

A Disparities Foresight Briefing
Health Equity: Focusing on Health in All Policies

February 25, 2009

Meeting Summary

Introduction

This Disparities Foresight Briefing on Health Equity: Focusing on Health in All Policies is an effort of the DRA Project in collaboration with the Congressional Black Caucus Health Brain Trust. Health equity is part of a larger trend in the US toward greater equity or fairness. Although significant health disparities exist in the United States, many people living there do not perceive them. However, the pursuit of health equity, a trend similar to the Anti-slavery, Civil Rights, and Women's Rights movements, is growing. The Healthy People 2010 Objectives for the Nation, the Institute of Medicine's *Crossing the Chasm* and *Unequal Treatment* reports, and commitments from organizations such as the Robert Wood Johnson Foundation and the World Health Organization document this health equity movement. Similar to previous progressive movements, the achievement of health equity requires time and support; however, identifying particular disparity reducing advances will accelerate this process.

The Disparity Reducing Advances (DRA) Project and the DRA Partner Network, with over 60 organizations and growing, devotes itself to the acceleration of the Health Equity movement. The DRA Project is the Institute for Alternative Future's (IAF) multi-year, multi-stakeholder project formed to identify and accelerate advances that can reduce healthcare disparities. Funders for the DRA Project have included Novo Nordisk, the National Cancer Institute, the Agency for Healthcare Research and Quality, the Robert Wood Johnson Foundation, the Centers for Disease Control and Prevention, the American Cancer Society, the University of Texas Medical Branch, and Florida Hospital. A complete list of sponsors and partners involved with the DRA Project and our projects, including the focus of this Health Equity Briefing is available at www.altfutures.com/draproject.

The February 25th briefing on Health Equity was sponsored by Novo Nordisk, and held in the Thomas Jefferson Building of the Library of Congress. Attendees included Congressional staff and a spectrum of leading health, voluntary, and government organizations.

Leading experts in the field of health equity presented data on the importance of focusing on the social determinants of health to reduce disparities. These experts included: Larry Cohen, Executive Director of Prevention Institute; David R. Williams, Florence & Laura

Professor of Public Health at the Harvard School of Public Health, and Professor of African and African American Studies and of Sociology at Harvard University; Dolores Acevedo – Garcia, Associate Professor of Society, Human Development, and Health at Harvard School of Public Health; and Brian Smedley, Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies. Congresswoman Donna M. Christensen, Chair of the CBC Health Braintrust gave the opening remarks for this briefing, and Clem Bezold, Chairman of the Institute for Alternative Futures introduced these speakers and the DRA Project and moderated the event.

In order to most effectively reduce health disparities, the DRA Project identified eight specific advances to focus on, each of them categorized as “Public Health” or “Health Care” efforts. This Hill Briefing addressed foresight in “Community and Social Determinants of Health & Disparities,” a Public Health advance. Health care is important; however, medical care only accounts for ten percent of the variance that influence health, whereas behaviors and environment account for 60 percent. Although people argue that individuals are responsible for their own behavior, an individual’s social circumstance, environment, and community dictate many behaviors that will grossly affect the individual’s health. Thus, it is vital to identify and change these social determinants of health to effectively reduce health disparities.

Congresswoman Donna M. Christensen

Congresswoman Donna M. Christensen, delegate from the United States Virgin Islands, opened the briefing by thanking staff, sponsors, and speakers and recognizing reports that work towards identifying and eliminating health disparities. Congresswoman Christensen recognized one of the biggest challenges in the elimination of health disparities is political will, and focused on specific bills that will bring about a reduction in, and ultimately eliminate, health disparities.

Congresswoman Christensen identified primary prevention as an opportunity to save the most lives and as a driving force to save this country in terms of healthcare dollars. The current U.S. president, Barack Obama, has given us an opportunity to present prevention in health care as part of the fiscal stimulus.

Delegate Christensen will reintroduce the Health Empowerment Zone Bill, which tries to encapsulate in legislative form addressing health disparities from a primary prevention point of view. The bill is based on economic empowerment zones of the 1990’s and will be designated in a community that demonstrates health disparities. Once the community is designated, it is given federal funding priority in any agency that can help the community achieve their designated plan to reduce healthcare disparities.

