as the "dominant orientation in the United States . . . profoundly restricts the content of public health programs."[5(p25)]

DEVELOPING THE LANGUAGE OF INTERCONNECTION

As Dan Beauchamp,[6] Ann Robertson,[7] and others have noted, the moral framework underlying the public health approach differs from the predominant moral framework of individualism. Robertson argued that health promotion "represents a moral/ethical enterprise" and that the language of public health is essentially "a moral discourse that links health promotion to the pursuit of the *common* good" (emphasis added).[7] Focusing on the health of populations inevitably raises questions about the health effects of how society is organized—questions difficult to raise in a public discourse suffused with individualism.

Perhaps intuitively recognizing this difficulty, many public health advocates tend to fall back on a language of service provision and behavior change—clear, concrete, easily understandable approaches. But that strategy reinforces the first language of individualism by emphasizing a risk factor approach that leads to a discourse about behavioral strategies and treatments for existing conditions.[5] Discussion of social, political, and economic context is often only cursory. When these contextual issues—the more complicated story of public health—are not discussed, their importance is implicitly diminished and efforts to improve the health of populations are weakened.

To advance public health with the necessary comprehension and urgency requires articulating an over arching value that we call *interconnection*. Interconnection is not a new idea. It invokes long-held ideals associated with the words *public*, *social*, and *community*. Indeed, as Dan Beauchamp argued nearly 20 years ago, the practice of public health is premised on a "group principle" that "has tended to be subordinated to the language of individual rights." But "public health as a second language," he wrote, "reminds us that we are not only individuals, we are also a community and a body politic, and that we have shared commitments to one another and promises to keep."[26(p34)] Echoing Beauchamp, Robertson[7] called for the development of a "moral economy of interdependence" in which beliefs about justice and need are informed by a sense of mutual obligation that "acknowledges our fundamental interdependence."[7(p124)]

Various contemporary thinkers have also begun to develop this language of interconnection. Lakoff,[21] for example, envisioned a language of "cultivated interdependence" in which those who have been nurtured accept a corresponding responsibility to nurture others. Political theorist Mary Ann Glendon[27] argued for challenging the notion of the "self-determining, unencumbered individual, a being connected to others only by choice."[27(p12)] And political theorist Joan Tronto[28] argued for developing an "ethic of care" that would recognize that "humans are not fully autonomous, but must always be understood in a condition of interdependence."[28(p162)] She argued, "The moral question an ethic of care takes as central is not—What, if anything, do I (we) owe to others? But rather—How can I (we) best meet my (our) caring responsibilities?"[28(p137)]

Underlying all these visions is the belief that human existence is as much social as individual and that individual well-being depends to a significant degree on caring and equitable social relationships. Recognizing human interconnection broadens the moral focus of individual responsibility for one's self and family to include shared responsibility for societal conditions. Without the glue of interconnection, in fact, egalitarian and humanitarian ideals can lack moral heft. Robertson,[7] for example, based her proposed language of public health on the recognition of need. But to be effective in advancing public health, the notion of need must (as Robertson also suggested) be couched in terms of *shared* needs and reciprocity. It is less compelling to argue that autonomous individuals "should" help one another than to argue that our individual well-being is inescapably a product of the quality of our social relationships.[28]

There are instances in which public health professionals have effectively articulated this language of community to enhance population health. One example is the "reframing" of violence from being seen primarily as a criminal justice issue to being seen as a public health issue. For instance, over a 10-year period in California, the Violence Prevention Initiative engaged in a comprehensive, $70 million campaign to reduce the toll of handgun violence on youths. By highlighting the fact that handguns were the number 1 killer of young people in the state, emphasizing the role of social conditions in violence against youths, advancing specific public policies to reduce gun availability and increase violence prevention, and mobilizing citizen involvement to change "What's Killing Our Kids," the Violence Prevention Initiative helped to pass more than 300 local ordinances in 100 cities and counties and a dozen statewide laws limiting gun availability—and to secure an unprecedented increase in state funded violence prevention efforts.[29,30] A significant factor in the campaign's success was the resonance of its underlying *moral* messages: gun violence is not just the fault of young people's behavior, but of social arrangements created by adults, and adults have a shared obligation to improve these arrangements for the benefit of all. When young people are killing young people, the campaign argued, it's everyone's problem, and the appropriate response stems from compassion for young people rather than the fear-based, punitive approach of tougher criminal penalties.

There are also signs that Americans' understanding of interconnection is evolving in other policy areas in ways that may be of help to public health advocates. For example, many Americans use a cultural model of interdependency[31] to think and talk about the environment, a belief that species within ecosystems are interrelated and mutually dependent such that disturbances to one species will likely affect others. This model, which is now "widespread and thoroughly integrated into American culture," draws on "core American values" that include a sense of obligation to our descendants.[31(p61)] It may provide resources for thinking about human interdependence as well.

Globalization may also be forcing Americans to come to grips with the reality of human interconnectedness. From the increased recognition that our inexpensive consumer goods may be produced by children working in foreign sweat shops to the new reality of diseases such as severe acute respiratory syndrome (SARS) that travel quickly around the globe, Americans may be less inclined to see their country as an island. Yet recognizing the pragmatic reality of interconnection does not necessarily lead to accepting the normative value of interconnection, a fact also exemplified in the public panic surrounding SARS and other communicable diseases. A challenge for public health advocates is to capitalize on increasing understanding of the interconnectedness of global health without simply fanning xenophobic fears.

CONCLUSION

Developing the language of interconnection is crucial because once the moral focus is broadened, the definition of and response to public health problems can expand. As a moral and conceptual lens on the world, individualism restricts the range of public understanding, oversimplifying complex and multifaceted problems, boiling them down to their individual roots while leaving social responsibility and collective action largely out of the picture. Although personal responsibility is undeniably a key to health, so are a range of social conditions that are shaped not just by our individual choices, but by our collective choices manifest in public policy.

