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HEALTH INEQUITY:
A CHARGE FOR PUBLIC HEALTH

NACCHO
National Association of County & City Health Officials
The National Connection for Local Public Health

Introduction

Welcome to the 2016 NACCHO Annual Conference, Cultivating a Culture of Health Equity.

This meeting represents the third time that health equity has been featured as the theme for NACCHO's annual conference. The first, in 2001, with the theme of Confronting Disparities: Addressing the Social Determinants of Health, was one of the most diverse annual conferences held to date. The second, in 2007, convened simultaneously with the release of the PBS-distributed documentary series *Unnatural Causes: Is Inequality Making Us Sick?*[1] Since then, new challenges have arisen, with the continuing marked increase in social and economic inequality and its effects on health inequity.

As a preamble to this year's conference, this essay provides attendees with a summary of concepts, principles, root causes, and realities of health inequity, along with suggestions to spur dialogue and inspire reflection. Noting the dilemmas, tensions, and struggles that local health departments (LHD) face, we offer some guidance on prerequisite conditions for a coordinated response in confronting the root causes of health inequity.

According to the introduction from the World Health Organization's (WHO) Commission on Social Determinants of Health Final Report in 2008, "Social justice is a matter of life and death."[2] WHO's main recommendation states, "tackle the inequitable distribution of power, money, and resources," but it does not state how. NACCHO hopes that participants will engage in provocative exchanges, share insights, and build solidarity with like-minded colleagues exploring how to implement that recommendation. This essay and NACCHO's health equity program seek to prepare LHDs for the task of having an impact and supporting the preconditions for health equity in their communities.

"Social justice is a matter of life and death."

LHDs often find themselves under conflicting pressures. They face uncertainties as funding is often dependent on shifting political interests, priorities, and influences. Further constrictions result from statutory mandates and institutional rules that hamper change. Public health threats and needs change for some groups more than others. Likewise, LHDs vary tremendously in size of staff and jurisdiction served, resources, scope of sources, authority and the capacity of its workforce. Given these variations and pressures, many LHDs remain uncertain about not only their role, but what to do about health inequity, which requires expanding their boundaries regarding legitimate practice. Of particular

concern is sometimes the lack of distinction between the concept of "health disparities" and "health inequities." Health disparities are simply differences in health outcomes with no political implications. Health inequities, by definition, involve issues of social injustice.

The result of these pressures and interpretations has been an almost exclusive emphasis on treating the outcomes of inequity rather than tackling these outcomes directly at their source, which takes time. Most LHDs, for example, are familiar with remediating the consequences of health inequity through programs and services, which is an absolute necessity, and a fundamental part of public health practice. They are often less comfortable, for many reasons, with probing the underlying injustice generating health inequity in the first place. Our central point is twofold: first, any approach that avoids the question of injustice, substituting the notion of unfortunate or tragic circumstance, will find difficulty in getting to the roots, beyond remediation. Second, expanding the legitimate boundaries of public health practice for health equity is both necessary and feasible, if it is to become institutionalized.[3]

Health Inequity and its Consequences

The United States not only has the worst health in the industrialized world, but also one of the highest levels of health inequity.[4-6] What is health inequity? Paraphrasing Professor Margaret Whitehead, University of Liverpool, health inequity refers to differences in population health status and mortality rates that are systemic, patterned, unjust, and actionable.[7] Health inequities, most importantly, are not the result of unfortunate, random events or differences caused by individual behavior or genetics.

Health inequity—an unacceptable and growing stain on American society—limits many groups' ability to achieve their full human capabilities and access to material resources and experiences that would provide good health and well-being to achieve that potential.[8-10] Its manifestations range from premature death, poor health, and limited life chances to permanent life stress, stunted lives, degradation of culture, loss of cultural identity, and greater insecurity.[11,4,6,8] Equally important, health inequity limits democracy by restricting access to decision-making processes that affect life conditions.[12-13] The loss of well-being at a systematic level reduces us as human beings, and diminishes our dignity, sense of self, and ability to participate in the world. Health inequity is not inevitable, random, or accidental but is actively produced. Therefore, its eradication depends on a commitment to broad social and policy change.[14]

Three Definitions of Health Equity

There are numerous definitions of health equity. British philosopher and economist Dr. Amartya Sen suggests that health equity is realized when all people have the opportunity to achieve their full capabilities and potential for health and well-being. The WHO says that "[Health equity is] the absence of systematic and potentially remediable differences in one or more aspects of health across populations or population groups defined socially, economically, demographically, or geographically." Dr. Camara Jones, Morehouse College, states that "Health equity is assurance of the conditions for optimal health for all people. Achieving health equity requires valuing all individuals and populations equally, recognizing and rectifying historical injustices, and providing resources according to need."

