



Expanding the Boundaries

Health Equity and Public Health Practice

NACCHO
National Association of County & City Health Officials



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Foreword

This publication is the result of the experiences and insights of many colleagues, consultants, community partners, state and local health officials, and the work of two expert panels. The National Association of County and City Health Officials' (NACCHO) Health Equity and Social Justice Committee also provided guidance throughout the process.

It is motivated by the recognition that health is profoundly influenced by social inequalities. This raises important considerations for health departments, including the need to expand the boundaries of their practice to use their resources, perspectives, and alliances to more directly confront the social inequalities that are the roots of health inequities.

The manuscript went through several rounds of review over many months, including a day-and-a-half review and discussion by an expert panel convened by NACCHO in November 2013. The result is substantially revised from the draft reviewed by the panel, based on their critical insights and guidance.

A core team responsible for overseeing this project consisted of Marilyn Metzler, Senior Analyst for Health Equity, and M. Clare Reidy, Health Scientist, both of the Division of Violence Prevention at the U.S. Centers for Disease Control and Prevention; Richard Hofrichter, Senior Director for Health Equity at NACCHO; and Bob Prentice, co-founder and former director (retired) of the Bay Area Regional Health Inequities Initiative, who also worked for nearly two decades at the San Francisco Public Health Department.

The primary author of this document was Bob Prentice. Others who served on expert panels, reviewed, and commented on various iterations of the draft and/or provided information used in the text included Jeanne Ayers, Sonali Balajee, Rajiv Bhatia, Dorothy Bliss, Doak Bloss, Ashley Bowen, Paula Braveman, Renée Canady, Subha Chandar, Kathryn Evans, Amy Fairchild, Nick Freudenberg, Kristina Gray, Jonathon Heller, Paula Tran Inzeo, Joanne Klevens, Reshma Mahendra, Linda Rae Murray, Lexi Nolen, Ngozi Oleru, Kirsten Rambo, Dean Robinson, Linda Rudolph, Baker Salisbury, Tom Schlenker, Doran Schrantz, Amy Schulz, Umair Shah, Mikel Walters, Lynn Weber, David Williams, and Sandra Witt.

Despite the best counsel of many dedicated and bright public health practitioners, however, this publication is hardly a definitive statement on health equity practice. It is rather a preliminary exploration of the ways in which social inequalities can influence health and an attempt to articulate key elements of a public health practice that can more effectively advance health equity. It is offered in the spirit of inviting dialogue among colleagues in health departments and their community allies so we can collectively define an invigorated and expanded health equity practice. If this publication can help in that process, then it will have served its purpose.

Introduction

Health equity has become a more prominent priority among many state and local health departments throughout the United States. It has been incorporated into *Healthy People 2020* as one of four overarching goals.¹ The Centers for Disease Control and Prevention (CDC) recently published *A Practitioner's Guide for Advancing Health Equity*.² The National Association of County and City Health Officials (NACCHO) has an online course exploring the roots of health inequities.³ An influential documentary series, *Unnatural Causes: Is Inequality Making Us Sick?*, produced by California Newsreel with Vital Pictures, Inc., first aired on Public Broadcasting system in 2008 but subsequently was widely distributed and helped make health equity a focus of discussion in health departments and communities across the country.⁴

Yet, this higher profile for health equity continues to run up against the persistent inequalities that produce substantial differences in health across the nation.

The central theme of *Expanding the Boundaries: Health Equity and Public Health Practice* is that health equity practice should consider the underlying social inequalities that are the root of health inequities, rather than only their consequences.

Much of the work involved in contemporary health equity practice emphasizes reducing risk factors for preventable illness and death in low-income communities, which are also disproportionately

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communities of color. The CDC's *Practitioner's Guide* and its Community Transformation Grants,⁵ for example, support environmental approaches to promoting tobacco-free living, active living, and healthy eating—risk factors that together account for more than one-third of all deaths in the United States.⁶ Smoke-free policies in housing, healthy retail, farmers' markets, safe routes to schools, active transportation, health language in land use general plans, and many other related public health initiatives are important and essential contributions to making healthier communities. They are indeed a defining edge that extends beyond communicable disease control, clinical care and prevention, case management, health education, and other public health categorical programs, and they have charted a new course for public health practice.

However, it is important to keep perspective on the scale of what we as public health practitioners are up against. Differences in life expectancy among some of the communities involved in these initiatives compared with more affluent neighborhoods in the same city or region are a decade or more in places such as Louisville,⁷ Minneapolis and St. Paul, Kansas City,⁸ the San Francisco Bay Area⁹ and Los Angeles,¹⁰ and even two decades or more in Baltimore,¹¹ New Orleans,¹² and California's agricultural heartland.¹³ It is not enough to take communities where we do our best public work as a given and start from there to make improvements in various aspects of their environments. Instead, we should consider asking how those communities came to be in their current configurations—not just the physical environment but also who lives there and why—and how public health can influence the way those communities are shaped now and in the future.

Some neighborhoods are food deserts; have an abundance of retailers specializing in alcohol, tobacco, and junk foods; lack open space; are unsafe; have concentrations of public housing; lack adequate public transportation; and are located near ports, refineries, freeways, and other sources of exposures to toxicants and air pollution. People who live in these neighborhoods typically have low incomes, high rates of

unemployment and underemployment, and they are disproportionately people of color. The physical and social configurations of these neighborhoods are the result of a constellation of public and private policy decisions that have been made over the course of decades. There is a role for public health to play in how those kinds of decisions get made now and in the future, informed by an understanding of how they were made in the past but committed to confronting the inequalities that produce harmful and unjust effects on our health. That is the direction of an emerging health equity practice in health departments.

The ways in which health is a reflection of social inequalities, however, are not limited to the differences in where people live. Many of those differences have been, and continue to be, heavily influenced by structures of inequalities related to class, race, gender, and sexual orientation, among others. Measures of morbidity and mortality, for example, are highly correlated with wealth and income, which have become an even greater public health issue as the concentration of income and wealth and the extremes of wealth and poverty have now reached nearly unprecedented degrees in United States history.^{14,15} Life expectancies are shorter and infant mortality rates are higher for Native Americans and African Americans, and although Latinos and Asians have longer average life expectancies, on most measures their health status declines over generations in the United States.¹⁶ Women are more likely to be victims of sexual violence, including one in five who have been raped in their lifetime.¹⁷ One in five lesbian, gay, bisexual, transgender, and queer (LGBT) middle and high school students have been physically assaulted at school because of their sexual orientation, and LGBT youth are two to three times more likely to commit suicide.¹⁸

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is not an academic exercise. Recognizing these differences enables public health practitioners to use their perspectives and resources more directly toward undoing the ways in which social inequalities contribute to inequities in health.

This formulation of our task is not new. It is deeply rooted in the history of public health and calls for a reclaiming of a legacy engaged in the improvement of overall living conditions. That is the challenge for contemporary public health—to understand the larger forces that shape the way we live and how they affect our health. For health equity practice, it also requires understanding how the prospects for health and well-being are so heavily influenced by social inequalities.

Organization of the Text

The first section is a brief overview of the early history of public health and how some of the greatest achievements prefigure a contemporary health equity practice.

The second section explores the roots of health inequities, particularly in relation to the social construction of inequalities defined by class, race, gender, and sexual orientation.

The third section profiles four health departments that illustrate elements of health equity practice focused on social inequalities underlying health inequities.

The fourth section is a more general review of elements of health equity practice that have emerged from the work of state and local health departments across the United States.

The final section offers reflections on the potential for a future health equity practice.

Health Equity and the History of Public Health

Many of the great accomplishments in public health during the nineteenth and early twentieth centuries were achieved as part of broad social reform movements. The origins of public health in the United States had much to do with the rise and spread of diseases associated with industrialization, urbanization, and immigration, particularly as they were linked to the relationship between poverty and disease. Sanitation led to requirements for indoor plumbing connecting houses to water and sewer lines. Separation of residential areas from manufacturing and other sources of environmental exposures gave birth to zoning and land use planning. Food safety was improved through regulation and inspection of food production and sales. Laws restricting child labor were enacted, and the field of industrial hygiene grew to protect workers from occupational exposures to disease and injury. Public health nursing emerged from work in tenements and other low-income housing where poor health was one consequence of the living conditions people endured. Sanitarians, physicians, nurses, and other public health practitioners worked in general accord, and in varying degrees of alliance, with labor, women's rights organizations, child labor activists, housing advocates, and other social reformers to improve living and working conditions and their consequences for health.¹⁹

Public health from the mid twentieth century forward was defined more by the developing bio-medical sciences, and its work was based increasingly in laboratories and clinics. Some of the great accomplishments in public health during the twentieth century resulted from developing

vaccines and controlling infectious diseases through improved surveillance, screening, and clinical prevention and management.²⁰ The ethos of science on which it was constructed, however, distanced public health from social reform. Improvements in health that resulted from organized labor's ability to gain better wages and benefits for its membership, or legislation that created Social Security; unemployment insurance; federal support for housing; or public assistance for families, seniors, and people with disabilities were not by and large seen as public health matters.²¹ The premise that activism is at odds with the objective disposition of science precluded public health from playing a more prominent role in social reform that made important contributions to improving health.