Accepting C. Wright Mill's[32] challenge to "continually . . . translate personal troubles into public issues,"[32(p187)] public health advocates can help the public to see the causal connections between their own wellbeing and that of others. All humans have needs that others must help them to meet, especially in the complex social, economic, and political systems of today. A society that accepts the reality of human interconnection and effectively structures itself so that egalitarian and humanitarian values are more fully reflected in public policy will be a society that better understands the meaning of public health and responds more appropriately to its challenges. It will be a society that not only talks about community but translates its values into caring—and more effective—public policy.

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2. Helping Public Health Matter: Strategies for Building Public Awareness

Makani Themba-Nixon

Public health. Sounds benign enough. Two good words brought together to describe how government and nonprofit agencies work together to ensure our safety and well-being. And, polling data show that once people understand what services live behind the term, public health enjoys strong public support.

A 2004 poll by Research!America and the American Public Health Association revealed that nearly three-quarters of respondents believed that their communities benefited from public health services and more than half knew someone who worked in the public health field. Those numbers shot up even higher when respondents were asked if they benefited from specific services, such as child immunization programs, restaurant inspections, or sexual assault hotlines.

Yet when asked to rank public health related research among other national priorities, including homeland security, education, and job creation, the ranking drops much lower to the bottom half of respondents. In polling overall, even fewer people express support for raising the public revenues required to sustain these services.

Given the political realities of shrinking resources and competing budgets, public health workers can no longer ignore the fact that we need to communicate with our public more effectively about what we do, why it matters, and why it deserves serious investment.

BEYOND SCARE TACTICS

Typically, public health communication strategies center on scare tactics-dire news of the consequences mounting from the problem at hand, even though people can rarely be shocked into taking action. Most of us are fairly jaded by now and have already assumed the worst. Therefore, it should come as no surprise that media-effects research confirms that practical information on what can be done about an issue, rather than communication bemoaning the severity of a problem, is what moves us. This is not to say that we don't need to communicate the seriousness of a given issue. We do; but we need to help others understand what can be done.

Good messages are affective (they touch us emotionally), effective (they convey what we need to understand), and connect with shared dreams and beliefs. They cause to surface what James Scott called in his seminal book *Domination and the Arts of Resistance*, the hidden transcript. This hidden transcript constitutes the private conversations most of us have about the injustice and the unfairness of those in power; about the "right thing" we ought to do but find too difficult to undertake on our own; and even that which we fear. People are more willing to act in circumstances when that hidden transcript is unearthed and they can see that it is widely-shared, that they constitute the majority: that they are not alone. It is like someone else saying out loud what you were thinking all along. Of course, this shared recognition requires that a message-a galvanizing one-be grounded in the language and idiom and even the dreams of our target audience. So how do we begin? With good listening skills and lots of planning.

EFFECTIVE MEDIA PLANNING

Developing a communications plan requires attention to strategic planning. Although time is tight and there is much to do, staff and management input into this process—beyond the person tasked with day-to-day communications—is important. Staff investment in the process up front helps create clarity and confidence down the line.

Set clear goals. What are you trying to accomplish? What outlets are you trying to reach? This is the most important step in preparing for media advocacy because it will define what you communicate about and to whom you'll be communicating. Identifying goals requires an honest assessment of your program's strengths and weaknesses, the political climate, and thorough research of the available options.

Know to whom you are talking. Most media advocacy is focused on policymakers because it is policymakers who have the power to enact the desired change. In some cases, groups use media advocacy to mobilize supporters as a preliminary step in targeting policymakers. It is important to note that although media can support organizing goals, it can never be a substitute for organizing. That's why most groups shape their media strategy to target policymakers and support their organizing goals.

Spend time researching how your "targets" get their information. Most elected officials and other gatekeepers read the editorial pages of local newspapers to gauge community concerns. Television news and radio talk shows also help set the public agenda and affect the "public conversation" on a particular issue. In any case, identifying the target will help shape a more effective and efficient strategy.

Know what you're saying. Now you are ready to take the final step in preparation: developing a message. A message is not a soundbite or a slogan (although it can help shape them). It is the overarching theme that neatly frames your initiative for your target audience. Messages should be relatively short, easy to understand, emotive, and visual. The message should reflect the hard work and research that went into developing the initiative and should be supportive of the overall strategy.

Test messages on friends and co-workers. Those who are not familiar with your issue are particularly effective. Colleagues who work on similar issues are another good resource. Listen carefully to feedback: Did the message convey the importance of your issue? Did they "get" it? Keeping your target in mind, use the input to help shape and refine your message.

FACING THE BUDGET MONSTER

Perhaps the toughest communications task is selling the public on funding—especially when our programs are on the chopping block. We begin by translating the issue from abstract cuts into human stories. What are the compelling stories behind the budget negotiations? Here are some places to start looking.

Potential Budget Story Theme	Where to Begin
■ Raising new revenues	■ How long has it been since new revenues were raised? How much do these revenues really amount to when you control for inflation? What are some of the good proposals? Any recent tax cuts causing problems?
■ Pulling open the budget curtain	■ What's the real process? Who has influence?
■ Health and health care threats and losses	■ What's at stake? Who will be hurt? What cuts have broad impact if only the public knew?
■ Cessation and treatment makes receiving a difference	■ A grandma who was finally able to quit smoking. A cancer survivor program support. In what ways is our work making a difference?
■ Youth programs and interventions that changed lives	■ Are young people learning important lessons of democracy and activism? Better indicators for youth health and well-being? Let the public know.
■ Losing community resources	■ Are there losses and threats beyond health? Jobs? Buildings? Parks? Tally it up and tell the stories.
■ Who's on the frontlines	■ Who's hit the hardest by the cuts? Who's protected? If your state is like most, children, women, people of color and seniors will be hurt the most. Look for disparate impact, bias, and unfairness in losses and benefits.
■ Making the case for developing the public and nonprofit sectors as a vital part of the economy	■ Cutting public and nonprofit jobs hurts the economy even more than losing private sector (especially service) jobs. With budget cuts, you lose important higher wage jobs with benefits and local spending power. What's the percentage of public and nonprofit jobs in your state, city or county? In many states, about one in five jobs is created in the public or nonprofit sector. In some states, it's closer to one in four. Reporters need to understand that these jobs and programs are not mere fiscal "pork," but important engines of the state economy

DEVELOPING MEDIA INFRASTRUCTURE

It is important to translate great data into even more compelling stories. Start by identifying and compiling a list of the right spokespeople. Who is the best person to deliver the message to which audience? Consider the breadth and diversity of communities affected. What are your opponents saying? Devise strong counter images and messages.