The Health Empowerment Zone Bill is part of the Health Equality and Accountability Act, a more comprehensive bill introduced in the prior Congress. The Health Empowerment Zone Bill allows the country to address the social determinants of health and has been recommended to be part of the stimulus package. This bill assists communities to identify their specific health care challenges, is specific about the application process and requirements, and is not costly. The Congresswoman requested that those present watch for the introduction of the bill.

Congresswoman Christensen stated that because President Obama understands and has mentioned the importance of health care and prevention, there is an opportunity to bring about the changes to be discussed at this briefing. These changes will bring the U.S. to ultimately eliminating health disparities, so that everyone in the country moves forward to a better health and wellness.

A video clip summarizing “Unnatural Causes,” a PBS broadcasted documentary series, introduced the discussion of the social determinants of health.

Larry Cohen

Larry Cohen is the founder and executive director of Prevention Institute, a non-profit national center dedicated to improving community health and well-being by taking action to build resilience and prevent problems before they occur. The Prevention Institute moves beyond approaches that target individuals to those that create systematic, comprehensive strategies that alter the conditions that impact community health, with a particular focus on equitable health outcomes.

Mr. Cohen discussed the need to “take two steps back to the social determinants of health” in order to promote health equity. Exciting new developments such as the passage of the economic stimulus plan and renewed discussion on healthcare reform have created a unique opportunity to improve health, safety, and equity outcomes. However, conversations about reform are too focused on healthcare and the medical arena, while the greatest impact and opportunities for improving health and disparities come from investing in prevention and addressing the underlying conditions that affect our wellbeing. Studies have shown that the vast majority of the factors that influence health are related to conditions in the environment and their influence on behaviors and safety, rather than access to healthcare. The words of President Obama reflect this opportunity, “Simply put, in the absence of a radical shift towards prevention and public health, we will not be successful in containing medical costs or improving the health of the American people.”

Cohen explained that where we live, work, and play affects our health. Many people understand the link between the environment and safety in terms of toxins, pollution, air, and soil; however, the social environment also play a significant role in shaping people's health. The way our environment is constructed, the types of services and products we have access to, and how we get around all affect our wellbeing. The environment shapes norms, which affect our behaviors, and in turn affect our health and safety (e.g. smoking regulations in the workplace). Cohen introduced a series of pictures that capture the link between health and food, transportation, violence, and physical activity (These slides and the rest of Mr. Cohen's presentation can be viewed at [Promoting Health Equity: Taking 2 Steps Back to the Social Determinants of Health](#)). The Institute of Medicine best summarizes this point by noting that, "It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change."

Taking "two steps back" allows us to look at the relationship between exposures, the environment, behaviors, and health. Generally, when discussing how to address the five leading causes of death (heart disease, cancer, stroke, diabetes, and injuries and violence), most people picture pharmaceuticals and operating rooms. An examination of current healthcare spending in the U.S. reflects this same notion. Despite the fact that our environment and behavior account for 70% of the variance in health, 96 % of national health expenditures is spent on medical services, while only four percent is spent on prevention (without a focus on quality, primary prevention). Cohen prompted the audience to step back and, as an example, focus on tobacco as the underlying cause of cancer. The strategy for combating disease then changes from providing medical services and prescriptions to combating tobacco use. Taking another step back, we must address the marketing of tobacco. Similarly, we should look at the promotion of unhealthy foods and the availability of healthy, fresh foods, to combat diabetes. People thrive when they have easy access to parks, playgrounds, and grocery stores selling nutritious food. People cannot thrive in unhealthy environments and are therefore suffering from the many diseases and injuries plaguing the United States. Disease prevention can be achieved by addressing the underlying community conditions.

