

Laying the Groundwork for a Movement to Reduce Health Disparities

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Prevention Institute

is a nonprofit, national center dedicated to improving community health and well-being by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on injury and violence prevention, traffic safety, health disparities, nutrition and physical activity, and youth development.

The Time Has Come for Substantial Change

Reducing disparities in health outcomes requires more resources, more energy, and a clear, coherent, intensive approach. At this time we see scattered efforts which, while vital and well-intentioned, are inadequate. Together, we can work strategically to build the necessary political will to insist on reducing disparities. At the same time, we need to ensure that as the indispensable attention and resources coalesce, advocates and others are prepared to seize the opportunity. Until then, we need to assure that those working toward disparities reduction are working in a synergistic, deliberate way to build this will and make the maximum possible difference. This draft report starts to lay out what exists to date and what it would take to create a synergistic, strategic approach.

To what extent is current work synergistic and deliberate? How is political will being built and what are the opportunities to build this will further? Prevention Institute undertook a quick review of current work—an attempt to understand both the “disparities landscape” and what the building blocks are that can be capitalized on in building the movement to reduce disparities.

This work revealed a number of key findings that inform what we can and must do to make a difference. There is a lot of activity that is of great value but, on the other hand, it is not well-linked or coordinated and the focus is often too late in the trajectory of disparities, after the disproportionate onset of illness and injury.

Our major findings clustered into attention and resources, coordination and participation, and strategy. They are summarized here and detailed later in this document. In particular, we found:

Attention and Resources

- The resources allocated and attention paid to health disparities are growing.
- The major emphasis on addressing disparities is on the medical care system and improvements in treatment.
- There are indications of a growing awareness of community conditions for health.

Together, we can work strategically to build the necessary political will to insist on reducing disparities.

- In spite of a few key efforts, attention has not been sufficiently paid to the framing and understanding of the issue.

Coordination and Participation

- There is a lack of coordination and cross-fertilization across sectors, efforts, and disciplines.
- Although there are significant efforts taking place in terms of both research and practice, there is inadequate interaction and cohesion.
- Many sectors do work that impacts disparities, but they don't see themselves as engaged in reducing disparities in health.
- There is a need to coalesce and project a stronger community voice.

Strategy

- Efforts to reform health systems at the state and national level provide opportunities for change.
- There is no coherent plan for developing strategy, political will, and public traction to reduce disparities.

DEVELOPING THE PLAN & THE CENTRAL INTELLIGENCE

In different ways, disparities in health affect everyone—through disproportionate illness and suffering, treatment costs and lost productivity, and not achieving our own standards of fairness and opportunity in the US. It is time that this condition is recognized as the significant issue that it is and that closing the health gap become a national priority. To close the gap in health disparities, we need a large-scale, high impact change effort. Two successful examples of similar efforts are the Manhattan Project, which organized the nation's leading scientists to quickly and secretly produce the first atomic weapons, and the Marshall Plan, in which the US helped reconstruct the allied nations of Europe after the devastation of WWII. While these examples certainly are not similar to disparities reduction in purpose, they are similar in the extent of effort and coordination required and the importance of clarity and specificity in strategy. We call this coordinating approach *central intelligence*.

Key ingredients of the Manhattan Project's success include unlimited resources, high-level attention and prioritization, single focus, universality of threat, and ensuring that the best scientific minds of the time were engaged. It served as an organizing principle about how to bring together different capacities, how to mobilize resources, and how those people and resources could add value. It was, in effect, a resourced central intelligence figuring out how to solve a prioritized problem. The Marshall Plan's success could be credited to significant investment for rebuilding, long-term vision, high-level leadership, and embedding the plan in policy. The reality is that the forces that produce health disparities are so fundamental, disparate, and powerful that a sector-by-sector and highly professionalized approach is destined for marginal

success at best. Disparities are shaped by social determinants (community conditions), and in order to marshal the resources and will to fundamentally alter the patterns, something resembling an expansive social movement will be required. If we are to achieve the same level of impact and success, we need a coherent strategy to get us there: one that is rooted in an understanding of the problem, its current status, and how to make broad-scale change. This paper summarizes those elements to inform strategy and the next steps.

KEY QUESTIONS

In identifying the next steps to redress health disparities, the following questions can serve as a starting point. The findings in this document help to answer these questions and also helped to shape some of them.

- **STRATEGY OR ROADMAP:** If the next President of the United States came to us and asked for the national strategy to reduce health disparities in the US, what would it look like? What would be the key elements? What roles would different sectors play? Are there particular policies that can be addressed as change targets? How would we ensure impact at the community level?
- **POLITICAL WILL:** What current political opportunities could be identified as the springboard for attention and will? What framing, positioning, or language will engage the type of support needed for change? Is there a clear champion(s) who could take this on? Are there specific groups we could engage who could help build political will?
- **REFINED CONCEPTUAL APPROACH:** How can we ensure that a conceptual approach focused on underlying determinants and community solutions and emerging research translate into effective policy and practice?
- **ENGAGED SECTORS WITH DEFINED ROLES:** Who are the key partners and players to engage in building political will? In refining the approach? In implementing the strategy? In leadership and coordination? What should they be doing? How does it build on their current efforts and how is it different?
- **IDENTIFY TOPICAL ISSUE AREAS AND ROLES:** What work on specific health issues (HIV prevention, physical activity and nutrition, asthma prevention) is most relevant and most critical to include? Who are the key players? How does it build on their current efforts and how is it different?
- **LEADERSHIP AND COORDINATION:** How can we ensure cross-fertilization across sectors and disciplines? What will it take to ensure that all disparity reducing efforts are working in concert and not in competition? What type of leadership structure can be mobilized, and who will mobilize and lead this structure?