Identify a broad range of outlets through which to tell your stories, including media in languages other than English. Be sure to have spokespeople who can communicate in other languages as appropriate. These audiences are key potential supporters.

Make time to practice so that everyone is comfortable and able to stay "on message" without getting sidetracked or saying anything to contradict what you are trying to communicate. Roleplay interviews and ask one another tough questions. Practice communicating your message without getting distracted. Remember, you are communicating *with your target audiences*. The reporter is a conduit. Speak accordingly.

Avoid holding press conferences unless you are sure to attract press. When possible, look for other newsworthy events on which you can piggyback. Work to cultivate reporters who are already covering your issues through one-on-one meetings and phone calls, and sending well-packaged, concise information with contact information for spokespeople. When packaging information, think of the data, spokespeople, and other information reporters will need to do a good job covering the issue.

Public health professionals have great stories and even greater motivation to tell them, because our success depends upon an informed public. With some attention to planning, story development and audience, we can develop the media outreach mechanisms necessary to build greater awareness and support for this vitally important work.

Appendix D: How Social Injustice Becomes Embodied in Differential Disease and Mortality Rates

1. Coronary Heart Disease, Chronic Inflammation, and Pathogenic Social Hierarchy: A Biological Limit to Possible Reductions in Morbidity and Mortality

Rodrick Wallace, Deborah Wallace, and Robert G. Wallace
(Selected Excerpts)

The origin of "racial," "class," and "ethnic" disparities in health has recently become the center of some debate in the United States, with remedies proposed by mainstream authorities characteristically and predictably focused on individual-oriented "prevention" by altered lifestyle or related medical "magic bullet" interventions.

A recent paper finds close correlation of CHD mortality with patterns of racial segregation in New York City, one of the world's most segregated urban centers. More generally, similar works shows that all-cause black-white mortality differences are highest in metropolitan areas with the greatest racial segregation.

"[T]he clinical hypothesis that an enhanced immune response results in increased plaque vulnerability begs the question as to why a population distribution of inflammation exists in the first place and what the underlying determinants of this distribution might be." This question is, precisely, the principal focus of our analysis.

...Social conditions—in this case, a particular form of hierarchy—in fact represent "social exposures" which can be synergistic with other physiologically active agents—for example, classic toxic substances. The analysis is, however, complicated by the essential role of culture in human life, which, to reiterate the metaphor used by the evolutionary anthropologist Robert Boyd, "is as much a part of human biology as the enamel on our teeth." CHD seems, then, to be very much a life-history disease associated with a particular kind of sociocultural environment—what we call pathogenic hierarchy. We shall be interested in a model of how such an environment might write itself onto the immune function.

...[T]he special role of culture in human biology, particularly as associated with social hierarchy, becomes directly and organically manifest in the basic biology and dynamics of plaque formation. That is, for human populations, “cultural factors” like racism, wage slavery, and exaggerated social disparity—what we will call pathogenic social hierarchy—are as much a part of the “basic biology” of coronary heart disease as are the molecular or biochemical mechanisms of plaque deposition and development.

...[I]mmune cognition and cognitive socioculture can become fused into a composite entity—and that...composite, in turn, can be profoundly influenced by embedding systems of highly structured psychosocial and socioeconomic stressors. In particular, we argue that the internal structure of the external stress—its “grammar” and “syntax”—is important in defining the coupling with the Immunocultural Condensation.

We suppose that the tripartite mutual information representing the interpenetrative coagulation of immune, CNS, and locally “social” cognition, is itself subjected to a “selection pressure”, i.e., influenced by a larger embedding but highly structured process representing the power relations between groups. Most typically, these would constitute pathogenic hierarchical systems of imposed economic inequality and deprivation, the historic social construct of racism, patterns of wage-slavery or, very likely, a coherent amalgam of them all.

We thus propose that chronic vascular inflammation resulting in coronary heart disease is not merely the passive result of changes in human diet and activity in historical times but represents the image of literally inhuman “racial” and socioeconomic policies, practices, history, and related mechanisms of pathogenic social hierarchy imposed upon the immune system, beginning in utero and continuing throughout the life course. Our interpretation is consistent with, but extends slightly, already huge and rapidly growing animal model and “health disparities” literatures.

Pathogenic social hierarchy is a protean and determinedly plieotropic force, having many possible pathways for its biological expression: if not heart disease, then high blood pressure; if not high blood pressure, then cancer; if not cancer, then diabetes; if not diabetes, then behavioral pathologies leading to raised rates of violence or substance abuse; and so on. We have explored a particular mechanism by which pathogenic social hierarchy imposes an image of itself on the human immune system through vascular inflammation.

[Recent research]... implies, however, the existence of multiple, competing, pathways along which deprivation, inequality, and injustice operate. These not only write themselves onto molecular mechanisms of “basic” human biology, but become, as a result of the particular role of culture among humans, literally a part of that basic biology. The nature of human life in community and the special role of culture in that life ensure that individual psychoneuroimmunology cannot be disentangled from social process, its cultural determinants, and their historic trajectory. Psychosocial stress is not some undifferentiated quantity like the pressure under water but has a complex and coherent cultural grammar and syntax which write themselves as a particular distorted image of pathogenic social hierarchy within the human immune system: chronic vascular inflammation. For marginalized populations, this is not a simple process amenable to magic bullet interventions. Substance abuse and overeating become mechanisms for self-medication and the leavening of distorted leptin/cortisol cycles. Activity and exercise patterns may be constrained by social pathologies representing larger-scale written images of racism.