Realities of Health Inequities and Their Causes

Inequitable health outcomes, arising from social injustices, occur over long periods to create catastrophic historical legacies that cannot be effectively approached from conventional professional expectations or current definitions of the field.[3] Instead, they require an investigation of the social processes and structures that repeatedly generate health inequities. The nature of the injustice extends beyond the material to wider oppressions: social exclusion, subordination, hierarchies, and exploitation, manifested in structural racism, class oppression, gender inequity, and homophobia.[15] These oppressions are products of inequalities of power.[16]

The Urgency of Confronting Root Causes of Health Inequity

Inequities in the distribution of illness, disease and death are increasing in tandem with and produced by rising social and economic inequality.[11,17-18] The most equitable societies in the world with the least amount of social and economic inequality have the best health status.[19] They also place more resources into the foundations for health by setting the prerequisite conditions.[5] By many measures the United States—despite its great wealth—is one of the most inequitable countries in the world and continues to experience a staggering, growing degree of social and economic inequality not seen since the Great Depression and, possibly, the Industrial Revolution.[20] The top one percent owns more wealth than the bottom 90 percent combined. In the past 30 years, there has been a massive redistribution of wealth and power in the United States, with enormous consequences for both health and democracy.[16,17,20,21]

While the United States has had great gains over the last 110 years in life expectancy and reductions in mortality rates, the gains have not been distributed equally; we are 43rd in life expectancy.[22] A British study found one in three deaths related to the level of income inequality.[23]

Rates of disease and illness for people forced to live in poverty are worsening across almost all categories and geographic areas in the United States.[5,24] Despite slight gains, African Americans still have 2.5 times or more the infant mortality rate of whites in many jurisdictions.[25-27] Life expectancy shows a 3.4-year difference.26 Immigrants tend to experience worsening health the longer they live in the United States.[28-29] Native Americans, dispossessed of their land and culture, have some of the worst mortality outcomes in the country.[5] A total of 21 percent of our children live in poverty.[30-31]

The restructuring of the volatile global economy with high unemployment; continuing wage depression; reductions in the standard of living; ongoing budget cuts; and lack of

Root Causes

Root causes, such as structural racism, class oppression, and gender inequity refer to the political and economic determinations of health inequity. They interact with other core systems of social exclusion, marginalization, and exploitation in society. Root causes function through processes and mechanisms associated with political power imbalances within decision-making networks that generate and reproduce social and economic inequities.

public investments in infrastructure leads to negative life conditions. Such developments constrict the capacities of peoples' biology.[32-33] These disorganizing effects disrupt stable social life more severely for those populations already oppressed, leading to ongoing social injustice that sustains inequitable outcomes in illness and disease. Moreover, our social immune system—the supportive infrastructure of schools, public transportation, housing, water supplies, social welfare, and environmental standards—has been dismantled along with the purposeful destruction of the public sector.[34] Because health inequity is inseparable from *structures of inequality* that determine life chances, public health must attend to causes if we are to end it.

Why Root Causes?

These realities and the injustice of health inequity suggest that the root causes of health inequity derive from fundamental social disadvantage (e.g., the ability or lack of ability to influence investment and social policy), based on imbalances in political power or privilege. Eliminating the inequity requires changing the conditions, structures, and systems of privilege that produce inequity, rather than merely treating its consequences, through programs or social services.