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A combination of public health achievements and improvements in general living conditions for much of the population resulted in an increase in average life expectancy of nearly 30 years during the course of the twentieth century. Successes

in control of infectious diseases and longer life spans translated into a relative increase in the burden of chronic disease, which accounted for roughly three-quarters of illness and death by the end of the century. The social etiology of much of chronic disease, however, posed a challenge for which public health was not well-prepared. Tobacco programs' confrontation with the tobacco industry or the recent ventures of nutrition and physical activity into the built environment reclaimed some of the legacy of a public health practice concerned with social conditions, but they emerged largely separate from and functioned parallel to existing categorical programs in health departments focused on clinical care, case management, and health education. Moreover, organizing health department programs around single diseases, risk factors, and populations made

it difficult to consider the broad spectrum of poor health associated with deeper social inequalities or to forge a practice that could more directly address the sources of health inequities.

The civil rights movement of the 1950s and 1960s directly challenged inequalities based on race and helped spark a growth in activism by racial and ethnic groups, a new wave of feminism, and an invigorated gay liberation movement. Although public health was not always engaged with the social movements that arose to confront inequalities in society, those movements nonetheless had an influence on public health. Despite overall improvements in health during the twentieth century, the persistence of sometimes significant differences in health related to race and ethnicity, income, gender, and sexual orientation challenged public health to come to terms with what were called health disparities.

Public health was reluctant to move beyond its own professional boundaries. The 1985 *Report of the Secretary's Task Force on Black & Minority Health*, for example—which launched the Office of Minority Health a year later and influenced the subsequent development of *Healthy People 2000*—documented disparities in mortality between Blacks and other minorities compared with Whites, and provided recommendations regarding health information and education, health services, health profession development, cooperation with the non-federal sector, data, and research.²² *Healthy People 2000* made reducing health disparities one of three broad goals for the nation and it took differences in health among populations as a starting point and set targets for improvement through health promotion, health protection, and preventive services.²³ Consistent with President Clinton's "Dialogue on Race," chaired by the noted African American historian John Hope Franklin, *Healthy People 2010* established as one of two

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overarching goals for the nation the elimination, not just reduction, of health disparities, and unlike its predecessor, did not have separate tar-

gets for different populations but rather adopted the highest standard for all groups. Its objectives were framed within five major risk factors—physical activity, overweight and obesity, tobacco use, substance abuse, and responsible sexual behavior.²⁴

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to advance health equity. Citing differences in life expectancy of more than 35 years among nations, the WHO report states:

Social justice is a matter of life and death...These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by the political, social, and economic forces.²⁵

The implications of the WHO report suggest that we cannot get to the root of health inequities if we do not address the underlying social inequalities. The principles of action recommended by the WHO report included the need to “(i)mprove the conditions of daily life...(and) tackle the inequitable distribution of power, money, and resources—the structural drivers of those conditions of daily life....”²⁶

The WHO report also articulates the difference between *health disparities*, a term used almost exclusively in the United States, and *health inequities* or *health inequalities*, terms used by WHO and most other countries. Health disparities generally referred to differential rates of morbidity and mortality among different population groups, and the practice it generated tended to focus on diseases and risk factors. Health inequities or health inequalities, on the other hand, referred to the now-classic Margaret Whitehead definition as “...differences that are unnecessary and avoidable but, in addition, are also considered unjust and unfair,”²⁷ which invokes a more explicit sense of social justice.²⁸

The combined influences of the WHO report and an emerging health equity practice in state and local health departments in the United States are evident in *Healthy People 2020*, which has made “achieve health equity, eliminate disparities and improve health of all groups” one of four overarching goals for the nation.²⁹ The inclusion of social determinants of health as one of 12 leading health indicator topics was a clear recognition of the WHO report and a growing interest in social determinants of health in U.S. public health practice:

Social determinants are in part responsible for the unequal and avoidable differences in health status within and between communities. The selection of Social Determinants as a Leading Health Indicator recognizes the critical role of home, school, workplace, neighborhood and community in improving health.³⁰

Earlier *Healthy People* reports acknowledged that the environment is important, but as the location in which contemporary public health practice could use the tools of health promotion, protection, and other prevention measures to minimize risk factors for disease and injury. To suggest that the social environment could be partly responsible for unequal and avoidable differences in health, however, provides an opening to another way of thinking about public health practice. Schools,

for example, can have healthier food and more physical activity, which will contribute to improved health, but who goes to which schools and under what conditions, and what that portends for their health and well-being, is a different matter.

The notion of an expanded health equity practice that can directly confront the sources of social inequalities is not a wistful claim to a romanticized history of public health.

To suggest that the social environment could be partly responsible for unequal and avoidable differences in health, however, provides an opening to another way of thinking about public health practice.

It is, rather, an argument that a public health that uses its resources, perspectives, commitment, and savvy to challenge the structures of power that create and maintain social inequalities and unhealthy living conditions is grounded in its own history. A resurgence, or what Amy Fairchild and her colleagues have characterized as “back to the future,”³¹ has been

evident in the coalitions that came together to counter initial indifference, for example, in the early stages of the HIV/AIDS epidemic,³² or taking on the tobacco, lead, and soda industries. That legacy is what public health can draw from and enlarge upon in order to direct its work toward the root causes of health inequities.

Social Inequalities and the Root Causes of Health Inequities

Exploring root causes of health inequities is a way to consider how public health can influence the social inequalities that contribute to “unnecessary, avoidable, unjust and unfair” differences in health. The following discussions of how class, racism, gender inequity, and heterosexism can affect health capture neither their complexity nor relationship among them, but rather are attempts to illustrate why each is important for public health. We often witness or experience in our everyday lives how class, racism, gender inequity, and heterosexism play out at the individual and interpersonal levels. However, these explorations consider how they operate and interact through structures and processes that generate social inequalities. Understanding them as systems of advantage and disadvantage can help us acknowledge the common roots of differences in health outcomes based on class, race, gender, and sexual orientation, and build a public health practice that can contribute to their undoing.

Class

Public health, which relies heavily on epidemiology as its evidence base, has generally adopted the empirical social sciences use of socioeconomic status, or SES, as a proxy for any understanding of class. Measures of health status are correlated with some demographic variable such as income, race/ethnicity, education, age, or sex. Although these correlations make important contributions to our understanding of the relationship between health and social inequalities, they lack a

critical component of the original meaning of class—that it is fundamentally a system of power. How wealth and income are generated or distributed, or how social inequalities are produced and reproduced, are the result of public policies, institutional practices, and private decisions that are shaped through the exercise of power.

Although these correlations make important contributions to our understanding of the relationship between health and social inequalities, they lack a critical component of the original meaning of class—that it is fundamentally a system of power.

The relevance of this perspective is especially compelling now. Over the past few decades, the concentration of wealth and degree of income inequality in the United States have become greater than they have been since at least the 1920s.³³

The top 1 percent, which had 10 percent of total income in 1980, held 22 percent by 2012,³⁴ and just 10 percent of the population now owns 75 percent of the wealth.³⁵ The foreclosure crisis deprived millions of families of their only source of wealth—whatever equity they had in their homes. Meanwhile, the principle of universal public education as a vehicle for social mobility has been supplanted by a stratified system of private, charter, and public schools; the average debt for two-thirds of college students who took out loans to earn a bachelor's degree is nearly \$25,000.³⁶ Globalization and technology have displaced many of the jobs that afforded people reasonably adequate and secure incomes. Growth in the finance and technology sectors that has enabled some to earn large incomes has been accompanied by expansion in the low-wage service sector. Agricultural workers, a large percentage of whom are immigrants, including many undocumented, often live on the margins financially and politically. The portion of the workforce represented by labor unions is at a low of 11 percent, including less than 7 percent in the private sector.³⁷

These are public health issues. As British epidemiologists Richard Wilkinson and Kate Pickett conclude in their book, *The Spirit Level: Why More Equal Societies Almost Always Do Better*,³⁸ the most important

influence on life expectancy and other measures of health in developing countries is economic development, while in more developed societies it is the degree of inequality. By that standard, the United States fares poorly. It has become during recent decades the most unequal among developed countries.³⁹ The United States has also experienced a relative decline in life expectancy compared with other nations, going from seventh in the 1950s to 51st in 2013.⁴⁰ Although correlations at this level of abstraction do not translate readily into causality, the overall direction underscores the importance of deeper investigations into the relationship between inequality and health, and the development of a public health practice that can help reduce those inequalities.