The writing of pathogenic social hierarchy onto human immune function over the life course seems to be a fundamental, and likely very plastic, biological mechanism equally unlikely to respond in the long run to magic bullet interventions. Rather, an extension of the comprehensive reforms which largely ended the scourge of infectious disease in the late 19th and early 20th centuries seems prerequisite to significant intervention against coronary heart disease and related disorders for marginalized populations within modern industrialized societies. This analysis has obvious implications for the continued decline of CHD within the U.S. majority population. Our own studies show clearly that the public health impacts of recent massive deindustrialization and deurbanization in the United States have not been confined to urbanized minority or working-class communities where they have been focused, but have become "regionalized" in a very precise sense so as to entrain surrounding suburban counties into both national patterns of hierarchical and metropolitan regional patterns of spatially contagious, diffusion of emerging infection, and behavioral pathology. In essence, social disintegration has diffused outward from decaying urban centers, carrying with it both disease and disorder.

In precisely the same sense, it seems virtually inevitable that American Apartheid, as expressed in patterns of pathogenic hierarchy entraining all subpopulations, will similarly constitute a very real biological limit, in Robert Boyd's sense, to possible declines in CHD among both white and black subpopulations.... Nobody is more enmeshed in, and hence susceptible to, the pathologies of hierarchy than those of a majority whose fundamental cultural assumptions include the social reality of divisions by class and race.

While the overall structure of diabetes mortality was poverty-driven, the New York metropolitan region, one of the most virulently segregated in the United States, showed a startling decline in the strength of the relation between diabetes mortality rate and poverty rate over the two time periods, ...[T]he marked weakening of the relation for the New York metro region is not a sign of improvement in the lot of the poor—rather, it means that high incidence is spilling over into areas with low-to-moderate poverty rates, i.e., high incidence is crossing class lines. The explanation, they infer, may lie in either or both of two hypotheses: the level of stress once associated with poverty is affecting those above the poverty line in this metro region, or the response to stress once concentrated in the population below the poverty line has been adopted by those not living in poverty.

We find that American Apartheid and similar systems of pathogenic social hierarchy are classic double-edged swords which wound both dominant and subordinate communities, placing a very real biological limit to the possible decline of coronary heart disease across the entire social spectrum. Programs of social and cultural reform affecting marginalized populations will inevitably entrain the powerful as well, to the benefit of all.

2. Social Sources of Racial Disparities in Health

David R. Williams and Pamela Braboy Jackson

Racial disparities in health in the United States are substantial. The overall death rate for blacks today is comparable to the rate for whites thirty years ago, with about 100,000 blacks dying each year who would not die if the death rates were equivalent.[1]

This paper outlines factors in the social environment that can initiate and sustain racial disparities in health. Race is a marker for differential exposure to multiple disease-producing social factors. Thus, racial disparities in health should be understood not only in terms of individual characteristics but also in light of patterned racial inequalities in exposure to societal risks and resources.

We illustrate some of these social processes by examining racial differences in mortality from 1950 to 2000 for five causes of death that reveal divergent pathways to current health disparities. Three of these causes of death—homicide, heart disease, and cancer—show wide disparities between black and white populations; two of these causes—pneumonia and flu, and suicide—show virtually no disparities. Data are available for blacks and whites for the 1950–2002 time period only. We present both absolute (black-white differences) and relative (black-white ratios) indicators of disparity.

PERSISTENT RACIAL DISPARITIES IN HEALTH

Homicide. Exhibit 1 presents national trend data for black-white disparities in homicide, heart disease, and cancer. The homicide rate in 2000 was almost six times greater for African Americans than it was for whites. However, homicide deaths for blacks were almost 30 percent lower in 2000 than in 1950, and the racial gap in homicide death rates, both absolutely and relatively, was smaller in 2000 than in 1950.

Homicide makes a small contribution to racial differences in mortality. It is the fifteenth leading U.S. cause of death and is responsible for about 17,000 deaths each year. In contrast, the annual death toll for the three leading causes of death—heart disease (700,000), cancer (550,000), and stroke (160,000)—are markedly larger. These illnesses and related chronic conditions, such as hypertension, diabetes, and obesity, are the key contributors to excess levels of ill health, premature mortality, and disability among blacks. Heart disease, for example, is the leading U.S. cause of disability and years of life lost for both men and women.

Heart disease. Death rates from coronary heart disease were comparable for blacks and whites in 1950, but by 2000, blacks had a death rate that was 30 percent higher than that for whites (Exhibit 1). Death rates from heart disease declined markedly from 1950 to 2000 for both racial groups, but because the decline for whites (57 percent) was more rapid than for blacks (45 percent), both the relative and absolute racial differences were larger in 2000 than in 1950.

Age-Adjusted Death Rates for Blacks and Whites for Three Causes of Death, and Racial Disparities, 1950–2000

EXHIBIT 1

Cause	1950	1960	1970	1980	1990	2000
Homicide						
White	2.6	2.7	4.7	6.7	5.5	3.6
Black	28.3	26.0	44.0	39.0	36.3	20.5
Difference	25.7	23.3	39.3	32.3	30.8	16.9
Ratio	10.9	9.6	9.4	5.8	6.6	5.7
Heart Disease						
White	584.8	559.0	492.2	409.4	317.0	253.4
Black	586.7	548.3	512.0	455.3	391.5	324.8
Difference	1.9	-10.7	19.8	45.9	74.5	71.4
Ratio	1.0	1.0	1.0	1.1	1.2	1.3
Cancer						
White	194.6	193.1	196.7	204.2	211.6	197.2
Black	176.4	199.1	225.3	256.4	279.5	248.5
Difference	-18.2	6.0	28.6	52.2	67.9	51.3
Ratio	0.9	1.0	1.2	1.3	1.3	1.3

Source: National Center for Health Statistics, Health, United States, 2003.
Notes: Deaths per 100,000 population. “Difference” is calculated as black death rates minus white death rates for each cause of death. “Ratio” refers to the ratio of black deaths to white deaths.