There are 13 factors of community health plus 5 factors of medical services:

- Equitable Opportunity
 - Racial justice
 - Jobs & local ownership
 - Education
- Place
 - What's sold & how it's promoted
 - Look, feel & safety

- Parks & open space
- Getting around
- Housing
- Air, water, soil
- Arts & culture
- People
 - Social networks & trust
 - Participation & willingness to act for the common good
 - Acceptable behaviors & attitudes
- Medical Services
 - Preventive services
 - Access
 - Treatment quality, disease management, in-patient services, & alternative medicine
 - Cultural competence
 - Emergency response

To address disparities and improve health, we must pay attention to policies in areas beyond healthcare and an investment in prevention must be made a priority. It is critical to improve access to and quality of treatment for illness. The Institute of Medicine's report *Unequal Treatment* describes the specific issues within the medical system that exacerbate inequities and provides many of the steps and actions needed to resolve them. However, Improving health cannot be addressed effectively disease-by-disease. In order to improve equity and community health, we must understand the relationship between health and other sectors, such as transportation, land use, agriculture, infrastructure, and economic development. The upcoming Transportation Bill, for example, could result either in more roads with increased impact on climate change and respiratory illnesses, or in an increase in walking, bicycling, public transit, and linking communities to additional jobs and recreational opportunities. In another example, Karen Bass, at that time a community organizer and now the California Speaker of the Assembly, worked on zoning and the availability of alcohol in South Central Los Angeles. Over three years, her community organization efforts resulted in the closing of 200 liquor stores. This led to an average of a 27% reduction in crime within a four-block radius of each closed liquor store. The decrease in alcohol sales led to a decrease of injuries and violence, which is the fifth leading cause of death in the United States.

Prioritizing prevention through community wellness programs has substantial financial benefits as well. Investing in prevention saves lives, improves the health of the population, improves health equity, and saves money for government, business, healthcare, families, and

individuals. According to a study done by the Prevention Institute and Urban Institute, every dollar invested in prevention would result in a one-dollar return in two years. In five years, we would see a return of \$5.60 per person for every dollar invested in community prevention.

In conclusion, Cohen presented the following recommendations to promote prevention and health equity:

1. **National Strategy** to promote health equity across racial, ethnic, and socioeconomic lines
2. **High-level leadership** at the White House and the Department level
3. **Build capacity of federal, state, and local health agencies** to lead population-based prevention and health equity work
4. Fund **community-based initiatives**
5. **Technical assistance and tools** to support community-level efforts
6. **Population-based prevention** and health equity with emphasis on **translating research into targeted, community specific strategies**

These recommendations and others for the new administration are available in the report by Prevention Institute and the Health Policy Institute of the Joint Center, available at http://preventioninstitute.org/documents/HealthEquityMemo_022609_000.pdf

David R. Williams

David R. Williams, Ph.D., a professor at the Harvard School of Public Health, provided insights about the attention and resources that serve as evidence regarding the movement towards addressing the root issues of health and health care. A growing movement towards and national interest in focusing on these issues were highlighted through the specific examples he presented (His presentation slides can be viewed at [David R. Williams Hill Briefing Presentation](#)).

The Robert Wood Johnson Foundation, the largest private funder of research in the health area, invests resources towards addressing issues of health care access, coverage, and the quality and intensity of medical care. However, the Commission to Build a Healthier America focuses on factors outside of the health care system, the main drivers of health. Whereas medical care serves as a repair shop, this Commission focuses on what would allow people to be healthy in the first place. Places in which people live, learn, work, play, and worship have a greater influence over their health than medical coverage or care. The Commission feels that although all people need coverage and medical care, solving the health insurance problem would not solve the health problem because medical care is not the largest determinant of health. The Commission studies the macro social environments that drive health in order to offer the choice of health to all people.

The Commission exists to increase levels of understanding around these larger determinants of health. A body of scientific research exists on these social determinants that do not yet guide health policies. Also, many people who recognize the influence of social determinants on health have become overwhelmed with the complexities involved in addressing these problems. The Commission also studies programs that implement solutions to address these complexities. The Commission uses and studies these programs to show examples of changes in health through addressing non medical factors and social factors that drive health.