Tax policy, minimum wage, living wage, organizing low-wage workers, foreclosures, education, immigration policy, and other issues related to inequalities of wealth and income are public health matters, although public health will not often be in the lead. Public health will instead more commonly have to align strategically with social movements and political forces that are advocating for policies and practices that will reduce inequalities and improve health, lending public health evidence and perspectives to larger campaigns.

Racism

Much of public health practice focused on racial and ethnic disparities in health has consisted of clinical management and prevention or health education targeting diseases and risk factors for specific populations—for example, smoking or obesity rates among African Americans, diabetes among Latinos and Native Americans, or tuberculosis among Asians. Recent public health practice, however, has begun to focus more on broader living conditions and their effects on health. Maternal and child health programs, for example, have relied primarily on improved access to perinatal care, case management, and health education to help achieve significant reductions in overall rates of infant mortality. The persistence of differences in infant mortality

rates as much as three times higher among African Americans compared with Whites, however, has led to the development of “life course” models that take into account the stresses of racism over the span of a lifetime, or across generations, and how they are reinforced by adverse daily living conditions.⁴¹ Concerns about higher rates of nutrition- and activity-related diseases among racial and ethnic populations, to cite another example, have gravitated more toward attention to the built environment, healthy retail, and other aspects of the social and physical environment. These approaches to reducing health disparities are generally concentrated in low-income communities of color.

An expanded health equity practice, however, asks how these low-income communities of color came to be the way they are, and how public health might influence the forces that shape them rather than contend only with the consequences. One of those forces is structural racism, or what John A. Powell prefers to call structural racialization, because it suggests a set of processes and does not always involve a racist actor—what he refers to as a “web without a spider.”⁴²

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The formation of many urban areas over decades and the resulting patterns of residential segregation provide an illustration. Migration toward cities for jobs during World War II typically resulted in multiracial, although segregated, popula-

tions. During the post-war period, however, a combination of federally funded highway construction, housing policies, banking practices (e.g., redlining), and real estate restrictions (e.g., racially restricted covenants) made possible the process of suburbanization and White migration out of the cities. Increasingly, residential segregation, even when it was no longer legally sanctioned, took the form of city and suburb, or urban areas—ghettos—that became predominantly black neighborhoods,

and which established the underlying structure for development over subsequent decades. Those neighborhoods were often characterized by disinvestment (e.g., limited employment opportunities, retail stores, etc.) and proximity to environmental health hazards. Urban renewal funds were often sought by local officials, while big city mayors lobbied the federal government for urban renewal funds to fix decaying infrastructures that resulted from the exodus of their tax base.

More recently, many of those same urban areas have become increasingly multiethnic, as growing Latino and Asian populations include people in the low-wage sector in search of affordable housing. The “web without a spider” has taken on different forms. During the housing bubble, banks often offered subprime mortgages to people with marginal and stagnant incomes who wanted not only to realize the dream of home ownership but also to establish even a modest amount of wealth in the form of home equity for long-term security. When the housing bubble burst, structural racialization was evident given the inequitable burden of foreclosures falling disproportionately on people of color. Of the roughly \$200 billion in wealth lost during the foreclosure crisis, those living in communities where the majority were people of color lost wealth at nearly a 70 percent greater rate than those living in White communities.⁴³ African Americans and Latinos were twice as likely to lose their homes as Whites.⁴⁴

The increasing gap in wealth and income has created other pressures on low-income communities of color. Growth in finance and tech sectors, with a younger and more affluent workforce drawn back to the cultural allure of cities, are driving up the costs of housing and other expenses of daily life for

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those already struggling to get by. Gentrification and displacement are a significant new force in shaping the conditions in these communities.⁴⁵

New developments in public health practice focused on improving the social and physical environments in low-income communities of color are important contributions to improving health. An expanded health equity practice, however, will also use public health resources and perspectives to challenge decision-making processes and power that create, sustain, and threaten those communities in a way that furthers racial and ethnic marginalization. Economic development; housing and employment policies; education; banking and real estate practices; and foreclosures, gentrification, and displacement are public health issues because they contribute to the social inequalities that result in racialized health inequities.

Gender Inequity and Heterosexism

Although public health struggles to come to terms with class and racism and their implications for health, the consideration of the effect of gender inequity on health status—and what that means for public health practice—lags behind.

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Differences by gender, typically explored through the biological sexes of male and female, are seen across many health outcomes. Perhaps the most obvious and persistent differences are those related to violence. For example, according to the National Intimate Partner and Sexual Violence Survey (NISVS), nearly one in five (18.3 percent) women reported experiencing rape at some time in their lives compared to one in 71 (1.4%) men.⁴⁶ Gender analysis in public health rarely, if ever, includes trans-gender communities, yet the same obvious and persistent differences,

experiencing rape at some time in their lives compared to one in 71 (1.4%) men.⁴⁶ Gender analysis in public health rarely, if ever, includes trans-gender communities, yet the same obvious and persistent differences,

including those in violence, exist. For example, according to the National Transgender Discrimination Survey, which had a sample size of more than 6,000 transgender and gender nonconforming participants, 41 percent of respondents reported attempting suicide compared to 1.6 percent of the general population.”⁴⁷

Gender inequity, like class and racism, is a socially constructed system of power. As such, individual level demographics make for weak proxies. For example, use of the biological sexes of male and female is helpful in identifying inequitable distribution of outcomes, yet insufficient to analyze, understand, and act on gender inequities in health and safety. Individual level demographics, like sex, sexual orientation, race, and socioeconomic status, simply do not capture the relational aspects of power systems. Thus, we need to look at indicators of gender inequity embedded in our structures and systems to understand where and how to focus prevention efforts.

The gender wage gap is a prime example of gender inequity at the structural level. Although women surpass men in educational attainment and academic performance,⁴⁸ women’s incomes still lag behind that of men. In 2012, women earned 76.5 percent of men’s earnings,⁴⁹ and the gap is reflected across all income levels. For example, college-educated women start out earning 5 percent less than their male peers, even when they are equally qualified. The gap then widens over their years of employment.⁵⁰ Gender inequity at the structural level is also evident in the concentration of women in “pink-collar” jobs (e.g., school teachers, childcare assistant, administrative assistants), which typically pay lower wages than male-dominated professions,⁵¹ and in widespread employment discrimination against transgender people. According to the National Transgender Discrimination Survey, 90 percent reported experiencing “harassment, mistreatment or discrimination on the job or took actions like hiding who they are to avoid it” and 47 percent said they had “experienced an adverse job outcome, such as being fired, not

hired or denied a promotion because of being transgender or gender non-conforming.”⁵²

A pattern similar to that described around gender is also present around sexual orientation. Once again, we see stark differences in violence-related outcomes: According to the CDC’s NISVS Sexual Orientation Report,

“individuals who self-identify as lesbian, gay, and bisexual have an equal or higher prevalence of experiencing intimate partner violence, sexual violence, and stalking as compared to self-identified heterosexuals. Bisexual women are disproportionately impacted. They experienced a significantly higher lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner, and rape and sexual violence other than rape by any perpetrator, when compared to both lesbian and heterosexual women.”⁵³

Yet again, simply using sexual orientation as a demographic category is insufficient in explaining these inequitable outcomes. Here, we should consider identifying the practices and processes of heterosexism, which operates at the structural level. For example, among lesbian, gay, and bisexual respondents to the 2008 General Social Survey (GSS), 42 percent had experienced employment discrimination at some point in their lives, and 27 percent had experienced employment discrimination just during the five-year period prior to the survey. Employment discrimination was higher (38 percent) among those employees who were open about their sexual orientation at work than those who were not (10 percent).⁵⁴

Profiles of Health Equity Practice

Exploring social inequalities and the root causes of health inequities might seem like a far stretch from the work of many health departments. This section, however, profiles four health departments—Alameda County (California), Minnesota, San Francisco, and Ingham County (Michigan)—that have made long-term commitments to advancing health equity and have begun to work on many of the issues raised in the previous sections. They are not a representative sample, and profiling them is not intended to ignore creative and important work to address health inequities going on in other health departments around the country. Rather, they were chosen in part because of their accessibility within a limited capacity to survey a more comprehensive sample, but more importantly because they illustrate some basic themes in an emerging health equity practice. As will become clear, the profiles reveal innovative work on issues related to class and racism, but much less so on gender inequity and heterosexism, which is probably a fair reflection of the state of public health practice more generally.