Disparities are shaped by social determinants (community conditions), and in order to marshal the resources and will to fundamentally alter the patterns, something resembling an expansive social movement will be required.

The Trajectory of Health Disparities

Central intelligence requires a coherent understanding of the health disparities issue and how it can be resolved.

Some of the key information from the previous Prevention Institute document developed for the DRA project is summarized below.

Disparities in health among income, racial, and ethnic groups in the US are significant and, by many measures, expanding. These disparities arise from many factors including access to and quality of healthcare, genetics, and individual behavior. However, the most powerful factors shaping both health and health disparities are social and economic determinants. These determinants are also referred to as the “the community conditions for health” in order to increase resonance beyond public health professionals and researchers and clearly establish the community as the key venue for intervention.* Improving treatment in low-income communities and for people of color is vital for improving health, but treatment-oriented strategies only affect individuals and only once they are ill or injured. In order to significantly alter the patterns of disparities, quality primary prevention must be employed to reduce the incidence of disease and injury in the population. The majority of our attention and resources have been focused on healthcare. To improve health and the distribution of health, we need to give proportionately greater attention to addressing the economic and social determinants of health disparities through a prevention-oriented approach.

Prevention Institute’s *Trajectory of Health Disparities* provides a visual representation of how health disparities are produced. The trajectory that follows depicts three elements that contribute to inequitable health outcomes. First, individuals are born into a society that neither treats people nor distributes opportunity equally (*root factors*). These root factors, such as discrimination,

* The choice of language used in this context is a complex issue. The terminology “social determinants” has been used in extensive dialogue and research and as a result has value and resonance with certain audiences. For the purposes of this paper we consider the terms to be synonymous with an acknowledgement of the need for additional discussion about strategic usage.

PEOPLE AFFECTED BY HEALTH DISPARITIES MORE FREQUENTLY LIVE IN ENVIRONMENTS WITH:

- **Toxic contamination** and greater exposure to viral or microbial agents in the air, water, soil, homes, schools, and parks
- **Inadequate neighborhood access** to health-encouraging environments including affordable, nutritious food, places to play and exercise, effective transportation systems, and accurate, relevant health information
- **Violence** that limits the ability to move safely within a neighborhood, increases psychological stress, and impedes community development
- **Joblessness, poverty, discrimination, institutional racism**, and other stressors
- **Targeted marketing** and excessive outlets for unhealthy products including cigarettes, alcohol, and fast food

poverty, and other forms of oppression, play out at the community level, affecting the overall community environment (*environmental factors*). Environmental factors influence health in two ways: directly and indirectly. Directly, environmental toxins in air, water, soil, and building materials as well as the stressors associated with the manifestation of root factors (living in poverty or impoverished communities, the cumulative effects of racism and discrimination, etc.) affect the body in specific ways that result in greater onset of disease and infection or vulnerability to it. Indirectly, people affected by health disparities more frequently live in environments with toxic contamination and greater exposure to high rates of joblessness, inadequate access to nutritious food and safe places to be active, less effective transportation systems, and targeted marketing of unhealthy products. These kinds of environmental factors in turn shape behaviors (*behavioral factors*), such as eating and activity patterns, tobacco and alcohol use, and violence. The combination of environmental and behavioral factors contributes to an increased number of people getting sick and injured and requiring screening, diagnosis, and treatment (*medical services*). Inequities in access to and quality of medical services for people of color are well-documented and contribute to even greater disparities in health outcomes (though they are not the primary shaper).



The environmental factors present the most powerful levers for improving health outcomes for populations. While broad in many cases (e.g., sending jobs overseas, unfair labor practices, lack of a living wage, redlining, segregation, privatization, underfunded schools), these factors shape the communities in which we live, work, and play. Transforming communities through a focus on environmental factors—and particularly on the institutional practices and policies that shape them—is the key to improving health and reducing disparities. Further, focusing on changing the physical and social environment enables local residents and advocates to affect root factors in their communities. Indeed, change at this level is about unraveling and controlling the extent to which root factors and macro forces such as poverty and oppression play out and shape health. Identifying the factors, policies, and practices that most influence health outcomes in a specific community, characterizing their interaction, and developing activities and approaches capable of addressing them and reshaping institutions, is essential to reducing health disparities.

In 2006, Prevention Institute developed a report for The Disparity Reducing Advances Project (DRA) titled *The Imperative for Reducing Disparities through*

Prevention, which laid out a community health framework for addressing health disparities. That report made the case that a community health approach builds on strengths and assets within communities and advances community elements that have an impact on health and safety. The report laid out ten key strategy areas for reducing disparities:

- 1. PRIMARY PREVENTION:** Primary prevention, with an emphasis on community health, shapes comprehensive solutions to improve community conditions. With its emphasis on a community orientation, multi-disciplinary collaboration, and organizational and policy-level changes, this approach can improve the health among those most affected by poor health and premature death.
- 2. COMMUNITY CONDITIONS FOR HEALTH:** Prevention Institute identified three clusters and 13 community factors that shape health and safety: *People* (social networks and trust; participation and willingness to act for the common good; acceptable behaviors and attitudes), *Place* (what's sold and how it's promoted; look, feel and safety; parks and open space; getting around; housing; air, water and soil; arts and culture), and *Equitable Opportunity* (racial justice; jobs and local ownership; education). Together they point to levers that can be moved to improve health at the community level.
- 3. THE BUILT ENVIRONMENT:** Over the past decade there has been a growing recognition of the critical ways in which physical structures and infrastructure (the built environment) impact the physical and mental health of community residents. Issues of design and what is and isn't permissible land use demand the attention of advocates interested in reducing disparities.
- 4. SUSTAINABLE AGRICULTURE:** The way that food is produced and distributed in the US and the policies that shape production patterns have numerous effects on health. Sustainable agriculture is generally portrayed as a progressive middle-class white issue, but it is much broader than suburban dwellers desiring organic carrots for their children. The problems affect all Americans, but our current agricultural production and distribution system harms low-income populations and people of color, to a greater degree and in additional ways.
- 5. ECONOMIC DEVELOPMENT:** While economic development is rarely recognized as a key strategy to reduce disparities, in fact, well-designed economic development efforts can address multiple community health issues simultaneously. Applying a health lens to economic development is critical to ensuring that these efforts help close the health gap.
- 6. NORMS CHANGE:** Norms are one of the most powerful mechanisms through which environmental factors translate into behaviors that affect health. Typically health practitioners have tried to change behaviors by

providing information on a topic—passing out brochures, holding health fairs, and so forth—but it is increasingly recognized that norms change can catalyze the transformation of knowledge about health into behavior change and can be the tipping factor in improving health.

7. COMMUNITY-BASED PARTICIPATORY EFFORTS: Residents of many communities are often excluded from the very decisions and policy-making that shape the health of their communities. Community-based participation not only unlocks the energy and knowledge that exists in a community around a specific issue, it also builds on community networks and capacity to address other issues.

8. COMPREHENSIVE APPROACHES: It is important to understand that research is still examining which community factors may have greatest influence. However, it is clear that no single strategy, program, or policy is the answer. Multiple changes and a coordinated, multifaceted effort are needed to shift community norms toward healthier behaviors.

9. INTERDISCIPLINARY COLLABORATION: Reducing health disparities and improving health outcomes requires participation from key public and private institutions working in partnership with communities. For example, institutions, including banks, businesses, government, schools, healthcare, and community service groups, have a major influence on community environments.

10. COMMUNITY RESILIENCE: “Community resilience” is the ability of a community to recover from and/or thrive despite the prevalence of risk factors and adversity. A resilient community can be described as having social competence, problem-solving capacity, a sense of identity, and hope for the future. A resilient community provides a triad of protective factors: caring relationships, high expectations, and opportunities for participation.

The previous report provided analysis of why applying a community health perspective is a critical first step toward reducing disparities. This paper begins to lay out how to build on that perspective to engage a broad effort to reduce health disparities.

Assessing the Landscape

Prior to proposing or initiating new projects or directions, it is critical to understand the current state of activity. In order to assess current status and inform recommendations about opportunities and actions, Prevention Institute undertook an environmental scan of the health disparities reduction landscape. In order to gather information we engaged in web research, pulled information from previous projects we’ve completed, attended meetings of groups focused on reducing disparities, and interviewed key individuals.

Based on extensive discussion, the matrix below was developed to visually catalogue and capture the collected information. Essentially we began with the trajectory of health disparities described above and aligned each disparity reducing effort with one of the elements that produce inequitable health outcomes (root factors, environment, behavior, medical services). Within each of

LANDSCAPE MATRIX OF HEALTH DISPARITIES EFFORTS

THE TRAJECTORY →	ROOT FACTORS	ENVIRONMENT	BEHAVIOR	TREATMENT	HEALTH DISPARITIES
Research					
Measurement					
Practice(s): Communities Institutions					
Understanding and Framing					
Policy					

those elements, we identified a set of specific methods that cover the range of activities (research, measurement, practice, understanding, and policy) employed to reduce disparities. Using this rubric we were able to position each effort, initiative, or project into a descriptive cell or cells. The ensuing matrix allowed for analysis of the current landscape based on overall characteristics as well as comparison along both vertices and between cells. The rubric itself represents a novel and comprehensive way of conceiving of the landscape of disparities reducing efforts. Synthesizing the information in the cells and cross-cutting themes, and analyzing what's known and where resources are allocated, we generated a number of findings about the overall landscape.

In addition to reviewing the landscape of reducing health disparities, we also reviewed and synthesized some research on social movements generally and health and social justice movements in particular. Based on this review, we pulled out recurring themes and clustered them to reflect elements of effective movements. These are summarized in “Elements of Successful Social Movements.” “Key Elements and Opportunities,” analyzes these elements in the context of the current landscape of disparities efforts described below.

The Current Landscape of Health Disparities Activities

Based on our review of the landscape of health disparities reducing activities, we were able to assess efforts along the trajectory, and this analysis is summarized in Table 1 (see next page). What is clear from analyzing the overall landscape is that there is increasing attention to health disparities in some circles, and ample evidence both that health disparities exist and why. However, there is not widespread public understanding about the issue, its origins, or its solutions, nor is there political will for change. Among the efforts currently underway, the bulk of activity and resources are directed toward healthcare inequities. The full range of findings is detailed in the next section.