Cancer. Blacks moved from having a lower cancer death rate than whites in 1950 to having a rate that was 30 percent higher in 2000. Cancer death rates for whites have been relatively stable over time, with the mortality rate in 2000 being almost identical to the rate in 1950. In contrast, cancer mortality for blacks has been increasing, with the rate in 2000 being 40 percent higher than in 1950. Over time, lung and ovarian cancer death rates increased for both racial groups, while mortality from colorectal, breast, and prostate cancer markedly increased for blacks but was stable or declined for whites.[2]

Racial differences in socioeconomic status, neighborhood residential conditions, and medical care are important contributors to racial differences in disease.

Socioeconomic status. Whether measured by income, education, or occupation, socioeconomic status (SES) is a strong predictor of variations in health.[3] Americans with low SES have levels of illness in their thirties and forties that are not seen in groups with higher SES until three decades of age later.[4] All of the indicators of SES are strongly patterned by race, such that racial differences in SES contribute to racial differences in health. Moreover, the differences in health by SES within each racial group are often larger than the overall racial differences in health.

Education. Among adults ages 25–44, homicide rates are strongly patterned by education.[5] The homicide rate for black males who have not completed high school is more than five times that of black males with some college education or more. Similarly, there is a ninefold difference in homicide rates by education for white males, a fourfold difference for black females, and a sixfold difference for white females. At the same time, large racial differences in homicide persist when blacks and whites are compared at similar levels of education. For example, the homicide death rate for African American men with at least some college education is eleven times that of their similarly educated white peers. Strikingly, the homicide rate of black males in the highest education category exceeds that of white males in the lowest education group.

Income. Income also plays a role in understanding racial differences in coronary heart disease and cancer mortality. For example, death rates from heart disease are two to three times higher among low-income blacks and whites than among their middle-income peers.[6] In addition, for both males and females at every level of income, blacks have higher coronary heart disease death rates than whites. Mortality from heart disease among low- and middle-income black women is 65 percent and 50 percent higher, respectively, than for comparable white women.

Health practices. Another pathway underlying the association between race and chronic diseases is the patterning of health practices by race and socioeconomic status.[7] Dietary behavior, physical activity, tobacco use, and alcohol abuse are important risk factors for chronic diseases such as coronary heart disease and cancer. Moreover, changes in these health practices over time are patterned by social status. Disadvantaged racial groups and those with low SES are less likely to reduce high-risk behavior or to initiate new health-enhancing practices. For example, people with high SES have been markedly more likely to quit cigarette smoking over the past several decades compared with their lower-SES counterparts. They also have greater health knowledge, are more receptive to new health information, and have greater resources to take advantage of health-enhancing opportunities than their low-SES peers.[8]

Stress. Exposure to psychosocial stressors may be another pathway linking SES and race to health. Chronic exposure to stress is associated with altered physiological functioning, which may increase risks for a broad range of health conditions.[9] People of disadvantaged social status tend to report elevated levels of stress and may be more vulnerable to the negative effects of stressors. In addition, the subjective experience of discrimination is a neglected stressor that can adversely affect the health of African Americans.[10] Reports of discrimination are positively related to SES among blacks and may contribute to the elevated risk of disease that is sometimes observed among middle-class blacks.

Residential segregation. The persistence of racial differences in health after individual differences in SES are accounted for may reflect the role that residential segregation and neighborhood quality can play in racial disparities in health.[11] Because of segregation, middle-class blacks live in poorer areas than whites of similar economic status, and poor whites live in much better neighborhoods than poor blacks. Other U.S. racial/ethnic minority groups are less segregated than blacks, and although residential segregation is inversely related to income for Latinos and Asians, the segregation of African Americans is high at all levels of income.[12] The most affluent African Americans (annual incomes over $50,000) experience higher levels of residential segregation than the poorest Latinos and Asians (incomes under $15,000). Segregation is a neglected but enduring legacy of racism in the United States. Instructively, blacks manifest a higher preference for residing in integrated areas than any other group.[13]

Impact on income. Residential segregation is a central mechanism by which racial economic inequality has been created and reinforced in the United States.[14] It is a key determinant of the observed racial differences in SES because it determines access to education and employment opportunities. For example, an empirical study of the effects of segregation on young African Americans making the transition from school to work found that the elimination of residential segregation would completely erase black-white differences in earnings, high school graduation rates, and employment and would reduce racial differences in single motherhood by two-thirds.[15]

Violence. In addition, segregation creates health-damaging conditions in both the physical and social environments. Research has identified specific pathways by which neighborhood conditions can encourage violence and create racial differences in homicide.[16] Because of its restriction of educational and employment opportunities, residential segregation creates areas with high rates of concentrated poverty and small pools of employable and stably employed males. In turn, high male unemployment and low wage rates for males are associated with high rates of out-of-wedlock births and female-headed households.[17] Single-parent households are associated with lower levels of social control and supervision of young males, which, in turn, lead to elevated rates of violent behavior.[18]

The association between family and neighborhood factors and the risk of violent crime is identical for blacks and whites.[19] However, because of residential segregation, blacks are more exposed to these conditions than whites. In the 171 largest U.S. cities, there is not even one in which whites live in socioeconomic conditions that are comparable to those of blacks. As Robert Sampson and William J. Wilson concluded, "The worst urban context in which whites reside is considerably better than the average context of black communities."[20]

Links to disease. Independent of individual SES, factors linked to poor residential environments make an incremental contribution to the risk of a broad range of health outcomes, including heart disease and cancer.[21] Multiple characteristics of neighborhoods are conducive to healthy or unhealthy behavioral practices. The perception of neighborhood safety is positively associated with physical exercise, and this association is larger for minority group members than for whites.[22] Neighborhoods also differ in the existence and quality of recreational facilities and open, green spaces. The availability and cost of healthy products in grocery stores also vary across residential areas, and the availability of nutritious foods is positively associated with their consumption.[23] Also, both the tobacco and alcohol industries heavily market their products to poor minority communities.[24]