Alameda County Public Health Department

The Alameda County Public Health Department work on health equity has roots in the decision to decentralize programs and create community health teams in neighborhoods with poor health during the mid-1990s. Although the community health team approach later gave way to community organizing models, it established the importance of place as an anchor for the health department's work on health equity over subsequent decades. It also launched an organizational

development process to explore what is involved in uniting public health with social justice.⁵⁵

The Community Assessment, Planning, Education and Evaluation (CAPE) unit was designed to integrate epidemiology with programmatic work, but it also became the base for organizational development. A Public Health 101 process was conducted to help all staff better understand the history of public health, cultural competency and cultural humility, undoing racism, social and health equity, and community capacity building. A five-year strategic plan (2008–2013) established department-wide priorities in internal capacity building, building community capacity, and action on public policies that produce social inequities. A population health report, *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*, was released in 2008, detailing the relationship between health and segregation, income and employment, housing, education, transportation, air quality, criminal justice, and other social conditions that affect health.⁵⁶ Internal organizational capacity building was complemented with community capacity building, including participatory community health assessments, resident action council leadership training, migrant programs, time banking, and youth capacity building. Community organizers were hired to work in two neighborhoods—Sobrante Park and West Oakland—where living conditions contributed to the poorest health.⁵⁷ Restructuring the organization created a Deputy Director for Policy, Planning, and Equity to further institutionalize the commitment to health equity laid out in the strategic plan.

The extensive organizational and community development work created the context from which a health equity practice was being developed. The CAPE unit continued to produce data chronicling the relationship between health and social inequities, including reports on place, racism, and poverty; the growing threat of increasing income inequality; and the health consequences of foreclosures and displacement.⁵⁸ The health department became involved in social justice issues

including a conflict to prevent Chinese seniors from being evicted by a wealthy landlord, work in West Oakland to reduce air pollution from the the port, and inequities in transportation, and displacement. Two areas of activity, however, are particularly worth further exploration because they reveal several key elements of health equity practice: work related to the Port of Oakland and work on foreclosures.

The Alameda County Public Health Department involvement in West Oakland—a community with high rates of poverty and unemployment and a large percentage of people of color that sits at the nexus of a busy port, rail-ways, freeways, and an elevated commuter train track—offers important insights into what the work entails. The health department was not in the lead, except when it needed to be, but it has played a crucial role along with community and environmental justice groups and some key public agencies. The population health report, *Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County*, had mapped mortality rates by census tract, which showed West Oakland to be one of the neighborhoods with an average life expectancy of at least 10 years less than the most affluent areas. Subsequent reports documented similar patterns of disease rates, including asthma, cancer, and cardiovascular disease. At the same time, environmental justice groups and a regional asthma coalition in which the health department was an active participant had formed a Ditching Dirty Diesel Collaborative to pressure the regional air quality management district to better monitor and regulate particulate matter. The familiar dynamic between environmental justice groups and regulatory bodies was profoundly influenced, however, when the issue was not only about environmental justice but kids with asthma, which helped gain the support of the air quality management district. The collaborative also organized to force the Port of Oakland to reduce diesel

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pollution that emanated from ships and trucks carrying cargo through the neighborhood. At a crucial juncture, when the organizing campaign ran up against resistance from the Port, the public health director, the director of the regional air quality management district, and the co-director of a West Oakland environmental justice group co-authored an op-ed that appeared on the front page of the Oakland Tribune:

...(The) Port of Oakland—the fourth-largest container port in the United States—fumbled badly on a critical opportunity to show true environmental leadership when commissioners voted to ignore strong scientific and experience-based clean air recommendations from the Bay Area Air Quality Management District, California Air Resources Board, U.S. Environmental Protection Agency, local environmental, labor and community groups, neighborhood residents and Alameda County Public Health and Environmental Health departments.

In a 5–1 vote, the port adopted a toothless and noncommittal Maritime Air Quality Improvement Plan, effectively devaluing the health of those who work at or live near the port and its major transportation routes, and deferring instead to large retailers and global shipping interests who prefer to avoid responsibility for cleaning up the pollution created in the course of moving their goods....

West Oakland residents are exposed to three times more diesel particulate matter (soot) than other Bay Area residents. West Oakland residents have the highest rates of asthma hospitalizations in Alameda County, 2.5 times greater lifetime risk of cancer, and live on average 14 fewer years than other Oakland residents who live only a few miles away. West Oakland residents and truck drivers are literally subsidizing the transportation of goods with their health. The price they are paying is in lung

cancer, emphysema, heart attacks and premature death. There is no need for this.⁵⁹

Although it was unusual that a public health director and the head of a regional air quality management district would align themselves with an environmental justice activist to so publicly and critically challenge another public agency, the strong base and momentum of the organizing campaign created a willingness, even an obligation, to take the political risk.

The Ditching Dirty Diesel Collaborative, with support on the inside and outside from the health department, had focused on regulations setting limits on idling of diesel trucks, state legislation that helped

independent truck operators convert to modern diesel exhaust filtration systems, and requirements that ships turn off their engines and plug into electric outlets to maintain onboard operations while docked. As a result of the collaborative work over several years, data recently reported indicate that particulate matter associated with diesel in West Oakland had declined by 70 percent between 2005–2012.⁶⁰ Although it is rare to achieve such substantial and measurable results, they are intermediate and the campaign is poised to continue into other domains. Those domains include land use and transportation planning to challenge why trucks are routed through West Oakland residential areas and goods movement to question why so many goods are shipped through the port.

In another campaign, the Alameda County Public Health Department became involved with foreclosures. In addition to being an unprecedented loss of wealth for people of color in the modern era, there were health consequences ranging from the immediate effects of utilities being turned off to the longer-term effect of displacement and insecure housing. A multiethnic community-based social justice organization, Causa Justa: Just Cause, began organizing tenants' rights

...the strong base and momentum of the organizing campaign created a willingness, even an obligation, to take the political risk.

clinics to fight illegal evictions and utility shutoffs. The health department recognized the health implications and joined with them. They subsequently co-authored a report, *Rebuilding Neighborhoods, Restoring Health: A Report on the Impact of Foreclosures on Public Health*,⁶¹ which both articulated the health consequences of foreclosures and proposed several policy recommendations. The joint effort was able to get a local resolution preventing water shutoffs and provide support for state legislation ending utility shutoffs. Causa Justa:Just Cause and the health department's Place Matters Housing Workgroup were also able to get passage of a local ordinance in Oakland mandating banks to register and maintain foreclosed properties in order to reduce blight.

Consistent with the principle of building long-term relationships with communities that can cover a range of issues over time, Causa Justa:Just Cause and the Alameda County Public Health Department more recently issued a report, *Development without Displacement: Resisting Gentrification in the Bay Area*, which documents the displacement in particular of African Americans and Latinos from formerly low- and moderate-income neighborhoods in Oakland and San Francisco. Causa Justa:Just Cause was primarily responsible for authorship of the text, but the health department provided health impact data analysis, and contributions to the policy analysis and recommendations.⁶²

Minnesota Department of Health

The Minnesota Department of Health (MDH) is engaged in a comprehensive effort to make health equity a central priority in their work. This includes changes in the organizational culture of the health department, a critical examination of the narrative that is used to define health, a major rethinking of their relationships with communities, and cultivation of public and political support to enable them to become involved in activities that expand the boundaries of public health practice.⁶³

The focus on health equity emerges from a deeper examination of what most influences health, and from a critical look at the role of a health department in assuring the conditions in which people can be healthy. One of the earliest concrete steps was an examination of the limited narratives of diseases and risk factors, narratives which tend to be the focus of health department programs and population health reports. Since many of the conditions that affect health are, in fact, well beyond the bounds of what a health agency usually does, it became necessary to promote an understanding of health consistent with this broader view. MDH leadership recognized that the health department has a role and a responsibility to present a more accurate and complete understanding of health, and that failing to do this actually contributes to poor policy making. This, with the active involvement and leadership of the Healthy Minnesota Partnership,⁶⁴ led to a decision to approach assessment and planning from a different perspective.