Based on an analysis of the landscape, a number of major findings emerge that provide a context for understanding what it would take to create a synergistic, strategic approach. **Attention and resources** to addressing health disparities have been growing, which provides a foundation on which to build. However, the emphasis is largely on healthcare and this needs to be broadened if we are truly to reduce the number of people disproportionately becoming sick or injured in the first place. We see the need to greatly expand **coordination and participation** in order to ensure that the range of players and voices necessary to effect change are at the table and that their efforts work in synergy. Finally, we need to ensure that there is an overall **strategy** that guides efforts for maximum impact and makes use of existing opportunities.

Attention and Resources

The resources allocated and attention paid to health disparities are growing.

Attention and activity committed to reducing health disparities has been mounting in recent years. This is true at the levels of academic research, government and other institutional structures and reports, and funding from public and private sources. For instance, funding has increased for health disparities research and the creation of numerous academic and government research centers also demonstrate the increased recognition of health disparities as an issue. There are now centers for the study of health disparities at many of the universities with prominent Schools of Public Health including University of

TABLE 2: SYNTHESIS LANDSCAPE OF HEALTH DISPARITY REDUCING EFFORTS

THE TRAJECTORY →	ROOT FACTORS	ENVIRONMENT	BEHAVIOR	MEDICAL SERVICES
Research	There is ample research linking root factors to poor health outcomes, yet the mechanisms, causality, and linkages are not fully developed.	There is a growing body of evidence linking physical and social environment to health and safety (e.g., David Williams’ African-American Health: The role of the social environment). The mechanisms, causality, and linkages are not fully developed, and neither is the translation to practice: what works best, when, and how.	There is clear evidence that links certain behaviors, often termed lifestyle, such as alcohol and tobacco use, sexual behavior, and nutrition and activity levels with health and safety outcomes (e.g., McGinnis and Foege, The Actual Causes of Death).	Disparities in healthcare outcomes are well-documented (see: The Institute of Medicine’s Unequal Treatment) The bulk of research funding is directed at this level (e.g., National Institute of Health funding), including pharmaceutical research and development.
Measurement	There is growing attention to and momentum for using community health status indicators as a tool for measurement and change (e.g., Seattle-King County’s Communities Count).	There is growing attention to and momentum for using indicators as a tool for measurement and change (e.g., Community Health Status Reports, via CDC portal). Health Impact Assessments are gaining traction.	Most data and tracking occurs at these levels in the trajectory and data is available for different racial and ethnic groups. However, measurement issues are complicated in regards to disparities. Issues include: whether hard to reach/historically disenfranchised groups are accounted for, how people and groups are classified, and whether subgroups are left out of measurements because numbers are ‘too small’ (e.g., Native Americans, Southeast Asians, etc.).	
Practice(s): Communities Institutions	There are some emerging models for community practice and examining how root factors play out in institutions (e.g., Bay Area Regional Health Inequities Initiative and National Association of City and County Health Officer’s Tackling Health Inequities Handbook). However, attention to and funding for these efforts is not at all widespread.	There is some funding in this area (e.g., The California Endowment) and increasing interest and activity (e.g., Joint Center’s work). There are emerging frameworks for community action (e.g., Prevention Institute’s THRIVE - Tool for Health and Resilience in Vulnerable Environments). Models for community practice need to be more fully developed and disseminated. Many sectors do work that impacts disparities, but they don’t see themselves as engaged in reducing disparities in health.	Despite evidence that health and community education alone cannot change behavior, it is a major focus of ‘community’ efforts to reduce disparities and is emphasized in many graduate programs. Efforts include attention to cultural competency and language access. Some major initiatives span environmental and behavior change efforts (e.g., REACH and STEPS); though default practice tends to fall more in education/behavior change than environmental change.	There is growing attention and resources here, including language access, cultural competencies, provider training, physician recruitment from underrepresented communities and pipeline efforts, community clinics, and community models such as Promotoras de salud.
Understanding and Framing	There are growing and notable efforts to build more understanding of and support (e.g., California Newsreel’s documentary: Is Inequality making us sick? And the proposed Robert Wood Johnson Foundation Commission on Health Equity). There is no clear consensus about language or what frame would be most effective.	There are some indications of increasing awareness of community conditions of health. The predominant frame remains one of individual responsibility so the community environment and historical/institutional practices that have contributed to disparities are easily dismissed.	Since the predominant frame is individual responsibility, behavior is seen as individual choice and therefore by the general public as the ‘root’ or cause of disparities.	The Institute of Medicine’s report on Unequal Treatment unequivocally made the case for disparities in treatment. Yet, this reality is not necessarily known in the general public.
Policy	At this level, most health-related policy attention is focused on socioeconomic status (e.g., Earned Income Tax Credit). There have been policy attempts to ‘right’ injustices that are at the root of disparities (e.g., Affirmative Action).	There are many efforts to reform environments through policy (e.g., Healthy Places legislation proposed by Barack Obama). Typically the policy is typically focused (e.g., nutrition/activity-related) and/or without an eye to reducing disparities (e.g., land use and planning).	Policy directed at individual behavior change is controversial and typically successful when the threat is not to the individual but to others. Efforts at this level are not particularly directed at reducing disparities.	Healthcare reform efforts are prominent in many states and at the national level; for the most part, they do not explicitly address or acknowledge the need to reduce disparities.

California Berkeley, University of Michigan, Harvard, University of California San Francisco, and Emory University. Another example of increasing attention is the passing of the Minority Health and Health Disparities Research and Education Act of 2000.

The major emphasis on addressing disparities is on the medical care system and improvements in treatment.