Medical care. Racial differences in SES contribute to reduced levels of health insurance coverage for African Americans, and limited access to medical care plays a role in racial differences in disease. Moreover, the black-white gap in access to and use of health services did not narrow between 1977 and 1996.[25] Also, the racial gap in unemployment, median income, and poverty remained large and fairly stable throughout this period.[26]

Links to homicide. Medical care is a contributor to homicide and the racial disparities in homicide. Rates of violent crime have increased over time, but homicide rates have been fairly stable. The lethality of violent assaults has declined as advances in emergency medicine and trauma care have reduced the likelihood that a violent assault will end as a homicide.[27] However, black assault victims are less likely than their white peers to receive timely emergency transportation and subsequent high-quality medical care.[28] The Institute of Medicine (IOM) report Unequal Treatment also found that blacks receive poorer-quality emergency room care than whites.[29] It revealed systematic and pervasive racial differences in the quality of care provided across a broad range of medical conditions, including heart disease and cancer. Racial differences in the quality and intensity of treatment persist after SES, insurance status, patient preference, severity of disease, and coexisting medical conditions are taken into account.

Links to cancer mortality. African Americans are less likely than whites to receive preventive, screening, diagnostic, treatment, and rehabilitation services for cancer, and this probably contributes to racial differences in cancer mortality.[30] Although blacks have higher cancer mortality than whites, the annual incidence (new cases) of cancer is lower for black than for white women. However, when compared at the same stage of cancer diagnosis, black women have poorer survival rates than their white counterparts. Blacks also are more likely than whites to experience delays in the receipt of care after a positive screening test, delays in the initiation of treatment after a biopsy, the receipt of care from inadequately trained providers, and limited access to appropriate follow-up and rehabilitation services.

Impact of segregation. Black Medicare patients are more likely than white ones to reside in areas where medical procedure rates and the quality of care are low.[31] In addition, a small group of physicians, who are more likely to practice in low-income areas, provide most of the care to black patients. These providers are less likely than other physicians to be board certified and less able to provide high-quality care and referrals to specialty care.[32] Also, pharmacies in segregated neighborhoods are less likely to have adequate medication supplies, and hospitals in these neighborhoods are more likely to close.[33]

Disentangling the relative importance of the complex causal processes that lead to disparities in disease is challenging, but renewed efforts are needed to identify key points of intervention.

WHERE THERE ARE NO DISPARITIES

Flu and pneumonia. Examining racial disparities over time reveals that success stories do exist. Flu and pneumonia is one such story. It is the seventh leading cause of death and is responsible for more than 65,000 deaths annually. However, both the absolute and the relative racial differences for deaths from flu and pneumonia were minimal in 2000 (Exhibit 2). In contrast, large racial differences existed in 1950, with black mortality being 70 percent higher than that of whites. Over time, striking declines are evident for both races, with larger declines for blacks than for whites. Flu and pneumonia is an acute respiratory illness that can be prevented by vaccination and treated by antiviral medicines. It differs from the major chronic illnesses that typically have a large behavioral component, are long term in development, and have symptoms that are not always readily evident. The virtual elimination of this disparity suggests that the application of a widely diffused technology (facilitated by Medicare and Medicaid), in which social variations in motivation, knowledge, and resources play a small role, can eliminate a large disparity in health.

Age-Adjusted Death Rates for Blacks and Whites for Flu and Pneumonia and for Suicide, and Racial Disparities, 1950–2000

EXHIBIT 2

Cause	1950	1960	1970	1980	1990	2000
Flu & Pneumonia						
White	44.8	50.4	39.8	30.9	36.4	23.5
Black	76.7	81.1	57.2	34.4	39.4	25.6
Difference	31.9	30.7	17.4	3.5	3.0	2.1
Ratio	1.7	1.6	1.4	1.1	1.1	1.1
Suicide						
White	13.9	13.1	13.8	13.0	31.4	11.3
Black	4.5	5.0	6.2	6.5	7.1	5.5
Difference	-9.4	-8.1	-7.6	-6.5	-6.3	-5.8
Ratio	0.3	0.4	0.5	0.5	0.5	0.5

Source: National Center for Health Statistics, Health, United States, 2003.
Notes: Deaths per 100,000 population. "Difference" is calculated as black death rates minus white death rates for each cause of death. "Ratio" refers to the ratio of black deaths to white deaths.

Suicide. Suicide is a success story of another sort. Suicide is the eleventh leading U.S. cause of death (30,000 deaths annually). Suicide rates for both racial groups have been fairly stable over time, with a slight decline for whites and a slight increase for blacks in recent years. However, black suicide death rates have been consistently lower than those of whites. The suicide data are consistent with national data, which indicate that the prevalence of major psychiatric disorders are lower for blacks than for whites.[34] Suicide is an example of a health condition for which the socially disadvantaged group does not have elevated rates. This pattern highlights the importance of attending to protective resources that may improve health and protect vulnerable populations from at least some of the negative effects of environmental exposures. For example, high levels of self-esteem and religious involvement are potential contributors to blacks' better suicide and mental health profile.

POLICY IMPLICATIONS

Persisting disparities in health violate widely shared U.S. norms of equality of opportunity and the dignity of each person. Eliminating health disparities is also important for the overall well-being of the entire U.S. society. First, diseases that are initially more prevalent in disadvantaged geographic areas eventually diffuse and spread into adjacent affluent communities.[35] Second, the illnesses and disabilities associated with racial disparities limit the productive capacities and output of adults in their prime working years. This can negatively affect productivity at the local and national levels and can lead to declines in tax revenues and increased costs of social services.[36] Thus, effectively addressing racial disparities in health likely requires addressing distal social policies and arrangements that create the disparities in the first place.[37]

Addressing segregation. Racial residential segregation is one of the primary causes of U.S. racial inequality, and although discrimination in the sale and rental of housing was made illegal in 1968, considerable evidence suggests that housing discrimination persists.[38] Current public preferences and opportunities for the enforcement of equal opportunity statutes suggest that U.S. residential patterns are unlikely to change in the foreseeable future. Thus, the elimination of the negative effects of segregation on SES and health may require a major infusion of economic capital to improve the social, physical, and economic infrastructure of disadvantaged communities.[39] Such investment could improve the economic circumstances and productivity of African American families and communities and have spillover benefits for health.