In discussing causality—the drivers of health inequity—analysts often focus on social determinants of health, such as housing, education, and transportation. But it is inequitable social relations and power arrangements (the social determinants of health inequity) that create the unequal life conditions over which people have little or no control. Poor quality of housing and a degraded living environment may lead to negative health outcomes; however, systems of regularly produced patterns of interconnected

Epidemiologist Nancy Krieger, in her book *Epidemiology and the Peoples' Health*, identifies two distinctive frameworks for eliminating health inequity. They express the importance of how conceptual frameworks can influence research and strategies. She distinguishes between approaches that mitigate the consequences of health inequity versus acting on root causes.

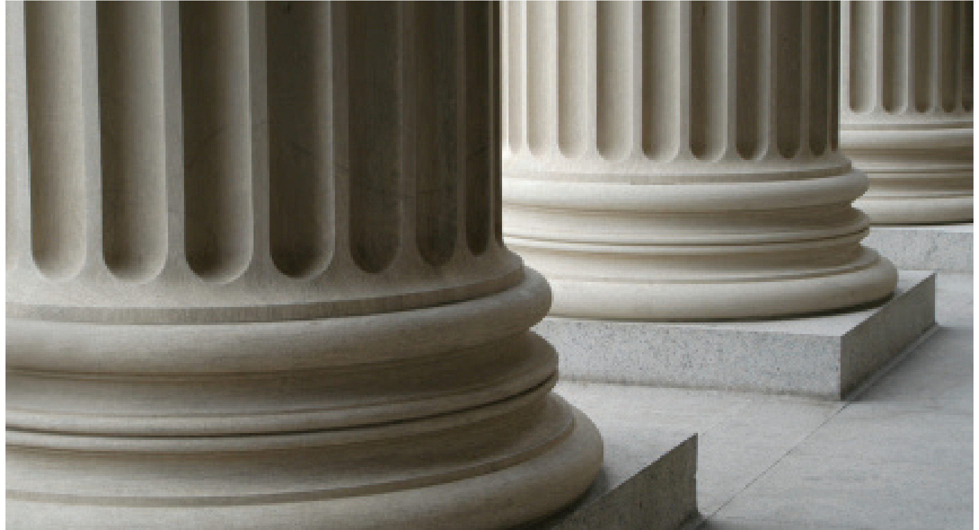
1. . . .*social determinants of health* [arise] from a 'social environment,' structured by government policies and status hierarchies, with social inequalities in health resulting from diverse groups being differentially exposed to factors that influence health—hence social determinants act as the *causes of causes*. (WHO CSDH)

   versus

2. . . . *societal determinants of health* [are seen as] political-economic systems, whereby health inequities result from the promotion of the political and economic interests of those with power and privilege (within and across countries) against the rest, and whose wealth and better health is gained at the expense of those whom they subject to adverse living and working conditions; *societal determinants* thus become *the causes of causes of causes*. (Anne-Emanuelle Birn)

-Krieger, N. (2009). *Epidemiology and the People's Health*. New York: Oxford University Press.

institutional decisions, rules, and processes over time, and without public accountability, are the true generators of inequitable health outcomes. As sociologist Hilary Graham says, "[T]he social factors promoting and undermining the health of individuals and populations should not be confused with the social processes underlying their unequal distribution."[35]



Structural Racism and Class

Two direct causes of health inequity are racism and class oppression. Racism is not simply another factor in a long list of determinants. Strongly shaped by class and gender inequity, structural racism is a fundamental cause of health inequity, associated with imbalances in political power throughout society.[36-38] It functions to normalize and legitimize cultural, institutional, and personal hierarchies and inequity that routinely advantage whites while producing cumulative and chronic adverse health outcomes for people of color.[36-38]

A vast literature documents basic facts about inequitable health outcomes and structural racism.[39-40] Racism itself, exclusive of its connection to material conditions, is a cause of health inequity.[41] It is manifested through systematic social exclusion, marginalization, and powerlessness. It inhibits access to quality education, sound housing, gainful employment, power, resources, and voice. Structural racism perpetuates residential segregation, concentrated poverty, disinvestment in neighborhoods, and targeting neighborhoods for toxic waste—all issues related to serious health outcomes.[42-44]

Class is about relationships among networked, organized, and powerful social groups directing society's major institutions, resources, and investments.[45-47] These networked interests (e.g., banking, insurance, oil, agriculture, telecommunications, and real estate) make decisions, typically without meaningful public participation, accountability, or transparency. Besides influencing public policy, they set the rules for the exercise of power. Recognizing how class power works in tandem with structural racism helps to explain the continuing reproduction of health inequities over generations, even when eliminating immediate risk factors.