The Health of Minnesota: Statewide Health Assessment,⁶⁵ published in April, 2012 begins with an introduction emphasizing an “opportunity” framework for thinking about health and health equity. The first part of the report is organized around this broader narrative about health and focuses on some of the major influences on health—urban and rural; immigration and diversity; aging and retirement; water, weather and air; and, roads, highways and bridges—and how opportunities for health are affected by education and employment, income and poverty, housing and home ownership, outdoor and indoor environments, social connectedness, community and personal safety, access to health care and public health infrastructure. This discussion is followed by a review of more familiar public health topics such as nutrition, alcohol, tobacco, drugs, chronic disease, injury and mental health. The expanded narrative—not to be confused with narratives often used as marketing or messaging strategies—continues to provide rich opportunities in the state to develop a deeper understanding of health and what this means in terms of a public responsibility to tell the truth about what creates health. The

narrative about “what creates health” also led to *Healthy Minnesota 2020: Statewide Health Improvement Framework*,⁶⁶ a statewide plan developed by the Healthy Minnesota Partnership that emphasizes the importance of improving conditions for health in the community. The themes of the framework—to capitalize on the opportunity to influence health in early childhood, to assure that the opportunity to be healthy is available everywhere and for everyone, and to strengthen communities to create their own healthy futures—reinforce this narrative and guides the work of MDH and their community partners.

This broader understanding of health is also informing a systematic approach to transforming the organizational culture of the health department. In contrast to a more traditional reorganization, this transformation is intentionally creating opportunities for staff to experience a collective re-examination of issues, such as the greatest influences on health, health inequities, structural racism, leadership development, and developing meaningful working relationships with communities. This organizational development process is an outgrowth of a concerted campaign by the health department, with the support of the Governor, to prioritize policies and legislation that will promote health equity. One result of that campaign was legislation mandating the Commissioner of Health, in consultation with local public health departments, health care providers and community partners, to submit to the legislature a report on recommendations to advance health equity in Minnesota.

Building on the shared learning and relationship development that occurred in the previous months and, in some cases, years, the formal phase of the organizational change and the development of the report began with a core group of a dozen leaders connected throughout the health department. They personally reached out to staff in their divisions to participate in a forum on equity, racism and their impacts on health, and the role of the health department in addressing these issues. Nearly 100 MDH staff met in October 2013 to learn about the health equity

initiative and to become equipped to hold community-based conversations that would yield critical information for the health equity report.

Conversations during this process revealed concerns about the ability of the state health department to be effective in and accountable for arenas not in the usual public health purview. Public health has a strong “subject matter expert” culture, and this is not necessarily a bad thing; MDH leadership recognizes the value of a culture that encourages expertise. But needing always to be the “experts” in the room can inhibit true community partnership; being hesitant to take on issues that are outside of the health department’s full control can limit innovation and effectiveness. Dr. Ed Ehlinger, Commissioner, MDH, paraphrasing British industrialist and renowned systems thinker Geoffrey Vickers, often says “Public health is the constant redefinition of the unacceptable in the human condition. We need to create some urgency around the unacceptable.” This urgency and unacceptability of inequities that result in poor health outcomes cannot remain the concern only of the public health department, but must be shared with all sectors of the community.

Through the organizational change process and involvement of so many MDH staff, a wide community involvement effort was launched for the health equity report. Over 180 “inquiry sessions” were led by MDH staff, involving over 1,000 people. MDH created an online survey to gather the information generated in these sessions, yielding over 200 pages of comments and suggestions, many of which were incorporated into the final report. Additional opportunities for public input included the posting of a draft report for review and comment, and a public hearing. The final report, *Advancing Health Equity in Minnesota*,⁶⁷ submitted to the legislature in February, 2014, was accompanied by a letter signed by the heads of

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—Dr. Ed Ehlinger, Commissioner, MDH, *paraphrasing British industrialist and renowned systems thinker Geoffrey Vickers*

24 state agencies committing to work with the health department to advance health equity.

In brief, the report offers a profile of health inequities in Minnesota, their relationship to social and economic inequalities—with a special acknowledgement of the importance of structural racism—and recommendations about public health practice to advance health equity. The recommendations include using a “health in all policies” approach, investing in successful efforts, providing statewide leadership, strengthening ties to community partnerships, redesigning the funding from the state health department to better support health equity goals, making health equity more central throughout the health department and using data more effectively to advance health equity. The report also recommends the creation of a Center for Health Equity at MDH, which was established in December 2013, as well as convening cabinet-level health equity efforts to implement the recommendations.

A major component of Minnesota’s overall strategy is redefining its relationship with communities. Jeanne Ayers, the current Assistant Commissioner of Health responsible for spearheading the Department’s health equity efforts, had previously been on the board of ISALAH, a faith-based community organizing organization dedicated to racial and economic justice in Minnesota.⁶⁸ As a public health advocate, she was instrumental in leading ISALAH to embrace health equity as one of its goals. The convergence of a well-organized community base advocating for health equity together with a state health department that makes health equity a central principle has created opportunities for strategies that maximize their respective contributions. One example that illustrates this potential was the response to a proposed light rail transit corridor between Minneapolis and St. Paul. The original proposal did not include stops in ethnically diverse, low-income communities. Among the arguments made by community groups that ultimately resulted in the addition of three more stops was the health impact of making transit more accessible. A health impact

assessment was then conducted under the leadership of ISAI AH with the health department participating through a technical advisory committee.⁶⁹ While the overall goal was to show the public health impacts of transit-oriented development, the process was intentionally developed to support community leadership as a crucial element in holding public decision-making processes accountable to those most directly affected by their results. The Minnesota Department of Health and ISAI AH are using this base of experience to help create a five-state Building Networks for Health Equity alliance between public health departments and community organizations.

The combination of changing the public narrative around health, transforming the organizational culture, creating a supportive political environment and building strategic relationships with communities is producing a context in which it is possible to use public health perspectives, data, and resources to address the social and economic inequities that underlie persistent health inequities. The report, *Advancing Health Equity in Minnesota*, and a subsequent White Paper on Income and Health,⁷⁰ for example, were cited as having important influence on legislation to increase Minnesota's minimum wage from \$6.15 an hour to \$9.50 an hour, a campaign in which ISAI AH and others played important roles.⁷¹ A labor group, Centro de Trabajadores Unidos en la Lucha, which represents cleaning crews sub-contracted by many large retailers, also used the health department reports to help gain improved wages, benefits and working conditions, as well as a commitment from the Target Corporation to adopt a Responsible Contractor Policy.⁷²

Although each local health department functions in its own administrative and political environments, part of that functioning is affected by its relationship with the state health department, or, in states with centralized governance, the relationship between local and statewide offices. These relationships are largely influenced and even defined by categorical funding and administration, which often sets local programs apart from one another to the extent that their accountability

is to their funding streams. But these are also mutual and reciprocal relationships, with both local and state public health departments having roles in creating the conditions and public understanding of what creates health. When state and local public health departments work together strategically they each play a part in building the public and political will. When local public health departments and community groups organize to create accountability and responsiveness from the state health department, they help create the political space needed to move more effectively toward policies and processes that support health equity. In the same way, the state health department can help locally by creating expectations and space to act on inequities in addition to other supports such as reorganizing funding to the extent that they can to support these goals.

San Francisco Department of Public Health

The Program on Health, Equity, and Sustainability at the San Francisco Department of Public Health has, for nearly two decades, been developing one of the most sustained and innovative approaches to health equity practice. The program has pioneered much of health department use of health impact assessments (HIAs), including work on living wage, minimum wage, paid sick leave, health and safety for day laborers, food equity, noise and air quality, transportation, and displacement. An extensive involvement in a major planned redevelopment of San Francisco's eastern neighborhoods, which include many low-income communities and active community organizations, resulted in creating a Healthy Development Measurement Tool, later called the Sustainable Communities Index. Work with labor groups, antidisplacement coalitions, tenants' organizations, and food justice advocates, often in tense relationships with business associations, landlords, and planning agencies, created openings for a health department to introduce public

health data and perspectives into major policy debates to help build greater consensus to advance health equity.