Narrowing the income gap. Over the past fifty years, changes in the black-white gap in income have been associated with parallel changes in the black-white gap in health. Between 1968 and 1978, in tandem with the narrowing of racial inequality attributable to the economic gains of the civil rights movement, black men and women experienced a larger decline in mortality than their white counterparts on both a percentage and absolute basis.[40] However, as blacks' median household income fell relative to that of whites from its 1978 level throughout the 1980s, the black-white gap in adult and infant mortality widened between 1980 and 1991.[41]

At the same time, although it is generally recognized that policies that disproportionately assist the disadvantaged are desirable, it is unclear whether those policies are best implemented at the federal, state, or local level and what optimal forms such policies should take.[42] Greater attention needs to be given to rigorously evaluating the extent to which policies in multiple sectors of society have consequences for health and health disparities, so that we can have an improved understanding of the conditions under which specific policy initiatives are more or less likely to achieve desirable results.

Improving medical care. Improving access to medical care for vulnerable populations, especially for preventive services, can play a role in reducing racial disparities in health. According to a 2000 study, only half of physicians or fewer routinely counsel patients who smoke about smoking cessation, treat patients with elevated blood lipids for this condition, treat hypertensive patients for their high blood pressure, and routinely screen patients for diabetes.[43] One way to improve medical care might be to provide physicians with incentives to ensure that they use evidence-based guidelines for treatment and follow national standards of care. Also, given that underrepresented minority providers are more likely than others to practice in underserved areas, increasing the numbers of blacks in the health professions is likely to be an effective strategy in improving access to care.[44]

Rethinking health policy. There is a need to rethink what constitutes health policy. Given the broad social determinants of health, policies in societal domains far removed from traditional health policy can have decisive consequences for individual and population health. A recent federal report outlines an ambitious agenda to eliminate disparities in cancer.[45] Recognizing that the determinants of cancer disparities transcend its scope, the U.S. Department of Health and Human Services (HHS) called for the creation of a Federal Leadership Council, led by HHS, that would leverage government-wide resources to address disparities. This proposed council would include all federal departments that have policies that can affect health and health disparities, including the Departments of Labor, Education, Defense, Justice, Energy, and Transportation. Similar coordination is necessary at the regional and local levels. There are political, professional, and organizational barriers to such intersectoral collaboration, but multiple strategies to address them have been identified, including the need to establish a permanent locus for intersectoral activity regarding health.[46] Although much is yet to be learned about the specific pathways by which the social environment creates disease, much progress can be made toward eliminating disparities by acting on current knowledge.

EDITOR'S NOTES

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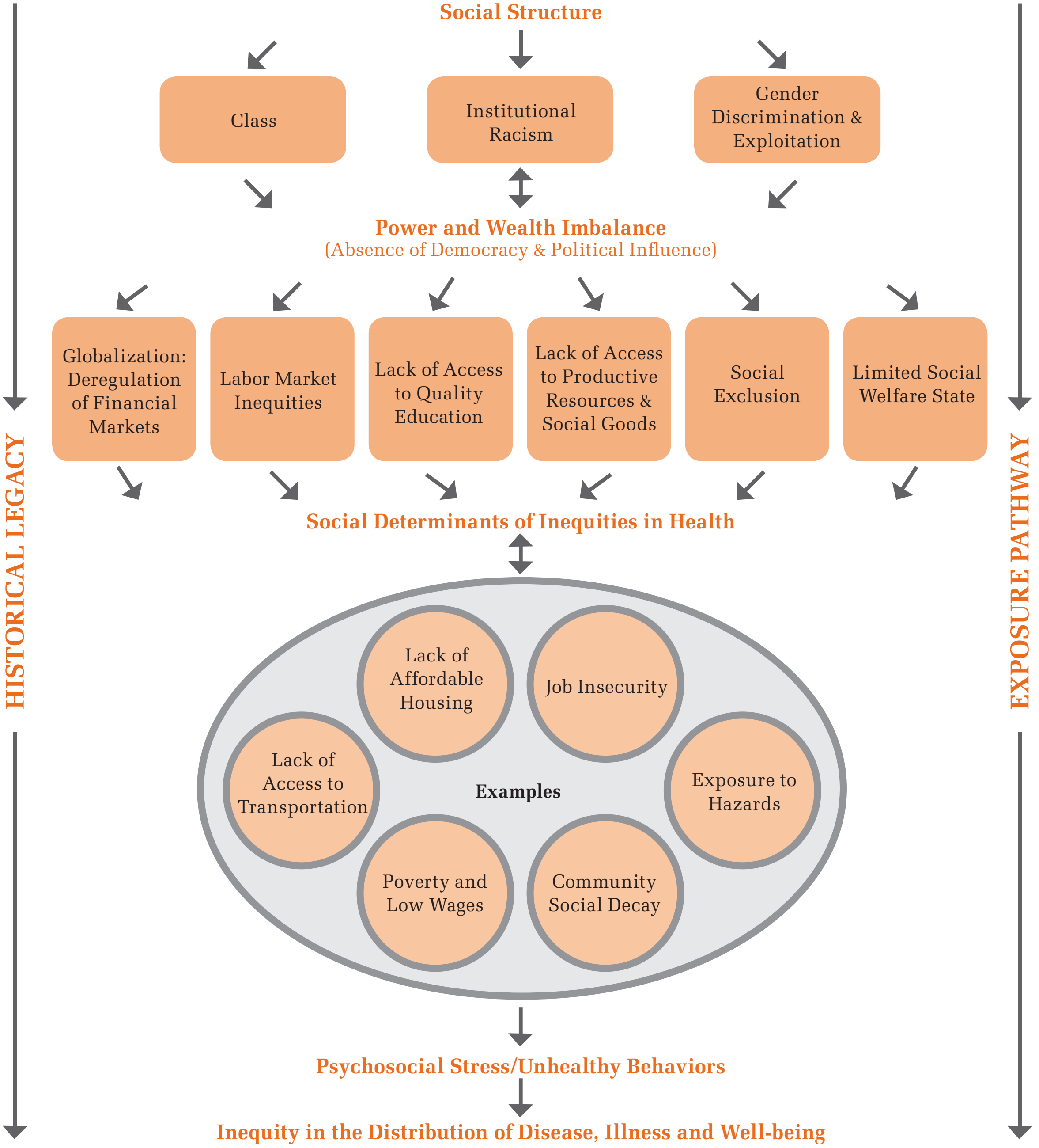
3. How Social Injustice Becomes Embodied in Differential Disease and Mortality Rates