The bi-partisan Commission is led by Mark McClellan and Alice M. Rivlin; all commissioners involved bring a broad range of skills, expertise and knowledge. The Commission involves itself in a range of activities including research, field hearings, and issuing reports. Recent products of the Commission include a postcard which gives evidence of health disparities inside the Washington Beltway. Assuming you board the Washington Metro near your home, where you board the Metro is a powerful predictor of your life expectancy and it varies dramatically, with those in the District of Columbia living 10 years less, on average than their suburban neighbors in Virginia and Maryland. This local pattern reflects what happens nationally and internationally. The U.S. ranks poorly in comparative health measures and we are losing ground. Life expectancy in the U.S. today is worse than it was in 1980, which is worse than it was in 1960.

Results of the Commission's analysis show that all Americans, even those with a college degree, fall below the national benchmark of achievable levels of health. Also, because of the gaps in health, people of low socioeconomic status, education, and who identify as racial and ethnic minority populations find it more challenging to reach these achievable levels of health. The U.S. should address this not only because of reasons regarding equity, justice, and opportunities, but also because this gap in health costs the American economy. The Commission had economists analyze health equity savings. These economists, who had served on the President's Council of Economic Advisers, found that if all Americans enjoyed the same levels of health as the college educated, the U.S. would save, by a conservative estimate, at least one trillion dollars each year. Simply put, the cost of social inequalities of health is at least one trillion dollars per year.

The Commission is also involved in field hearings which analyze the return on investments in early childhood education, potential solutions in communities and neighborhoods, and opportunities in work and the work place. Resources, tools, and publications are available on the commission's website (www.commissiononhealth.org). David Williams summarized the underlying message of the Commission: The U.S. should move beyond looking at medical care, coverage, affordability, and a focus on personal responsibility for

health to think about the living conditions in homes and communities, and the social and economic opportunities and resources that are in fact drivers of health.

Williams then described a second example of forces moving toward health equity, the Alliance to Make US Healthiest, formally the Alliance for the Healthiest Nation (www.healthiestnation.org/). This Alliance addresses the question, “Why aren’t we the healthiest nation in the world?” Similar to the Commission to Build a Healthier America, the Alliance focuses on the drivers of health and well-being. Bringing together local, state, and national organizations committed to making America the healthiest country in the world, the Alliance is made up of a range of health organizations as well as major corporations. Members of the Alliance include Target, the National Business Group on Health, CDC, Wal-Mart, NACCHO, Premier, Lysol, Hepatitis Foundation, Sensei, ASTHO, National Association of Local Boards of Health, Genesee County Health Department, American Public Health Association, Coca-Cola, B&D Consulting, Humana, Strategic Benefit Solutions, NCSL, National Business Coalition on Health, and Research America. The Alliance seeks to be “the hub that coalesces and engages our nation’s *trusted* thought leaders, key initiatives, organizations and programs in one organic ecosystem”. Importantly, the Alliance represents a new mechanism and strategy which reflects the growing national attention to these issues.

The World Health Organization had a Commission on the Social Determinants of health, lead by led by Sir Michael Marmot, recently released a major report focusing on health disparities and social determinants globally. This report explains the problems in simple technical language and provides potential solutions.

Williams praised Unnatural Causes, the seven part documentary series aired on PBS of which the introduction was aired at the beginning of this Briefing. This documentary has already made an enormous impact and has tremendous potential to shape dialogue about the social policies that affect health. And in the year following its release on PBS, even more Americans are watching this video series in their homes and communities. This documentary serves as a public campaign, and provides useful tools and resources for community leaders and others that assist with campaign outreach to address this topic. Unnatural Causes used an acronym to describe what composes the conditions for health:

- H** – Housing
- E** – Education & Environment
- A** – Access
- L** – Labor
- T** – Transportation
- H** – Hope and Happiness

David Williams summarized his presentation, by asserting that the U.S. must completely redefine health policies to address not only issues regarding insurance, physicians' offices, and hospitals, but to address policies in all domains of society that affect health.