The standard conception of class in its limited form as primarily an individual attribute or demographic characteristic such as income level or social status only takes us so far in designing strategies for the elimination of health inequity.[47] Although valuable for predicting health outcomes, social status cannot explain why inequality gets worse or

inform action to stop ongoing negative health outcomes. What produces the variations in class status and wealth and how? Why are class differences unjust? Class, examined as a relation of organized political power, helps us to recognize the connection to social divisions and then strategize *differently* about what to do. For example, it directs attention to institutions and social change, compared with behavioral change.

The elimination of health inequities over the long-term will depend on structural transformation and organizational reforms by committed public health practitioners and their allies, emphasizing root causes. Public health has a legitimate, critical, feasible, and obligatory role to play in confronting health inequity.

Advancing Health Equity: Social Change

The greatest advances in health status and life expectancy in the early 20th century resulted from major social changes associated with reform movements that led to the introduction of factory and housing codes, the abolition of child labor, the eight-hour work day, improvements in the standard of living, the guarantee of a minimum wage, right to free trade unions, and the introduction of safe-food laws.[48-49] Public health played a central role in pushing for reforms as an organized response to the negative consequences of industrial capitalism. It was not a golden age, yet the improvements were deeply connected to social reform.

Advances in the public's health were not mainly associated with economic growth or discoveries in medicine, technology, or better social services, but shifts in political power to achieve social change. Public health has retreated from this larger role—to repairing the damage rather than confronting its source directly.[49–51] The current model emphasizes adapting, managing crises, and changing individual behavior, not institutions. Diseases are still often the main target rather than the forces that produce social and economic *conditions* generating disruptions and chaos resulting in health inequity.

Social Justice: The Framework

"In any discussion of social equity and justice, illness and health must figure as a major concern….Health inequity cannot be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom."—Amartya Sen

Realizing the goal requires not merely redressing or ameliorating inequity or establishing a different system of redistribution of goods and services.[15] Instead it demands a society that does not produce inequality or organize its core institutions inequitably. More than policy changes, it considers rethinking and rearranging the structure of society's power arrangements because that is where social injustices arise. Social justice, applied to societies, requires groups of people to maintain control over their identities and culture, their labor, and the conditions of their labor.[15]

Embracing a framework based on these principles of social justice can help public health practitioners strategize ways to reverse unbalanced power dynamics and create the conditions that support health. Its principles enable us to imagine a different kind of society altogether. Social justice movements transcend reforming single institutions by evaluating society's structure at its core, rather than at its margins. The end of child labor, the right of women to vote, the Civil Rights movement, the eight-hour work day, and marriage equality for lesbians and gays are all examples of struggles for social justice—ones that have resulted in advances in life expectancy and reductions in mortality rates.

"Advances in the public's health were not mainly associated with economic growth or discoveries in medicine, technology, or better social services, but shifts in political power to achieve social change."

Although striving for social justice is difficult and requires long-term commitment and struggle, the effort is critical because it is a prerequisite for healthy human development and the basis for meeting basic human needs.[52]

Guiding Assumptions for a Health Equity Practice

Within this social justice framework, the assumptions that helped to guide NACCHO's work derive from values and beliefs tied to a common consensus about ways in which increasing social and economic inequality has shaped patterns of health and well-being. Some are explicit and others implicit.

- A first assumption is that conventional behavioral and other programmatic approaches in public health will not suffice as effective responses to health inequities. Preventing health inequity emphasizes the systemic, patterned, organized structures and power arrangements that perpetuate and reproduce inequities leading to negative living and working conditions.
- Second, health equity involves transforming social and political structures, not controlling diseases exclusively through bio-medical and epidemiological approaches. As a result, eliminating health equity will invariably involve political struggles because health is politically and socially constructed. In public health, there can be no "outside" or externalities.
- Third, acting on the root causes is a legitimate, feasible, and critical part of the work of public health. This includes helping to disrupt the forces that generate structural racism, class, and gender inequalities, given that such inequalities are not natural or inevitable, but contingent and actionable.
- Fourth, a social justice-based practice cannot be the exclusive responsibility of public health professionals alone. They need permanent allies.
- Fifth, advancing practice for health equity entails collective action and therefore political engagement on the root causes to achieve lasting change, and that such action may take years to produce measurable results.
- Sixth, given the tumultuous history of public health, those of us not in the trenches

of practice must remain acutely aware of the enormous pressures faced by health departments as their budgets are cut, the conflicting roles they play, changing priorities, and the political assaults mounted against them, among many.