Appendix E

Tips for Health

The messages given to the public by governments, health associations, and health workers are heavily influenced by the ways in which health issues are understood. Contrast the two sets of messages provided below. The first set is individually-oriented and assumes individuals can control the factors that determine their health. The second set is societally-oriented and assumes the most important determinants of health are beyond the control of most individuals. Which set of tips is most consistent with the available evidence on the determinants of health?

THE TRADITIONAL TEN TIPS FOR BETTER HEALTH

1. Don't smoke. If you can, stop. If you can't, cut down.
2. Follow a balanced diet with plenty of fruit and vegetables.
3. Keep physically active.
4. Manage stress by, for example, talking things through and making time to relax.
5. If you drink alcohol, do so in moderation.
6. Cover up in the sun, and protect children from sunburn.
7. Practice safer sex.
8. Take up cancer screening opportunities.
9. Be safe on the roads: follow the Highway Code.
10. Learn the First Aid ABCs: airways, breathing, circulation.

Donaldson, L., Ten Tips for Better Health., London UK: Stationary Office, 1999. Available at http://www.archive.official-documents.co.uk/document/cm43/4386/4386-tp.htm

THE SOCIAL DETERMINANTS TEN TIPS FOR BETTER HEALTH

1. Don't be poor. If you can, stop. If you can't, try not to be poor for long.
2. Don't have poor parents.
3. Own a car.
4. Don't work in a stressful, low paid manual job.
5. Don't live in damp, low quality housing.
6. Be able to afford to go on a foreign holiday and sunbathe.
7. Practice not losing your job and don't become unemployed.

8. Take up all benefits you are entitled to, if you are unemployed, retired or sick or disabled.
9. Don't live next to a busy major road or near a polluting factory.
10. Learn how to fill in the complex housing benefit/ asylum application forms before you become homeless and destitute.

Gordon, D., Posting (April, 1999) Spirit of 1848 listserv.

Appendix F: Exercise

Step Back/Step Forward: The Roots of the Racial and Ethnic Wealth Divide in Government Policies

DIRECTIONS

Facilitator:

- Explain to the participants the purpose of the Step Back/ Step Forward exercise. A key purpose of the exercise is to call into question the notion that we all start from the same starting line.
- Ask for at least 5 volunteers. The more diverse the group the better this exercise will work.
- Have the volunteers stand behind a line on the ground. (you could use masking tape to make a line).
- Inform the volunteers that they are required to step backward or forward when they hear a particular experience that relates to them.
- When the volunteers and the other participants are all clear about the exercise, the facilitator should begin to read from the list of experiences.
- If a volunteer is unsure at any point about whether an experience read pertains to them or not, the facilitator should provide some contextual information. If this does not help, the facilitator could ask the person to remain in their position.
- When the facilitator has read enough of the list of experiences to establish the real respective starting lines, s/he should stop and establish a dialogue (see example questions below).

These are a few possible discussion questions:

- What has this exercise demonstrated about the starting line?
- What does this exercise reveal about the roll of government in wealth accumulation?
- How does this exercise help me to rethink my own beliefs about my financial position and that of my family?

All sharing is voluntary.

STEP BACK IF	STEP FORWARD IF
■ Your ancestors lost land due to conquest by European colonizers or the US government.	■ Your ancestors got land under one of the Homestead Acts.

STEP BACK IF	STEP FORWARD IF
Your ancestors lived in danger of being lynched, with inadequate police protection.	Your ancestors got land in grants from monarchs in colonial days.
Your ancestors were slaves.	Your ancestors owned slaves.
Your grandparents didn't get retirement benefits from any government.	Your grandparents and/or parents got Social Security benefits.
Your Ancestors arrived as a Catholic or Jewish immigrant from Europe before 1950.	Your ancestors were voluntary Protestant immigrants from Europe to the American colonies.
You or your ancestors arrived as an immigrant from the Caribbean, Africa, Asia or Latin America.	You or your ancestors arrived as a refugee or immigrant from a country targeted as a communist enemy by the United States, such as Cuba, Nicaragua, Vietnam or the Soviet Union.
Your ancestors were forced to live on Indian reservations.	You or your ancestors arrived in the US with the promise of a good-paying job on arrival.
You have ancestors who lived in the US but weren't allowed to be citizens and/or to vote because of their race.	You are a US citizen and all your US family/ancestors have been citizens and eligible to vote.
You have ancestors who lived in the US but weren't allowed to own land because of their race.	During the Depression, your family member(s) got a public works job.
You had ancestors who lived in the US but were barred from attending most colleges due to their race.	You or your ancestors went to college on the GI bill
	You or your ancestors got mortgages through cheap VA or FHA loans.
	You or your ancestors owned a farm and got farm aid through the Department of Agriculture
Your parents or grandparents did domestic or agricultural work (and so were ineligible for Social Security).	Your ancestors belonged to trade unions that were white-only.
	Your parents or ancestors owned a small business that got government loans or contracts.
You attended an underfunded urban or rural public high school.	You attended a private (non-parochial) or well-funded suburban public high school.

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