

Health Equity: Exploring the Social and Economic Dimensions

**Richard Hofrichter, Senior Analyst, Health Equity
National Association of County & City Health Officials**



The National Association of County & City Health Officials (NACCHO) represents local health departments in the United States. NACCHO helps to create the conditions in which local health departments and their partners can succeed. NACCHO's mission is to be a leader, partner, catalyst, and voice for local health departments nationally in order to ensure the conditions that promote health and equity, combat disease, and improve the quality and length of all lives.

Introduction

Differences in health status among population groups that are unnecessary, unfair, unjust and actionable are referred to as health inequities.¹ Health inequities affect life chances and are not inevitable or caused by behavior or genes; they are the result of deep social divisions associated with racism, class structure, and sexism. A causal relationship exists between systematic social and economic inequality and health inequity.²

For example, one major feature of social and economic inequality is structural racism, an ongoing pathological process interwoven in many institutions.³ Even at the same level of wealth, African-Americans typically experience worse health and die sooner than European-Americans. This contrast often holds true for other populations of color.⁴ Not surprisingly, the first words of the recent World Health Organization report, *Closing the Gap in a Generation*, are these: "Social justice is a matter of life and death."⁵

Evidence that could help to explain differences in state rankings, in addition to that produced by epidemiology, derives from disciplines such as sociology, political science, and economics. Beyond indicators of individual demographic characteristics or even the conditions under which people live, it will be useful to examine the structures of society and the institutional rules responsible for generating the negative conditions leading to health inequity, for example, production volumes or presence of toxic waste in poor communities and communities of color, the absence of occupational and safety standards in neighborhood worksites, or indicators of living standards.

The traditional indicators used for public health surveillance and monitoring were designed for infectious disease. These surveillance systems and their indicators are useful and necessary, but they do not readily guide action to reduce inequity, because they fail to measure root causes of inequity. Interested parties, though, can take many actions to tackle health inequities.

Recommendations for Taking Action

Effective action to eliminate health inequities and establish the foundations for health requires organized, systematic efforts by organizations and individuals. The major advances in life expectancy in the U.S. that occurred in the early part of the twentieth century stemmed from massive social change and the movements that supported those changes, such as the end to child labor, the introduction of housing and factory codes, the eight-hour work day, improved wage and work standards, and so forth. Individuals, community leaders, employers, policymakers and health professionals have the responsibility to show leadership through a variety of actions. What actions will you take?

1. Exercise leadership: Local and state agencies and institutions outside the formal health community should use new indicators for analysis to help translate knowledge about health inequity into effective policies. The statutory authority of public health departments could be broadened or more broadly interpreted by its practitioners and governing boards. Job descriptions could include competencies related to health equity. Standards addressing equity could be included in accreditation processes for all relevant institutions. Living wage laws should be more broadly adopted.

2. Communicate: Encourage media to include more frequent explication of the structural causes of ill health and poor quality of life in their coverage to broaden awareness about the causes of health inequity. Community organizations and elected officials should hold town hall events such as the screening of the PBS Series *Unnatural Causes* as a tool for mobilizing constituencies.

3. Build strategic alliances locally: Create or strengthen local collaborations among journalists, community activists, residents affected by policy, and colleagues from other local organizations that have an impact on health such as those from housing, transportation, or planning. Ally with social movements — civil rights, labor, women's movements, human rights — with broad agendas, since they are already working in this political space.

4. Build expertise and trust: Articulate consistent and informed positions built on the relationship between new indicators and health. Provide documentation and expert testimony about social determinants of health equity to public bodies such as local city councils, commissions, and agencies, state health departments, and private forums on

the social determinants of health inequities. Recommend questions for hearings and get invited to testify as tactics to create interest, with the backing of the public and affected populations.

5. Use health impact assessments: Community groups should use health impact assessments which are “a combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population.”⁶

6. Engage with people whose health status is poor: Support popular engagement by acting as advocates for those whose lives and health have been affected negatively by inequity. Establish relationships with people in neighborhoods and their organizations to build trust. Share control, expertise and power with grassroots community groups. Identify risk and share information with the public. Expand educational opportunities for, hire and train community residents to perform health and medical services. Provide technical assistance to groups engaged in population work. Deploy permanent resources in neighborhoods. Get out the vote.

7. Diversify the workforce: Hire people from non-traditional disciplines (e.g., social sciences, community organizers).

8. Collect, monitor, use and report new indicators: Obtain and maintain data that reveal inequities in the distribution of disease. Analyze information that characterizes the social conditions under which people live.

Indicators and Measures for Explaining Health Inequity

New measures of social processes, structures, and decision-making are needed, for example, in the areas of transportation and access to healthy eco-systems, since these areas are directly responsible for negative outcomes and inequity. New metrics would provide a portrait of accumulated conditions and an historical context for differences in population health. More importantly, such measures would be dynamic, capable of explaining the role of multiple features of the social system, in contrast to static “risk factors,” interpreted as characteristics of individuals.⁷

A sampling of possible indicators which could be correlated with health outcomes or health inequity is provided below. Communities and researchers could together select indicators of interest to explore dimensions of social and economic life to provide a portrait of conditions, however imprecise, which can inform policy and action.