Dolores Acevedo-Garcia

Dolores Acevedo-Garcia Ph.D., Associate Professor of Harvard School of Public Health, presented research regarding housing in relation to health disparities (her presentation slides can be viewed at [Housing and Health Disparities](#)). A vast body of research gives evidence that housing is one of the most important social determinants of health. Thus, it is important to talk about housing policy for health, and housing policy decisions as a foundation for better health and to also reduce disparities. The U.S. faces a paradox at this moment, because great opportunities as well as challenges exist due to the social and economic situation. The economic crisis has roots in the functioning, or rather malfunctioning, of the housing market. Leading to a collective awareness regarding the importance of housing for lives and the economy, our current mortgage and housing crisis has created an opportunity to address this issue.

For decades, many people knew that large housing disparities as well as racial and ethnic disparities in housing outcomes exist. However, most people do not know that the huge racial and ethnic disparities in housing outcomes are directly linked to health disparities. Thus, housing policies can be used as a tool to address these disparities. Conversely, if the U.S. fails to take action now regarding housing issues, health problems and disparities will increase. A number of available housing policies could help address health issues. And evidence showing that certain housing policies produce a better or more direct affect exists, and should be used to actually determine housing policies.

The following are policy reports regarding housing and health that serve as additional resources:

- National Center for Healthy Housing, 2009, Housing Interventions and Health: A Review of the Evidence.
- National Commission on Fair housing and Equal Opportunity, 2008, The Future of Fair Housing.
- Charles Hamilton Houston Institute for Race and Justice, 2009, Things I Have Seen and Heard: How Educators, Youth Workers and Elected Leaders Can Help Reduce the Damage of Childhood Exposure to Violence in Communities, Candice Player and Susan Eaton.

Acevedo-Garcia outlined the numerous links that exist between housing and health. One obvious link is the connection between housing affordability and health. Families sometimes face serious trade-offs between expenditures on housing and expenditures on other health necessities such as food for their children, which has a clear direct impact on health.

The direct link between neighborhood environment and health, another connection between housing and health, shows that one's neighborhood environment directly impacts one's health, especially for children. Because the U.S. implements neighborhood based schools, a child usually experiences similar neighborhood and school environments. Children who live in disadvantaged neighborhoods are particularly at risk and experience direct health and developmental consequences. Research on disparities between neighborhood environments along racial and ethnic lines found a misconception that Latino and African American children are more likely to live in poor neighborhoods because they are more likely to have poor families. Although family income accounts for part of the explanation of a higher proportion of minority children living in poor neighborhoods, it does not account for the whole factor that accounts for this disparity.

A concept referred to as double/triple jeopardy states that children who live in poor neighborhoods are particularly challenged to be successful because they experience resource limitations in their family, neighborhood, and school. In the largest 100 metropolitan areas across the U.S., 1.4% of poor White children live in a poor neighborhood. However, 16.8% of poor black children and 20.5% of poor Hispanic children live in those same poor neighborhoods. Thus, Latino and Black children are much more likely to experience double jeopardy than white children, also experiencing an impact to their health and development.

The Home Mortgage Disclosure Act establishes another disparity in housing outcomes directly linked to health. Data provided through this act show that in neighborhoods in which 80% or more minorities reside, about 30% of the population experienced subprime loans. Thus, living in a high minority area significantly reduces one's income in terms of the likelihood of getting good housing loans. The opposite is true for areas with low levels of minority populations. These same people have a higher probability of experiencing mortgage burden and foreclosure, both of which are directly linked to tradeoffs between housing and health related factors, including food, nutrition, stress, and good mental health. Based on this information, it is likely that the current economic crisis will increase health disparities.

The U.S. needs to promote housing policies that address health disparities. To do this a health impact assessment of all housing policies should be done, eventually leading to the legal framework of a health impact assessment for all non-health policies linked to disparities.