The perception of health as healthcare limits the reach of health disparities work and gears projects toward addressing disparities in the distribution of a given disease outcome rather than preventing disparities through a focus on communities. Relative to medical research and access to and quality of treatment, less attention has been paid to preventing health disparities by changing community conditions. Sectors traditionally concerned with health, such as academic research, medical care, and several major foundations have already adopted health disparities as an area of focus, but within this focus the bulk of resources center on health education efforts and medical care. By and large, health disparities work continues to be defined within the traditional parameters of the healthcare system.

As a first step in implementing the Minority Health and Health Disparities Research and Education Act of 2000, the National Institute of Health developed the Strategic Research Plan and Budget to Reduce and Ultimately Eliminate Health Disparities. While critical to reducing disparities, the work currently outlined in the Strategic Plan and Budget focuses on treatment research, inclusion of minorities in clinical trials, and recruiting physicians from underrepresented populations and populations experiencing the most disparate health outcomes. Another example of a national commitment to eliminate health disparities is the President's Initiative on Race and the Department of Health and Human Services campaign for "100% access to healthcare and 0% health disparities." Again, the missing component is a national commitment of resources to policies and practices addressing income inequality, discrimination, and community factors, not just treatment research and insurance coverage.

There are some indications of awareness of community conditions for health.

In 2006, the National Association of County and City Health Officials (NACCHO) published *Tackling Health Inequities through Public Health Practice: A Handbook for Action*, which presented multifaceted approaches and techniques for public health officials to use in addressing the community conditions for health. In 2008, PBS will air California Newsreel's series *Unnatural Causes: Is Inequality Making Us Sick?* which investigates the sources of disparities in community environments. The fact that this series was made is an indication of growing awareness, and its airing will contribute to broader discussion of the ways that disparities are produced by factors outside of the healthcare system. Organizations such as Prevention Institute and PolicyLink have been developing frameworks for community approaches to health and health disparities.

The perception of health as healthcare limits the reach of health disparities work and gears projects toward addressing disparities in the distribution of a given disease outcome rather than preventing disparities through a focus on communities.

This body of work was recently recognized at a Roundtable on Health Disparities sponsored by Kaiser Permanente and The California Endowment. CDC REACH (Racial and Ethnic Approaches to Community Health) and the STEPS to a Healthier US provide promising examples of nationally coordinated and funded programs that help support local communities in implementing prevention-oriented solutions and include as part of their goals to build community capacity and sustain change. Collectively, examples such as these indicate that there is momentum building in this direction and the foundation for future efforts is being laid. As awareness increases, we need to develop, tailor, and disseminate models and approaches to alter community conditions in support of health outcomes.

In spite of a few key efforts, attention has not been paid to the “framing and understanding” of the issues.

Health disparities are too often considered an us/them problem. Presentation and discussion are focused in terms of statistics related to particular groups or communities. While this is important, it is also important to recognize that it is the same causes that are eroding everyone’s health; they are just more persistent and frequent in low-income communities and communities of color. Disparities in health also have a broad effect in terms of overall productivity, civic engagement, and equality and fairness. There is very little activity and few resources directed toward framing and messaging disparities for a broad audience. Organizations such as the Opportunity Agenda have begun to do some of this work. The PBS documentary series *Unnatural Causes* presents an important opportunity to build public awareness and outrage about alarming socioeconomic and racial disparities in health and the breadth of impact. There is still no consensus or a clear strategy about what framing and language might be most effective in helping to build widespread support, understanding of the issues, and changing policy.

It is also important to recognize that it is the same causes that are eroding everyone’s health; they are just more persistent and frequent in low-income communities and communities of color.

Coordination and Participation

There is a lack of coordination and cross-fertilization across sectors, efforts, and disciplines.

While media attention and the growing number of academic and public health centers illustrate the rising momentum to address health disparities, an analysis of efforts across disciplines revealed lack of coordination between sectors, lack of coherent leadership nationally, and the underdevelopment of primary prevention strategies addressing the community conditions for health.

There have been efforts to discuss strategy and identify opportunities to address health disparities on various fronts. The Minority Health and Health Disparities Research and Education Act of 2000 represented a beginning step and precedent in laying out the resources to address health disparities. There have also been efforts to define a disparities agenda with a particular focus on policy solutions (such as the Commonwealth Fund’s State Policy Agenda to

Eliminate Racial and Ethnic Health Disparities). In September 2006, Kaiser Permanente Community Benefits and The California Endowment sponsored a roundtable titled Reducing Disparities: Goals, Roles, and Opportunities. Another effort at creating an agenda on health disparities is the proposed Robert Wood Johnson Foundation (RWJF) Health Equity Commission, which would be geared toward developing policy solutions to factors underlying health disparities, notably income inequality. What is missing from these efforts is recognition of the necessity to build a long-term effort by cementing political will, developing a coordinated strategy, assembling cogent leadership, and establishing a conceptual approach focused on community resilience factors.

Although there are significant efforts taking place in terms of both research and practice, there is inadequate interaction and cohesion.

There is significant and copious research being conducted at academic institutions about health disparities. Much of this research is focused on disparities in medical care or understanding how root factors such as income inequality shape disparities. There are also currently a number of well-funded initiatives taking action to reduce disparities such as CDC REACH and the STEPS to a Healthier US. What is missing is a clear dialogue between research and practice aimed at illuminating the role of community conditions in shaping disparities and identifying the key elements necessary for effective reduction. Movements such as sustainable agriculture are impacting disparities reduction but are poorly connected with researchers and others who could amplify their successes with regard to health disparities.