- Seventh, a contradiction exists between public health's values and mission and society's goals associated with markets, endless growth, and injustices.
- Finally, to engage with root causes requires an expansion of the legitimate boundaries of public health practice.[3] At a minimum, this means that the work would be interdisciplinary, extend outside the bio-medical paradigm, and bio-medical functioning, exploring not only how social and economic inequalities create inequity, but the power arrangements and interests that produce them.

NACCHO's Health Equity Program

The goal of NACCHO's Health Equity Program, begun in 2000, is to increase the capacity of LHDs to act more forthrightly on the root causes of health inequity—structural racism, class, and gender inequity. The program has moved from an improvisational to a more strategic, long-term approach to confronting health inequity. NACCHO supports LHDs to become a more powerful force for change, acting collectively for a progressive agenda.

Although in their everyday practice they must ameliorate the consequences of health inequities, circumstances require more thorough-going directed action on root causes. This involves strategizing about their role in addressing the structures and systems that generate health inequity and setting the prerequisite conditions for health. An essential tool in this endeavor is NACCHO's Web-based course, Roots of Health Inequity (www.rootsofhealthinequity.org).

Looking to the Future

Reversing social injustices requires more than policy changes associated with a redistribution of material goods and resources. It entails rethinking and rearranging the structure of society in its power arrangements because that is where social injustices arise. They take root in longstanding power imbalances. What are some requirements to move forward?

Developing a Progressive Public Narrative

At this moment, public health lacks stories, practices, or explanations of connected public events that provide meaning about why things are as they are and make sense of economic and social reality. In short, public health needs a public narrative that could move an agenda for health equity. Public narratives are about more than messaging. They can include language, social rules, institutions, ideologies, images, performances, photography, ideas, and practices—any aspect of culture.

The problem is an already dominant narrative, invisible and unnoticed, that reflects the power of well-organized interests, often negating the value of marginalized cultures, egalitarian principles, and democracy.[53] The narrative is dominant not only because it saturates the whole process of living, shaping perceptions of ourselves and the world, but

because it appears as neutral and self-evident. That is its power—becoming internalized as common sense.

An example of how a public narrative becomes common sense is the unquestioned acceptance of economic growth as overriding human need and well-being. Another is the unremarked centrality of the Dow Jones Industrial Average and GDP as the defining indicators of progress and well-being.

Public health could benefit from a common narrative that speaks to the needs of most people, expressing values and with an underlying world view more suitable to the lived reality of peoples' collective experience. That narrative likely has themes associated with meeting human needs; supporting a flourishing human; social and economic equality; political equality; and social cooperation. A successful narrative is inclusive, inviting people to join and represent themselves by seeing themselves as part of it.

A strong public narrative is coherent and develops out of peoples' experiences and values. It informs ways to make sense of the world, in which everyone has valid stories to tell.[53] It enables not only a clarity about the source of oppression and inequality as something produced, but ways to interrupt and counter it. Revealing patterns of oppression and devastation can capture the historical legacy imposed on groups of people as a slow form of violence, ordinarily obscured.

Building Power and Permanent Alliances

On first meeting a group of community organizers in the Midwest, as part of NACCHO's Building Networks initiative to align public health and community organizing, their first question was whether public health could identify allies with commitment and power—a question almost never asked by public health practitioners. They do not often think about building power with constituencies. This absence of a power base constricts the strategic capacity to advance an agenda for health equity.

Public health has a long history with connections to social movements that have created changes in power relationships and resulted in increased equity. The women's suffrage movement, the labor movement, the Civil Rights movement, the environmental and environmental justice movements, and many others find public health's presence.