Dr. Acevedo-Garcia identified four specific factors related to housing and health disparities, their policy implications and what could be done:

1. Living in high-poverty (low-opportunity) neighborhoods has negative effects on health.
 - **Policy Implication**
 - Housing assistance policy should address neighborhood choice, e.g. promote location in high-opportunity neighborhoods.
 - **Legislation**
 - Section 8 Voucher Reform Act (SEVRA)
2. Exposure to neighborhood violence has serious and long-term detrimental effects on children's mental health and educational performance.
 - **Policy Implication**
 - Support local, state and federal legislation that would engage communities and children in constructive activities, e.g. community improvement projects
 - **Legislation**
 - Youth Promise Act
3. Housing insecurity has negative effects on health, e.g. mortgage burden has a detrimental effect on mental health.
 - **Policy Implication**
 - Support legislation that would allow for court-supervised mortgage modification as a way to help families stay in their homes and avoid foreclosure.
 - **Legislation**
 - Helping Families Save Their Homes in Bankruptcy Act
4. Healthy housing standards promote the health of home occupants.
 - **Policy Implication**
 - Support legislation that would promote cost-effective approaches and market-based incentives to make homes healthier and safer without detracting from their affordability.
 - **Legislation**
 - Healthy Housing Bill

In summary, housing is a factor affecting health. Housing policies should be used as a tool to address health disparities. This is consistent with the prevention strategy mentioned earlier by Larry Cohen.

Brian D. Smedley

Brian D. Smedley, Ph.D., Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies, identified how to build stronger communities for better health (presentation slides are available at [Building Stronger Communities for Better Health](#)). Dr. Smedley opened by stating that we have an obligation to view the economic stimulus package as part of a potential down payment to achieve health equity goals. The possibility of an economic recovery depends on the full participation of all population segments in the U.S., including people of color and of low income. This means that all segments must be healthy and able to participate. The economic recovery presents money for transportation, education, and environment, all of which drive health. Thus, it is important to view the stimulus through a health equity lens, in affect putting a health economic assessment on the stimulus package.

A large body of research provides evidence of the powerful direct influence of neighborhoods over health, including stress, environments, and exposures. The indirect influence is that neighborhood environment shapes behavior and behavioral options. The culture in the U.S. focuses on individual responsibility; however, it is quite challenging to eat five fruits and vegetables each day and exercise when you neighborhood does not and cannot support those behaviors.

Currently, a number of challenges exist including:

- Health inequality: Widening health gaps due to the economic downturn create further inequality between people of color and low income groups relative to others. This crisis suppresses our nation's health as a whole. "When the nation's economy gets the cold, people of color get the flu."
- Residential segregation: Despite the historic election of 2008, the U.S. is not a "post-racial" society. Inequitably structured opportunities still exist, largely due to residential segregation. Systemic barriers to opportunity result due to place based inequalities such as inequitable education, job opportunities, and disproportionate environmental health risks.
- Individual determinist orientation: Our culture in the U.S. suggests that individuals can and should control their destinies. This ideal is reflected in the assumption that individuals should be able to control their health; however, health is largely shaped by the context in which we live. Residential segregation provides for separate and unequal health care facilities. Although individual responsibility is important, it does not trump environment.

In order to address these issues, the U.S. must focus on prevention, use multiple strategies against multiple sectors, and sustain investment in a long term policy agenda. These issues will not be solved in one year; however, the stimulus presents an opportunity to make a down payment on a longer strategy that may take a generation to achieve health equity.

Creating healthier conditions requires the utilization of place-based or people-based strategies. People base strategies focus on mobility and choice, place based strategies take advantage of resources available in communities and help address community conditions for health. The Joint Center focuses on place based strategies through a program called Place Matters. This program focuses on elevating the capacity of local leaders to address the social determinants of health in their communities. The leaders define both the issues and upstream social determinants that affect the community such as the retail food environment, violence in the community, and environmental health hazards. It is possible to utilize successful strategies on a community levels to address these issues. For instance, a health food initiative exists in Pennsylvania which provides incentives for farmers markets and grocery stores to locate in communities suffering from what is known technically as “food deserts” (no or very few grocery stores serving fresh foods, particularly vegetables). Some local governments are doing something about this, for example, the Los Angeles County Council imposed a moratorium on the establishment of new fast food restaurants in South Central L.A. to improve the retail food environment.