Even within institutions it can be complicated to figure out how multiple entities are interacting, responding to different funding streams, and how they are concretizing similar goals in disparate activities. For example, UCLA houses both the Center to Eliminate Health Disparities and the Center for Research, Education, Training, and Strategic Communication on Minority Health Disparities.

Many sectors do work that impacts disparities, but they don't see themselves as engaged in reducing disparities in health.

Sectors such as transportation, housing, and community design do work that has huge influence on the health of communities and are potentially significant partners but are not sufficiently acknowledged as resources for disparities reduction. An emerging opportunity for health disparities work can be found amongst sectors and movements that have not previously or don't at present consider themselves to be promoting health or reducing disparities. For example, the Smart Growth movement, while historically the domain of more affluent communities with the resources to intentionally design walkable neighborhoods, has increasingly focused on the need for healthy community design in low-income communities and communities of color. Other sectors conducting relevant work that could benefit from the application of a health

disparities lens and that could contribute to a coordinated approach to disparities include: economic development, youth development and education, community organizing, and sustainable agriculture.

There is a need to coalesce and project a stronger community voice.

One difficulty in advancing comprehensive and coordinated approaches to health disparities on the national level is that policy is data driven and the easiest data to collect is data on mortality, the distribution of disease outcomes, and medical and treatment data. Involving community members in the process of project definition can result in a very different set of data. For instance, in Seattle-King County the *Communities Count* report engaged residents in a broad process of input through community forums and phone surveys that led to the development of “valued conditions.” These valued conditions in turn defined research priorities, created a portrait of the county that reflected the issues most important to its residents and ultimately resulted in changing policy and organizational practice. Such reports serve to expand the definition of health beyond outcomes and also provide data and evidence (research) of the effectiveness of interventions (practice) over time. Projects such as REACH also have community involvement elements. However, looking at the entire landscape, disparities reducing efforts are overwhelmingly top-down. Though resources may need to come from the top, leadership and wisdom can percolate from the bottom.

Strategy

Efforts to reform health systems at the state and national level provide opportunities.

While at present state-level changes to the health system have focused on access to treatment and insurance coverage or expanded health education efforts, the depth and sustainability of these reforms depend on their including community-oriented prevention strategies that reduce the burden on the system and look explicitly at addressing disparities. Genuine health system reform would move beyond healthcare to encompass community conditions in the neighborhood, school, workplace, and healthcare setting. In California there has already been attention to this community health approach: the Governor’s “Vision for a Healthy California” included the California Obesity Prevention Plan outlining ten steps to improve nutrition and physical activity by addressing conditions in community environments such as schools, workplaces, and neighborhoods. Reform efforts in other states such as Massachusetts suggest the promising opportunity to address health and health disparities, and perhaps to expand the conversation from healthcare to a broader conception of community health and wellbeing.

Looking at the entire landscape, disparities reducing efforts are overwhelmingly top-down. Though resources may need to come from the top, leadership and wisdom can percolate from the “bottom.”

There is no coherent plan for developing strategy, political will, and public traction to reduce disparities.

Health disparities are deeply rooted, complex, and pervasive. In order to make substantive changes a high-impact coordinated effort is required. Looking at the landscape of current activity, it is clear that such an effort is not currently underway. Resources and momentum are building, but efforts are overlapping, important areas are not being addressed, and fundamentally disparities are not a high national priority. A few of the activities identified cross over into multiple cells in the matrix, but what is missing are efforts that encompass and strive to understand and coordinate the majority of cells.

Elements of Successful Social Movements

Given that health disparities are rooted in such factors as racism and socioeconomic factors, it is hard to imagine that the issue alone could achieve the same kind of singular focus and broad support it needs, such as that enjoyed by the Manhattan Project and the Marshall Plan, unless it grows out of popular demand. In order to address health disparities in this country, then, we need a social movement that can mobilize a broad base of people to demand the necessary attention, resources, leadership, and policy that will make a difference.

Understanding the key elements of effective movements will help inform our strategy and next steps. Common elements of successful movements include clearly articulated goals, a universal framing of the issues (e.g., this affects us all), mobilization of resources and people (leadership, grassroots activism/community voice, elite support), and political opportunity (e.g., a faltering healthcare system and healthcare reform debates, the aftermath of Hurricane Katrina, the 2008 presidential campaign). These elements are explained in more detail in the following paragraphs.

Established Goals

In order to be effective, movements must have clearly articulated goals. Movement goals are usually framed within the context of change targets or targeted opponents. Movements with change targets that are easily identified and vilified will have a higher likelihood of achieving their goals. In the case of alcohol and tobacco regulation, for example, the alcohol and tobacco industries were easily vilified change targets. The change targets of health-related movements are often policies and are often framed to reform or dismantle what's already in place. Typically, reform goals are more successful because they are perceived as less threatening to established powers than are displacement goals. Goals must present a clear vision of what changes would be significant, balanced with what is achievable, and should use strategic research to expose the problems and highlight available solutions.¹

Effective Framing

Framing refers to how a movement presents its goals to movement members and to the general public. Goals of a health-related movement must be framed

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within the context of risk and danger in order to mobilize people. Risk and danger must be presented as a threat to the public's wellbeing and must be backed by socially and scientifically credible evidence that establishes a causal link between the danger and the public's health. In order to be accepted as a credible threat, risk must be framed as universal (affecting us all) as opposed to particular (affecting only a specific population), attributable to the external environment as opposed to arising from the individual, and incurred by innocent victims who are involuntarily at risk and are deserving of governmental protection and control as opposed to culpable victims who voluntarily place themselves at risk. Elements of framing that are common to successful health-related movements are the articulation of clear policy goals, the ability to translate public health language and approaches into easily understood terms, the capacity to create and translate research-based practical knowledge for use by diverse groups of advocates and supporters, and the capacity to recommend policy options that can take advantage of political opportunities.²