Promoting change to end the extreme and unacceptable health inequities in American society demands a resurrection of such alliances and a renewed commitment to working closely with social movements for racial and economic equity.[54] Organizing for a common agenda increases the possibilities to disrupt and democratize the structures of power that produce and reproduce the unequal distribution of power, resources, and health. The work requires a commitment to deep democracy on a large scale to ensure accountability, transparency, and fully developed participation.

No one organization or field of study has the influence or knowledge to reduce social and economic inequalities. The source of health inequities remain deeply embedded in the structure and power arrangements of many core institutions. *Building a local constituency is critical*. This can entail establishing strategic alliances with powerful institutions that value the work of public health, whether with committed journalists, community activists, groups affected by policy, and like-minded colleagues, especially in agencies that have an impact on health such as housing, transportation, or planning.

Toward a Culture of Health Equity

The ability of public health practitioners to eliminate health inequity partially depends on public health becoming more independent and liberated to set priorities and agendas

for realizing the goal without being captured by powerful interests. It will involve a return to its roots in activism and social reform, and particularly inserting itself into uncharted realms, normalizing its role in areas such as safe and affordable housing, non-discriminatory land use policy, home foreclosure, mass incarceration, and viewing their accountability more directly to the public they protect. Directing attention to causes, whatever the scale, will be important. This, in turn, will mean modifying the bureaucratic model of adapt and accommodate, and command and control.

The conditions to achieve health equity are *not* mainly under the control of public health practitioners. Success will likely require the formation of permanent alliances with those who have power and influence to effect social change. That has been part of public health history. Public health will need political support from as many institutions within the local jurisdiction as possible.

Along with a clear and potent public narrative associated with principles of social justice, they will need the spaces: forums and venues for implementing that narrative, along with publications, a contingent of spokespeople, coordination with university research, and so forth.

Transformations to public health practice in the past have occurred because of health crises and threats. But equally important, they have resulted from the outcome of political struggles and pressures for reform, often driven by clashes between social movements and economic and professional interests. To succeed, public health must often hold local institutions accountable for actions that harm health if they are to have an influence on structures and social systems that produce inequality. To establish health equity as a priority requires gaining allies with power and commitment. It will involve public health *returning to its roots* in activism and social reform, remembering who we are and where we came from.

Progressive change will not happen without sustained pressure. Affected populations must be the ones to lead the efforts. Local health departments cannot be agnostic but rather fierce advocates and forces to be reckoned with.

Given the pressures and assaults on public health, the rising levels of inequality, and the opportunities and possibilities available, as you experience the sessions at the conference we ask you to consider how LHDs can act fearlessly for the public good, navigating the politics against the increasing levels of health inequity through the mechanisms of daily public health practice and beyond.

"We can resist what appears to be natural and fixed and present a progressive vision to move agendas, to reclaim the principles of social justice without apology, and to engage a constituency that supports health equity."

Call to Action

- Recognize the difference between social determinants of health and social/political determinants or determinations of health inequity.
- Recognize and act on causes of the human-constructed structures and processes that generate health inequity. These are related to imbalances in political power.
- Break out of the boundaries that limit critical thinking, especially about what constitutes legitimate public health practice.
- Gather, analyze, and disseminate information, beyond health outcomes, about the institutions and decision-making processes that generate health inequity.
- Focus attention on systems, social structure, power arrangements, and institutions as the source of inequalities to avoid blaming individuals for their condition, bad luck, or assume that inequity can be resolved through programmatic fixes.

- Express the distinction between mitigation or remediation of injustice versus social change to draw attention to social injustice and why it will continue without attention to shifts in power and social transformation.
- Identify colleagues to devise a regional movement-building strategy.

One of the greatest barriers to achieving health and racial equity is the belief that no named alternative exists to the current system, that whatever happens is inevitable. We can resist what appears to be natural and fixed and present a progressive vision to move agendas, to reclaim the principles of social justice without apology, and to engage a constituency that supports health equity. Our goal is to awaken the hidden history and legacy that made our communities what they are that has been forgotten or erased. For this to happen, people have to believe in and act to realize social transformation and recognize society as contingent, not fixed. Our collective health and well-being demand it.

Enjoy the conference!

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1100 17th St, NW, 7th Floor Washington, DC 20036

P 202-783-5550 F 202-783-1583

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