Other examples of what can be done to create healthy communities are:

- Structure land use and zoning to reduce the concentration of health risk.
 - Do not place schools next to environmental hazards
 - Think about the use of parks and recreation in zoning
- Institute a health impact assessment to assess public consequences of new programs and policies for transportation, housing, education, labor, etc.
- Improve air quality through land use
 - For example, place bus depot sites away from residential areas and schools
- Expand the availability of open space
 - Use transportation dollars smartly to encourage active life styles
- Address disproportionate environmental impacts
 - Prioritize stimulus money for communities that are most vulnerable to health threats

An important correlation exists between education and health. One step towards creating healthy communities involves addressing health through education, which most people agree yields “the biggest bang for the buck.” To do this, implement high quality pre-

school programs, whose benefits include better educational and job outcomes for child participants. Other ways to reduce health disparities through education include creating incentives to attract experienced teachers in low performing schools, equalizing school funding, improve curriculums, offer better college preparatory course work, and reduce financial barriers to higher education.

Another way to address health disparities includes expanding economic opportunities because an important correlation exists between socioeconomic status and health. Job training, economic development, facilitation of access from isolated neighborhoods to new job centers, and encouraging public and private investment in low income communities all expand economic opportunities. The provisions to implement these are written into the current stimulus package which offers money without policy guidance. Thus, the work begins now to provide the policy guidance with a health lens in mind.

Smedley concluded by reinforcing the idea that the stimulus bill is an important opportunity to work towards health equity because it not only includes provisions for healthcare, but also allows the U.S. to address health equity through the social determinants of health.

Discussion

The standing-room-only crowd in the Members Room of the Jefferson Building of the Library of Congress had many questions. The following highlights the question and answer session following the speaker presentations:

- With all this evidence of prevention and cost savings, how can we guide the Congressional Budget Office (CBO) into looking at prevention as a cost saving rather than a cost expense?
 - The Prevention Institute and the Trust for America's Health (TFAH) produced the report [Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities,](#) This report was crafted deliberately to show the cost savings of prevention within the CBO time frame using conservative estimates. We also need much more evidence from a variety of different sources regarding all kinds of prevention issues which have not been adequately studied.
 - One of the challenges also is that the right window of looking for cost savings will vary depending on the outcome.
- Can you speak to how you address poverty, housing opportunities, etc. in terms of infectious disease and the social determinants of health?

- One example is the collaboration between HUD and the CDC on a program that identifies individuals who are HIV infected and at risk of homelessness. It is a housing first approach, and it makes HIV a priority category for individuals to receive Section 8 housing support. This program has been evaluated with a rigorous methodology and has been shown to improve the housing outcomes as well as the clinical outcomes for the individual.
- How do we capture the attention of the public in buying into the fact that health is a macro concept in such a capitalistic and individualistic society?
 - There are 2 narratives in the US – the self made individual and the community. The second narrative is coming back into our discourse and we need our cultural, political, and civic leaders to reinforce that. We have moved away from a sense of community and shared responsibility for each other. But it is important to reinforce these values in cultural norms, traditions, media, and political leaders.
 - No one should deny individual responsibility, so this is not an “either or” debate. All of us need to choose better health, but for some the choices are very constrained. This produces a social obligation and responsibility to diminish the barriers so that people can exercise choice. This would mean finding a new way to discuss and acknowledge both individual responsibility as well as the social responsibility.
 - When we have huge underlying disparities, and a shock to the system, you see the effects of the concentration of poverty (For example, Hurricane Katrina). Given high levels of disparities, eventually when we have a problem or shock, we all pay for it. We need to make the point to the public that it is not possible to isolate the shock to impoverished communities. We all are affected by this.
 - At this time, given the current economic crisis, there is an emphasis on individuality as well recognition that often it is not that person’s fault. There are certain cultural and normative questions that must be addressed because we are all going through the current downturn. We should provide leadership as to how we talk about this issue.
- The speakers have all emphasized that there is a higher incidence of disease in poorer communities. What impact does doing the right thing have on actual cost?
 - For every dollar we spend we are saving \$5 by the fifth year – that is the research.
- For the awareness and the interventions, you need capacity at the community level. If you do in fact need that, how do you get that done with the opportunity that the stimulus provides?
 - Provisions in the stimulus for community health centers, prevention and wellness, and money for the Title 7 and Title 8 workforce. There is a lot of

leadership from community health centers thinking broadly about this issue. Leaders can define issues and elevate voices for change – one example is Help Matters. Leadership at the local level is a very powerful action tool.