Based on work that began in the 1990s, the Program on Health, Equity, and Sustainability, formally established in 2002, emerged in part from involvement in a campaign for a living wage in San Francisco. It was highly contentious legislation introduced by the President of the Board of Supervisors and supported by a Living Wage Coalition of labor and community groups, but opposed by a restaurant association, Chamber of Commerce, and the major daily newspaper. The Mayor tried to find elusive middle ground. As with many other issues health departments confront as they venture beyond familiar territory, the political dynamics have their own histories and terms of debate. On one side were labor and social justice advocates, who saw living wage as one measure to remedy the growing divide in the labor market between a large service sector work force struggling to get by in the midst of living expenses inflated in a city with more affluent workers in the growing finance and tech sectors. On the other side were businesses concerned that mandating wage levels could increase their expenses and, because the ordinance would apply only to employers doing business with the city, argued that taxpayers might be expected to pick up the additional costs. The head of the Program on Health, Equity, and Sustainability approached the President of the Board of Supervisors with an offer to calculate the mortality risk reduction and other measures of health status associated with various increments of increased income to help counter business opposition. An analysis of the health effects of a proposed living wage ordinance could not decide a highly politicized issue simply on its merits, but it did interject a consideration that had to be taken into account in the decision-making process. San Francisco ultimately adopted a living wage ordinance that required employers doing business with the city to pay their workers at least \$12.43 per hour (\$11.03 for nonprofits).

Involvement with the Living Wage Coalition gave the Program on Health, Equity, and Sustainability a base from which to continue work on wages and working conditions. San Francisco subsequently adopted a local minimum wage ordinance covering all employees in the city who work more than two hours per week that was \$2 more than the state minimum wage and made it the first jurisdiction with a minimum wage more than \$10 per hour. The Program on Health, Equity, and Sustainability similarly worked with labor and social justice organizations to help get a paid sick days ordinance passed, with local legislators calling on the health department to provide testimony. That local work led to related campaigns at the state and national levels. They also worked with day laborers and a local social justice organiza-

tion to gain improvements in health and safety for day laborers, and strategies to create greater job security.

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The Program on Health, Equity, and Sustainability also engaged in pioneering work to organize a citywide food system to promote food equity. The San Francisco Food Systems included restau-

rants, schools, food banks, free dining rooms, and other providers to develop policies and practices that would create greater food security and sustainability.

Involvement in the Eastern Neighborhoods Community Planning Process placed the health department in the middle of one of the biggest controversies in the city. Proposed rezoning of former industrial areas in the eastern neighborhoods of the city met with resistance from surrounding low-income communities who objected to both the proposals and the process. Concerns about affordable housing, employment, safety, and open space were part of a more general conflict over gentrification and displacement. Working with a broad coalition of community organizations, the Program on Health, Equity, and

Sustainability convened a community council to oversee an Eastern Neighborhoods Community Health Impact Assessment, which became the basis for the Healthy Development Measurement Tool and later the Sustainable Communities Index. This early use of an HIA on a major development plan pioneered not just the tool but the process for future health equity practice. The work in the eastern neighborhoods not only contributed to gaining important amendments to the plan but also helped the planning department learn how to work with communities in a different way.⁷³ It also became the foundation for an expanded use of HIAs with the support of the Sustainable Communities Index, which includes more than 100 measures for the economy, housing, education, transportation, environment, health, public realm, and community.⁷⁴

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Ingham County Health Department

The Ingham County (Michigan) Health Department has adopted an approach that emphasizes major change in the organizational culture and relationships with community partners based on a deeper understanding of how health is affected by social injustice. The process reveals the sources of resistance within the structure of the health department, and the potential for fundamental organizational change. The Ingham County dialogue process is a national model for organizational development to make health equity an overarching framework for health department programs and initiatives.

The Ingham County dialogue process has roots in a grant-funded *Community Voices* project in the late 1990s, which used a Freirean-influenced dialogue method with community residents to gain some consensus on priorities for improving community health. The process

raised questions about how the health department could see the resources of the community as their assets and, conversely, how the community could see the resources of the health department as theirs. Health department officials decided to use the facilitated dialogue process with health department staff and hired the facilitator from the *Community Voices* project for that purpose. A Social Justice Project was created, and a cohort of 20 staff representing various programs and occupations (excluding senior management) in the health department were recruited to go through a dialogue process to explore the root causes of health inequities. The Social Justice Team explored three root causes of health inequities: socioeconomic or class exploitation, institutional racism, and gender discrimination and exploitation. The Social Justice Team would formulate an action plan to guide health department and community activities to focus on the social inequalities that produce health inequities.

Does the health department raise the banner and lead the charge, or is the initiative more likely to come from community organizers and social justice activists?

The Social Justice Project had some rocky experiences in the beginning when the Social Justice Team met with senior management to convert their recommendations into an action plan. Some senior managers, who did not participate in the dialogue process, feared that team members were asking the health department to solve any injustices they saw. Some team members thought that senior management were not taking seriously the work of the Social Justice Project. Ultimately, however, the conflict led to more thoughtful discussions about, among other things, the role of a health department in matters of social justice. Does the health department raise the banner and lead the charge, or is the initiative more likely to come from community organizers and social justice activists? The conclusion was that there is a continuum, ranging from situations in which the health department provides data

or facilitates dialogue to others where the health department can be a catalyst for community action or, in some instances, takes the lead.

The facilitated dialogue sessions are not trainings, to the extent that refers to trainers imparting knowledge to participants, but rather an exploration of how class, racism, and gender inequity affect people's own lives and their relation to others. The intent of the method is to help people gain a deeper and more personal understanding of social injustice, including how it is the context in which they do their public health work. The Ingham County Health Department determined that a department-wide action plan that defines its activities in the community is less likely to transform the institution than focusing on the "hearts and minds" of the staff.⁷⁵ Completion of the Health Equity and Social Justice workshops is now required of all employees. A facilitated dialogue process is also used in relationships with communities, including such activities as community health assessments, neighborhood development, land use planning, affordable housing, and education.⁷⁶

With the support of grant funding, the dialogue process was adapted in the Louisville Metro Health Department, Harris County (Texas) Public Health and Environmental Services, Amherst (Massachusetts) Health Department, and New York City Department of Mental Health and Hygiene. Trainings on the dialogue process have also been made available to other health departments.

The experience of the Ingham County Health Department has facilitated a deeper understanding among staff and community of key elements of health equity practice: The focus of health equity practice should consider the roots of social inequalities and not just their consequences; social injustice is produced and reproduced

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through institutional decisions that are beyond the bounds of health department programs; undoing social injustice will most likely occur through community activism, and the health department will often have to figure out how to work in situations when the community is in the lead; and changing organizational culture is the foundation of sustained commitment to social justice and health equity practice.

Elements of Health Equity Practice

The profiles of a small sample of health departments engaged in innovative health equity work illustrate key elements of an expanded health equity practice. This section attempts to distill some of those elements into a more cohesive framework for advancing health equity in health departments. Each element in the framework is followed by brief examples from practice in selected jurisdictions, including several that were not among those profiled in the previous section. Although the examples are not comprehensive, they nonetheless reveal some constituents of an emerging health equity practice.

1

Some health departments have begun to explore a health equity practice directed toward the causes of social inequalities and not just the health consequences of those inequalities.

Some health departments have directly taken on policies and practices related to issues of class. San Francisco's HIAs on proposed living wage legislation, displacement associated with planned new developments, paid sick leave, and working conditions for day laborers,⁷⁷ or Minnesota's report in conjunction with community partners documenting that increases in income are associated with improvements in health,⁷⁸ are examples.

Some health departments are focusing on structural racism as a source of health inequities. The Boston Public Health Commission has made undoing racism a major priority within the health department, in its relationships with community groups and in its external practices.⁷⁹

The Seattle and King County Public Health Department is taking on the broader effects of racism through the King County Equity and Social Justice Initiative.⁸⁰ The Bay Area Regional Health Inequities Initiative (BARHII), a collaboration of 11 local health departments in the San Francisco Bay Area, is developing strategies to challenge structural racism in education.⁸¹ Minnesota's campaign to eliminate health inequities in the state has made confronting structural racism a key component.⁸²

The Wayne County (Michigan) Department of Public Health explored the relationship between gender and health through an HIA conducted jointly with a nonprofit organization to examine the health consequences of gender pay inequity.⁸³ The Commissioner of the Minnesota Department of Health published an article on the health benefits of marriage equality in the *Minneapolis Star Tribune*.⁸⁴

2

Some health departments have developed alliances with other agencies and organizations to create openings for participation in policy decisions, beyond the perceived boundaries of public health programs that directly affect the social inequalities at the root of health inequities.