Strong Leadership

Historically, identifiable leaders who can unite, motivate, and direct the actions of grassroots efforts have a greater chance of success than a diffused leadership structure. Although individual leaders are better able to provide a single voice to a movement's efforts, distributed leadership has the advantage of providing continuity to a movement's efforts in diverse localities and prepares movements to disseminate their power throughout society. Furthermore, change efforts backed by single leaders can wane in the event of the leader's departure or death.³ A large-scale change effort to redress health disparities will require a combination of leadership structures. A single, identifiable leader endorsed by the public and backed by a diverse leadership body will have a greater chance of achieving movement goals than will a diverse leadership body without a lead spokesperson or advocate. Similarly, a lead spokesperson without the support of a diverse leadership body will be less successful at maintaining movement momentum across diverse communities. In order to represent a unified voice that articulates a unified sense of purpose and direction, this leadership structure must be able to incorporate the beliefs, goals, and concerns of disparate members into the group's message, and effectively involve the group's members in decisions and activities.

Community Voice

Several aspects of community membership influence the effectiveness of a movement's ability to achieve its goals. Primary among these are public support and organized grassroots activism capable of engaging in local action. Lack of grassroots activism can actually derail a movement as failure to engage a grassroots base lends to the impression that movement goals are created by and for lobbyists' interests as opposed to having emerged by the populace and for the public's wellbeing.⁴ To this end, members must feel that they are in

A large-scale change effort to redress health disparities will require a combination of leadership structures.

control, that their goals are attainable, and that their efforts are worthwhile.⁵ Indeed, effective movements must be able to mobilize a diverse organizational constituency that consists of “preexisting formal and informal social networks through which individuals with common grievances are brought together.”⁶ Once coalesced, movement membership must be able to draw heavily on self-defined victims with the personal and social resources to engage in movement activity (e.g., white, middle-class, college-educated activists), as well as affected individuals who can advocate on their own behalf, such as breast cancer and AIDS survivors.⁷

Influential Support

Influential allies, especially in federal government, are invaluable in their ability to legitimize a movement’s goals by supporting legislation and keeping issues on the public’s radar. State and federal agencies that operate independently of Congress or commercial interests can create actions at the state and local levels that circumvent the considerable political influence of big business when necessary.⁸

Political Opportunity

Political opportunities to advance the movement’s goals (e.g., highly publicized smoking-related diseases or acts of gun-related violence, or loss of support from critical allies) and the ability to take swift and aggressive advantage of such opportunities facilitates a social movement’s success. The intersection of political opportunities with targeting opponents’ weaknesses or vulnerabilities can also increase a social movement’s success. Movement success is often connected to being active during a national crisis. The ability to mobilize resources and the actions of supporters and opponents are important only in terms of groups being able to be active during times of national crises.⁹

Mobilized Resources

Resources such as tangible assets (e.g., funds, space, access to mailing lists, etc.), as well as intangible assets (including organizational experience, scientific expertise, and social and political contacts) prove important primarily in terms of enabling a group to be ready to move forward in order to capitalize on political opportunity.

To have the broadest possible impact, movements must be able to clearly articulate what needs to change (goals) and how such changes can be achieved (strategy), which has clear implications for policy recommendations. These recommendations need to be vetted by a leadership structure capable of representing the movement’s goals and engaging a constituency and mobilizing resources to take advantage of political opportunities.

CONCLUSION

Key Elements and Opportunities

Taking the health disparities landscape as the context and an understanding of effective social movements, we can identify key elements *overall* for the type of high-impact, broad-scale effort necessary to substantively change the health disparities reality. In particular, we need political will, a refined conceptual approach, a strategy or roadmap, engaged sectors with defined roles, and leadership and coordination.

POLITICAL WILL

Inadequate resources and time have been put into thinking about how to communicate about health disparities in a way that engages a broad audience. There are particular messages and stories that need to be told in order to make it clear that health disparities is an “us” issue and not a “them” issue. Those messages need to be delivered consistently and through multiple means. The broader the audience that is engaged and motivated to support change, the more political opportunities such as the upcoming presidential election, dissatisfaction with the healthcare system, and revealing events such as Hurricane Katrina can be leveraged in support of structural changes necessary for disparities reduction.

REFINED CONCEPTUAL APPROACH

The conceptual approach laid out in *The Imperative for Reducing Disparities through Prevention* is a useful guide and can be refined further and applied more broadly to identify additional levers. The dissemination of that paper itself was and will continue to be a critical step in coalescing conversation and thinking about a community-level approach to reducing disparities. The key strategies identified in that paper, such as Economic Development and Sustainable Agriculture, need to be engaged, and a further analysis of the community factors and key health issues will lead to identification of additional strategies and sectors that need to be involved. A continued refinement of the conceptual approach will also help answer questions such as what the research agenda and policy platform for a high-impact disparities reducing effort should look like.

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STRATEGY/ROADMAP

In order to move public opinion, attract resources, and take advantage of opportunities, an informed strategy must be established and modified depending on changing conditions. The strategy will need to include many of the elements described here such as principles and policy platforms (and the use of such documents), communications, responses to political opportunities, and the convening of leadership groups and broader constituencies. It will also be necessary to consider key opportunities, needs, questions, and agencies and individuals who need to be engaged.