- There are 10 initiatives, at least, with the capacity to be successful on a community level.
- The role of foundations needs to change dramatically from funding pilots to investing in capacity, and we need a set of people with a whole new set of skills.
- I would like to pick up the “either or” issue – the confluence of the upstream and the downstream. How are the upstream and the downstream linked?
 - There is a challenge and opportunity to use the healthcare context to address the social determinants of health. One example is Cuba which spends for its health care a small portion of what the U.S. spends. Yet their overall health outcomes exceed ours. It’s not healthcare per se but the way that we practice health care as well as the social determinants. We should not phrase it as whether health care does or does not have a role in the social determinants of health. One specific example is the development of a preventive legal approach at the Boston Medical Center. When people come to the Center they receive an assessment of all of their needs. People work with them on all of these issues. Another example is based at the Briarwood Community Health Center in Springfield Massachusetts that focuses on the continuity of care for people who go to prison. This means that the physicians from the community health centers go into prison to work with their patients.
- Looking at partnerships for these issues, what about training organizations and institutions, and dental organizations, are you getting the same kind of commitment from them?
 - I don’t know what our outreach is to them, but in the area of dental care, the disparities are largest. Dental care is not just about your teeth but your overall health. Including dental care in health care coverage is very important. There really is a challenge for infrastructure building at the community level.
- The majority of examples focus on the urban context, what about the native and rural populations? We tend to focus energies on urban poverty – when talking about the black middle class, it is documented that they live in close proximity to urban areas, is there evidence that those people suffer from the adverse effects?
 - Most of the work done is in an urban context, and we need to pay more attention to the rural context. There is some research on low income communities and rural communities, but a more comprehensive look at rural health conditions and their solutions is needed.

- The issue of rural challenge is very important. Issues cannot simply be reduced to SES status. The black middle class has higher health risks than their white counterparts. This suggests that health determinants have to do with place and not just class.
- It is about place, African Americans are 36 times more likely than whites to live in high poverty areas. This also touches on the lived experience of race, and how this translates into health. In totality when we look at living conditions and treatment of people of color, these add up and accumulate in the body resulting in poorer health status.
- There is a competition of funds going on, how do we integrate all of this to comprehensively cover these issues?
 - Commonalities can be acknowledged, and it's critical to get everybody to think about these issues in very broad ways to link up opportunities.

Closing Remarks

- **Brian Smedley** – I would like to stress that we have an important opportunity with the stimulus to make a down payment on the investment towards health equity. It's important to think about the stimulus through the health equity lens.
- **Dolores Acevedo-Garcia** – Racial equity affects all of us, especially because we are soon going to be a minority majority country. We cannot afford the potential consequences of this type of inequity.
- **David R. Williams** - We need to recognize that most adults in the US are unaware that racial and socioeconomic status inequalities exist. We have a task to raise awareness. Once people are aware we need to harness the great ingenuity of the American spirit to address the inequities that exist.
- **Larry Cohen** - If this country is spending half the total world's resources spent on health care and getting our relatively poor outcomes, we can do a lot better. We don't fully know the answers to any of the issues, but we have a lot of promising arenas. The same solutions that are important for prevention are important for treatment. We should work together and build capacity.
- **Clem Bezold** – The social determinants of health provide the greatest leverage for improving health and health equity. The audience today and the questions reflect the growing recognition of these issues. The DRA Project will continue to promote awareness of the social determinants, as well as exploring the role of health care providers in leveraging the social determinants. Our thanks to Congresswoman Christensen and the speakers. The speakers are leaders in understanding and promoting health equity and the discussion today demonstrated that – Thank you.