The public health focus on the built environment during the past decade has established important precedent for health departments working in other agencies' terrain. Although meeting with initial resistance in some jurisdictions, public health participation in land use and transportation planning has become a more generally accepted practice nationally. Land use and transportation planning, however, are only part of what defines the living conditions in communities, and health equity practice often involves more contentious issues than those that can be accommodated within the bounds of collegial relationships.

A promising development for expanding public health involvement in decisions that affect how and where people live is Health in All Policies, which provides legitimacy to public health working in other arenas.⁸⁵ California has a Health in All Policies Task Force established by an executive order of the governor, which obligates 19 state agencies to take health consequences into consideration when they make their policy decisions.⁸⁶ Health in All Policies is a cornerstone of Minnesota's report on health equity to the legislature, with commissioners from 24 state agencies committing to working with the health department to achieve health equity.⁸⁷ In a different approach, King County (Washington) formally adopted an Equity and Social Justice Initiative as part of its strategic plan, which obligates the Seattle and King County Public Health Department to work with other agencies to advance equity and social justice in the county.⁸⁸

Absent the official endorsement of a Health in All Policies approach, health departments have adopted strategies directly with other agencies and organizations to help advance health equity. BARHII, for example, was able to participate in a regional land use and transportation planning process mandated by state legislation, which required reducing greenhouse gas emissions in part because planning officials believed that public health arguments would be more accessible than climate change arguments to some elected officials who oversee the planning process. Working with environmental justice organizations and sympathetic planning agency staff, BARHII was able to help get higher standards adopted and make equity one of the formal guiding principles in the planning process.⁸⁹

3

Some health departments have developed relationships with communities that are based on mutual recognition of each other's strengths and leadership capabilities, are long-term rather than situational and are based on shared interests in directly confronting the social inequalities that are the root of health inequities.

Health departments have developed relationships with communities in many forms during the range of their programs, including contracts with community-based organizations, advisory bodies, and coalitions tied to categorical programs, or situational alliances to take on specific issues. Health equity practice, however, more often requires deeper relationships with communities that can last over time and encompass a broad range of issues. The very nature of those relationships requires not only a sense of common purpose but development of trust, an understanding of shared leadership and the capacity to work together strategically over time.

Alameda County's approach to community organizing emphasizes long-term relationships with community residents and organizations to advance health equity, as illustrated by their partnership with a community-based social justice organization that resulted in jointly producing reports and policy recommendations regarding the effects of foreclosures and displacement on low-income communities of color.⁹⁰ The Kansas City health department provides space in their facilities for community organizations to help cultivate relationships informed by regular interaction and reaffirmation of shared interests.

On a larger scale, the Building Networks for Health Equity Project draws on the lessons from public health working with social movements, such as women's suffrage, and labor and environmental movements, to advance social justice and improve conditions for health. Health departments in five Midwestern states—Michigan, Minnesota, Missouri, Ohio, and Wisconsin—have joined with NACCHO and the Healthy Heartlands Coalition of congregations and faith-based

organizations to build a base of engaged community residents and organizations to take action through networks to address issues such as mass incarceration, low-wage work, educational opportunity, financial justice, and access to healthy food as part of a commitment to making strategic breakthroughs to achieve health equity.⁹¹

4

Some health departments have learned how to participate strategically in campaigns initiated and led by others, which might not be primarily about health but nonetheless advance health equity goals.

Health departments commonly use community health assessments to determine which health issues are most important, then convene community coalitions to help address them. Smoke-free environments, school nutrition, and active transportation are important examples from current public health practice. Health equity practice, however, often requires an understanding of how social movements and community organizing campaigns not necessarily defined as health issues can nonetheless have important health implications. Although health departments are not in the leadership, they can develop strategic alliances to help make explicit the health implications and contribute at key junctures during the campaign.

San Francisco's work on living wage or Alameda County's work on displacement and diesel pollution in West Oakland are excellent illustrations of health department involvement in campaigns initiated and led by community activists. The Minnesota Department of Health's work with ISAI AH on local and regional community issues, including sprawl, affordable housing, transportation, and racial inequity, and ISAI AH's leadership role in recent campaigns to consider the health consequences of a living wage or the potential effects of a Minneapolis/St. Paul Light Rail Project in low-income communities, show the

potential breadth of health department participation under community leadership.⁹²

5

Some health departments have developed strategies to protect against political risk, sometimes associated with health equity practice, by building a base that can help create openings to participate in activities that would otherwise be politically constrained.

Health in All Policies and building partnerships with other agencies can offer some form of protection for work that is outside the program boundaries or formal authority of a health department. Health equity work, however, can involve political risk. For example, although work on land use planning has been established as legitimate and important for improving neighborhood and regional conditions for health, it too has its perils. Getting health language in a land use general plan is one level of accomplishment, but challenging a proposed development on the grounds it will displace people in low-income communities invites a new layer of political reaction from developers and elected officials who support them.

One strategy is to build a base in communities to create demands for health department participation in matters that might be controversial. Community pressure can open political space for health departments that they could not necessarily create or enter on their own. The living wage coalition in San Francisco or the careful cultivation of a broad community base in Minnesota are examples of how health departments have made it possible to become engaged in issues that might have been otherwise proscribed. The Louisville Center for Health Equity⁹³ and the Boston Center for Health Equity and Social Justice⁹⁴ are examples of health departments that have established organizational bases to work systematically with communities and to help create new

expectations about what a health department's work on health equity should be.

Regional collaborations, such as the 11 local health departments in BARHII⁹⁵ or the five states with health departments participating in the Building Networks for Health Equity Project,⁹⁶ create a forum where health departments can learn from and teach each other, establish precedent for an expanded health equity practice in one jurisdiction where it is politically acceptable, and could eventually become a new standard of practice for more resistant jurisdictions.

6

Some health departments have adopted organizational development strategies that incorporate health equity principles into categorical programs as well as new and creative practice.

Many of the existing programs in health departments have a mission that is consistent with a health equity perspective. Disease control, maternal/child health, public health nursing, and nutrition, for example, all emerged from a concern for the living conditions associated with poverty and poor health. A health equity perspective attempts to encompass those public health programs within a larger framework focused on an explicit link between health and social justice, in which existing programs are part of a division of labor that includes an expanded practice focused more directly on the sources of social inequalities. The transformation of the organizational culture to better understand how a health department can more effectively contribute to achieving social justice is an important foundation for health equity practice.

Some health departments have adopted department-wide strategies to incorporate health equity into the work of all programs, in addition to developing new forms of practice. Alameda County conducted Public Health 101 and leadership development sessions with health department staff. Ingham County (Michigan) uses dialogue-based approaches

with public health staff and community to illuminate how class, racism, and other forms of oppression are the root causes of health inequities.⁹⁷ The Louisville Center for Health Equity⁹⁸ and Boston Center for Health Equity and Social Justice⁹⁹ are dedicated organizational bases that are continuously engaged in staff and community development to better understand the roots of health inequities and the health equity practice they require. The Wisconsin Center for Health Equity, a nonprofit organization with close ties to the Milwaukee health department and local universities, provides training and education on health equity, assessment, policy advocacy, and community organizing.¹⁰⁰ The Harris County (Texas) Department of Public Health and Environmental Services has incorporated health equity into its strategic plan and located lead responsibility for its implementation in the Office of Policy and Planning.¹⁰¹

The Seattle/King County and Minnesota health departments have embraced developing organizational cultures that can more readily engage in health equity practice. BARHII has an internal capacity committee that enables staff from its 11 member health departments to share strategies and jointly engage in organizational development to advance health equity practice. BARHII has also developed a Local Health Department Organizational Self-Assessment for Addressing Health Inequities Toolkit to help health departments engage in a more systematic approach to work on health equity.¹⁰²

Conversely, the failure to make health equity central to the larger organizational culture can also illustrate its importance. The San Francisco Program on Health, Equity, and Sustainability, which had national influence in its health equity practice, was isolated within an environmental health unit and had little interaction with other programs in the health department. Although the former health department director gave the architect of the program autonomy to develop the unit, a new health director was less supportive and he was forced to resign.¹⁰³ The future of the program and its path-breaking work is uncertain. It

underscores the importance of building broad organizational support for work that often entails political risk, not just on the outside but sometimes internally as well.