ENGAGED SECTORS AND DEFINED ROLES

Reducing health disparities requires a broad group of sectors owning the problem and working together for its solution. While multiple sectors and partners are needed, a few specific ones are noted here because of the substantial—though in some cases overlooked—role they can play as part of the solution.

Researchers

Research is needed that places a more intentional focus on the community conditions for health, the links to health outcomes, and what it takes to make effective change. Research in this area can help us understand what the most effective strategies are, how to translate approaches into community practice, what interventions will have the largest and most sustainable impact, and how interventions should be tailored to the specific needs of specific communities.

Funders

Funders can advance a high-impact, strategic effort to reduce health disparities by supporting organizations and individuals in other sectors who are engaged in activities to support the ultimate goals, by supporting the strategy development and coordinating efforts necessary for a sustained effort, and by visibly setting ambitious goals for disparity reduction through developing leadership, long-term strategy, and grassroots mobilization.

Government

Government has multiple roles to play, including participating in the strategy development, allocating resources to support activities, developing policies that support improving community conditions that shape disparities, and setting an ambitious agenda. If multiple government sectors (e.g., transportation, environmental protection, public health, economic development) assessed their own mandates through a lens of reducing disparities, they could make a significant contribution, particularly through coordinated efforts with others. Government leaders have a particularly important bully-pulpit and leadership

...as prominent facilities within communities, [businesses] help establish norms for their employees and the general public.

role to play in building support, making disparities a priority, allocating resources, and enacting policy change.

Business

The business sector has a deeply influential role in addressing disparities. The decisions made—such as where to locate supermarkets or alcohol outlets, what products to develop and how to market them, or what efforts to take to reduce hazardous emissions—influence health behaviors and health outcomes. As employers, investors, and purchasers, each has impact on the local economy. As providers of services, they influence what is and is not available to community residents. Finally, as prominent facilities within communities, many help establish norms for their employees and the general public. By providing activity breaks, creating welcoming stairwells, offering health insurance, or ensuring healthy affordable food options, businesses can create an atmosphere that supports healthy behavior. Finally, the business sector is well known for its influence on the political process through campaign donations and lobbying. There are models and examples of businesses contributing to solving social problems and also business development models in low-income communities which at first are dismissed and later found to be win-win in terms of community development and profitability.

Media

Media have a vital role to play in raising awareness of the importance of community conditions in determining health outcomes (avoiding resorting to stories of individual triumph over difficult circumstances), reporting of advances and successes in developing leadership and mobilization, and in general framing the issue broadly as a moral imperative as well as vital to collective health and well-being. The media can also play a powerful role through more equitable representation and reducing negative images and targeted marketing of unhealthy products in communities of color.

Coalitions

Coalitions have a long history of effecting meaningful change, including grassroots coalitions, governmental coalitions, and hybrids. Coalitions are often the most effective vehicle through which community voices are projected, particularly in historically disenfranchised communities, and they represent a vital opportunity to engage an authentic community voice. Further, there are a number of coalitions working on important issues that influence disparities (e.g., environmental justice), and we can coalesce the broad power of multiple coalitions in demanding action and changing policies and organizational practices.

LEADERSHIP/COORDINATION

Based on the breadth and number of activities we reviewed for this paper, it's apparent that substantial thought and effort is already being applied to understanding and addressing health disparities. However, it is also clear that those efforts are largely based on singular research initiatives or funding streams. The result is a disjointed whole and little coordination or exchange. In particular, there is a lack of interplay between research and practice and between those who focus on disparities in access and treatment and efforts at other points along the trajectory. Health disparities are produced by a complex interplay of factors (such as economic opportunity, cultural norms, access to safe streets) and the ameliorative efforts need to mirror that complexity.

Within different sectors there are centers of activity focused on disparities, and in some cases there is leadership or centrality within a sector (such as National Association of City and County Health Officers for public health and practice). What is lacking is an overarching leadership structure and hub for communication that draws expertise from different sectors and leaders and can coordinate activities, generate communications, and provide a passionate and consistent voice to push the agenda of reducing disparities forward. Similarly, resources exist within pockets, driving particular efforts, but what is missing are resources for coordination and building leadership.

We Must Take Strategic Action

The findings and analysis above provide some strong clues about what is necessary to engage a long-term, high-impact effort to substantially reduce health disparities. We can look at the findings about the current disparities landscape and extract lessons about enhanced coordination and translation and then consider aspects of successful change efforts such as developing a “central intelligence” and a broad mobilization.

We propose that the logical next step is to hold a small, intensive, national design meeting to begin to answer key questions about what is needed (strategy and political will) and how we can get there (movement building), such as: *What resources are necessary? What messages need to be crafted? What sort of leadership structures need to be put in place? And What the timeline for actions should be?* This design meeting would be structured to substantively involve participants in critically thinking about the current status of action and working together to outline specific elements of a theory of change. It would involve a carefully selected set of individuals from diverse sectors and would begin the process of laying out the specific actions as well as setting the broad agenda for a sustained, coordinated disparities reduction movement.

ENDNOTES

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- 3 Leadership in Social Movements. Retrieved March 9, 2007 from www.wam.umd.edu/~jklumpp/comm461/socmov.html
- 4 Hoffman, B. (2003). Health care reform and social movements in the United States. *American Journal of Public Health*, 93(1), 75-85.
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