7

Some health departments, as part of their health equity practice, have developed a public narrative that is not circumscribed by diseases, risk factors, or populations but rather articulates the relationship between health inequities and the underlying social inequalities.

Public narratives are shared understandings or interpretations, grounded in common values and beliefs, of why and how the world operates. For example, a public narrative is not a personal story about a victim of intimate partner violence, but rather the collective assumptions we knowingly and unknowingly make about how and why the violence happened in that situation, to that person. Public narratives are important because they shape public consciousness and thereby influence, often implicitly, decisionmaking.

The process to shift public narratives is emerging as a critical element of transformative public health practice. For example, the Healthy Minnesota Partnership, which brings together community partners and the Minnesota Department of Health, created the Narratives Strategy Team to develop the skills to build public understanding of the importance of assuring that everyone, everywhere has the opportunity to be healthy. The Narratives Strategy Team began work in April 2013 to uncover where the individual-based public narratives dominate discussions of health and start to identify emerging public narratives that would focus attention instead on the conditions that create the opportunity to be healthy: conditions such as safe housing, high school graduation, and a livable wage.

Statewide domestic violence coalitions engaged in primary prevention of intimate partner violence through the CDC-funded Domestic Violence Prevention Enhancements and Leadership Through Alliances, Focusing on Outcomes for Communities United with States (DELTA FOCUS) project are exploring the public narratives that reinforce the notion that violence is not preventable. Members of these coalitions are building capacity to recognize the impact of and shift public narratives in their communities.

Reflections on a Future Health Equity Practice

This entreaty for health departments collectively to define and engage in a public health practice that directly confronts the sources of social inequalities, rather than conceding them as the context in which health department programs carry out their work, reclaims an important legacy in the history of public health. Although many of the issues facing twenty-first century public health in the United States are different from its nineteenth century origins, they continue to emerge in the context of social relationships that both shape people's vulnerability to bio-medical illness and contribute directly to disease and death emanating from a social etiology. Although a century of development in public health has distanced the field from social reform and placed a greater reliance on science as its foundation, persistent health inequities challenge public health to come to terms with that ambiguous legacy in a way that uses science to advance the cause of greater social equality rather than serve as a protective shield from its political controversies.

That reconciliation is still a work in progress. The use of public health data in HIAs, particularly when they are part of a larger strategy and carefully developed set of relationships, can sometimes be an excellent example. Much of what guides contemporary public health practice, however, is still tentative and

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exploratory. The umbrella term *social determinants of health* is an important conceptual shift from a bio-medical understanding of disease, but it can also be a bit cloudy, sometimes inspiring a deeper understanding of social causation and at other times serving as a proxy for a list of seemingly unrelated environmental variables.

Recent developments, however, driven by a more comprehensive approach to health equity practice—for example, the Health Equity Index (Connecticut Association of Directors of Health), Sustainable Communities Index (San Francisco), Alameda County CAPE unit reports, or the many examples examining differences in life expectancy by neighborhoods in the same city or region—have helped expand the terrain of evidence-based public health practice. These tools and reports collectively support an entrée into such areas as economic development, employment, economic inequality, racism, gender inequities, heterosexism, criminal justice, education, housing, foreclosures, gentrification and displacement, environmental quality, land use, transportation, and quality of community life.

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history. Practitioners trying to control infectious diseases had to learn about hydrology and food production. Nutritionists had to understand how agricultural policies get decided. Health educators had to learn about the tobacco industry and its research and marketing practices. Obesity prevention has ventured into the language, culture, and political dynamics of land use and transportation planning. Expanding boundaries for health equity practice is part of that tradition.

It is not a matter, on the other hand, of public health practitioners having to become experts in everything related to social inequalities, but rather having the ability to use public health resources and perspectives

to influence policies and practices that contribute to their production and reproduction. It does not require a huge workforce, only dedicated staff who function as part of a larger health department division of labor and organizational culture committed to health equity. It relies heavily on the expertise and resources of other agencies and organizations, a task made easier when it is formally sanctioned by governing bodies, such as adopting the canopy of Health in All Policies or official policy directives that all public agencies will work toward equity and social justice as exemplified by King County, WA and Minnesota.

Even under the best of circumstances, however, health equity practice requires a keen strategic sensibility. A cofounder of Human Impact Partners, a nonprofit that has been a pioneer in the development of HIAs in the United States, has suggested, for example, that there are different theories about how HIAs can effect change. One is that data alone can help key officials make better decisions. Another is that data and good facilitation can create a consensus among different stakeholders to make decisions that will improve health. A third is that influence in key decisions is more likely to occur when data are combined with the power of organized communities most affected by the proposed changes. Although each has its time and place, work on health equity is more likely to require the third option, because it often confronts existing power relationships.¹⁰⁴ Health equity practice therefore most commonly involves well-developed, long-term relationships with community advocates and social justice organizations based on mutual trust and shared leadership that can foster inside/outside strategies to advance health equity over time.

Developing health equity practice, however, is best seen as a movement-building strategy.

Much of what has been described here is not possible in many jurisdictions. The notion that health departments can be involved in actions to help achieve greater social equality might be beyond permissible boundaries. In some, even use of the term *health equity* could be too controversial. Developing

health equity practice, however, is best seen as a movement-building strategy. It is a long-term process that requires a transformation of organizational culture and practice, and the larger public understanding of what most influences health. It will not occur evenly. Health departments are at various stages of organizational development, consulting with one another, sponsoring forums to view and discuss the documentary series *Unnatural Causes: Is Inequality Making Us Sick?* or making health equity a priority in their professional associations and accreditation processes. Some health departments are in better positions to take risks that establish new ground for health equity practice, although those risks can become important precedents for other health departments to learn from and adapt to their own jurisdictions.

The notion that developing health equity practice needs a movement-building strategy is better served, however, if it is organized in a way that takes full advantage of the collective interest and experience in health departments. It is encouraging to see regional collaborations of health departments forming, such as the Bay Area Regional Health Inequities Initiative, or statewide forums such as the Connecticut Association of Directors of Health work on the Health Equity Index, the New England health equity network, the Wisconsin alliance, or the five-state Building Networks for Health Equity Project. It is also important to have signs of a growing legitimacy, such as the inclusion of achieving health equity as one of four overarching goals in *Healthy People 2020*, the American Public Health Association's promotion of Health in All Policies, the creation of a national center to support HIAs, or the National Association of County and City Health Officials' (NACCHO) support for this publication. Eventually these developments can have greater influence on national processes, such as accreditation of health departments and credentialing the workforce. It would nevertheless greatly aid the further advancement of health equity practice to have a more purposeful movement-building strategy.

There is now an opportunity to propose a more broadly based strategy that can both acknowledge and support the wider range of health department interest in health equity and encourage the pioneering passions of health departments willing to push the boundaries of health equity practice. That strategy could include forming state health equity networks among groups of health departments working with communities, with the active support of NACCHO and other statewide public health organizations. The purpose would include a more systematic gathering of examples of organizational development and health equity practice to inform and embolden health departments, but also to become a force to make achieving health equity a guiding principle for public health more generally.

Just as the larger policy issues related to social inequalities involve community organizing and movement building, developing a public health practice committed to achieving health equity might require a movement of its own. That is the challenge for health departments to be able to reclaim the full legacy of public health and its ability to improve the broader conditions in which people live.

Finally, health equity practice requires a major dose of humility. Even under the best of circumstances, using HIAs under an umbrella of Health in All Policies is still unlikely to make health consequences the defining criteria for major policy decisions, particularly when they also involve issues of equity. Especially during a period that has produced a nearly unprecedented concentration of wealth and income in the United States, it is unlikely that articulating the health implications of such degrees of inequality will define the debates over, for example, tax policies. Issues of that magnitude will, not unlike the formative experiences of public health, require broad social movements, to change the larger contours of political culture. Recent campaigns for increasing the minimum wage in several states and localities around the country

reveal some potential for public health involvement. Perhaps, however, it also underscores the importance of health department work at the state and local levels, taking full advantage of those jurisdictions where such apostasy is tolerated or even encouraged, to chart a course toward greater health equity practice. Maybe, with more organized efforts, health departments can better prepare themselves to contribute to a more general commitment to social and health equity.

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