Income and Wealth

- Geographic concentration of income and wealth
- Patterns of decisions that lead to lower living standards
- Existence of living wage laws
- Concentration of poverty

Social Conditions

- Quality of physical environment
- Measures of the toxicants produced in industrial zones or the presence of hazardous/toxic waste sites in poor communities and communities of color⁸
- Level of residential segregation
- Quality of housing stock

Political Influence

- Access to power, and decision-making power itself (e.g., elected officials by race, gender, social position)
- Percentage of budget invested in public health
- Number and size of grassroots community organizations and unions

Corporate Decisions

- Home foreclosure rates
- Indicators of predatory lending practices in relation to sub-prime mortgage loans
- Investment and disinvestment in community infrastructure
- Indicators of corporate decision patterns, such as layoffs, outsourcing, price-fixing, financial speculation

Labor Process and Labor Markets

- Levels of occupational segregation
- Job security
- Employment rates and levels
- Occupational injuries

NACCHO and Local Health Department Initiatives

A goal of NACCHO's health equity initiatives is to improve the capacity of health departments and their communities to address the fundamental causes of health inequity in everyday practice. A central concern for NACCHO is to devise strategies to advance health equity by changing the on-going structures of decisions across multiple institutions that endlessly generate patterns of negative living and working conditions which result in health inequity. How do we transcend the need to ameliorate or treat the consequences of inequity with a knowledge base for action that can prevent

those conditions from arising? For over a decade, in collaboration with many local health departments and colleagues, NACCHO has sought to translate the research findings on the sources of health inequity into guidelines for public health practice. To learn more about NACCHO, visit www.naccho.org.

NACCHO's initiatives include a broad range of national projects. For example, in 2008, it established the Local Health Department National Coalition for Health Equity to function as an agent of change by building solidarity among health departments to institutionalize action (<http://healthequity.naccho.org>). Over the past three years, NACCHO collaborated with California Newsreel, which produced the award-winning PBS documentary series *Unnatural Causes: Is Inequality Making Us Sick?* Over 140 LHDs joined a campaign to conduct town-hall events in their communities screening the film, inviting community representatives and public officials to engage in dialogue and strategic planning (www.unnaturalcauses.org). In addition, NACCHO provides technical assistance and tools to LHDs, such as Guidelines for Achieving Health Equity in Public Health Practice.

Many local health departments across the country, often with NACCHO's support, are devising innovative approaches to tackling health inequity on a variety of fronts.⁸ Three (Louisville, Boston, and Milwaukee) have established a Center for Health Equity within their departments. The Bay Area Regional Health Inequities Initiative (BARHII) in Oakland, California, has established a regional collaborative of eight Bay Area Departments to rethink public health practice, given the way governmental functions that impact health are regional. In Lansing Michigan, the Ingham County Health Department initiated a comprehensive facilitated dialogue process over a period of years to raise awareness of social justice issues and engage staff in efforts to produce institutional change. The Connecticut Association of Directors of Health devised a Health Equity Index (HEI), based on the assumption that health inequities "are morally reprehensible... discernable and measurable, [and] thus...can be eliminated through organized design and action."⁹ HEI is essentially a tool for measuring the social and economic determinants of health inequity.¹⁰

Conclusion

Eliminating health inequities requires organized, collaborative work, at all levels of life, from community residents and neighborhood organizations to public health professionals, agencies of government, and academics. Apart from political will, achieving that goal depends on action directed at the decision processes and institutions that perpetuate inequity. The public health community has a central role to play in that effort.

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1. M. Whitehead, "The Concepts and Principles of Equity and Health," *International Journal of Health Services* 22(3), 1992: 430.
 2. J. Phelan and B. G. Link, "Social Conditions as Fundamental Causes of Disease" *Journal of Health and Social Behavior*, 1995: 80-94; M. Marmot, and R. Bell, "Action on Health Disparities in the United States: Commission on Social Determinants of Health," *Journal of the American Medical Association* 301(11), 2009: 1169-1171.
 3. See D. Williams and J. Y. Nazroo, "The Structuring of Ethnic Inequalities: Economic Position, Racial Discrimination, and Racism" *American Journal of Public Health* 93(2), February, 2003: 277-84; V. Shavers and B. S. Shavers, "Racism and Health Inequity Among Americans," *Journal of the National Medical Association* 98 (3), March, 2006: 386-396.
 4. M. Aguirre-Molina, C. W. Molina and R. E. Zambrana (eds) *Health Issues in the Latino Community* (San Francisco: Jossey-Bass, 2001).
 5. See Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity Through Action on Social Determinants of Health*, Geneva, World Health Organization, 2008.
 6. European Centre for Health Policy, *Health Impact Assessment: Main Concepts and Suggested Approach* (Gothenburg Consensus Paper), Brussels: ECHP, 1999.
 7. See J. Beckfield and N. Krieger, "Epi + Demos + Cracy: Linking Political Systems and Priorities to the Magnitude of Health Inequities—Evidence, Gaps, and A Research Agenda" *Epidemiologic Reviews* (May 27, 2009) doi:10.1093/epirev/txp002; Dennis Raphael, (ed.) *Social Determinants of Health: Canadian Perspectives*. Toronto: Canadian Scholars' Press, 2nd Edition, 2008. G. A. Kaplan, et al., "Income Inequality and Mortality in the United States: Analysis of Mortality and Potential Pathways," *British Medical Journal* 312, 1996: 999-1003; J. W. Lynch, et al., "Income Inequality and Mortality: Importance to Health of Individual Income, Psychosocial Environment, or Material Conditions," *British Medical Journal* 320, April 29, 2000.
 8. Some of the highest levels of pollution can be found in poor areas and where people of color primarily reside. Some have high concentrations of landfills, incinerators, toxic waste disposal systems, and polluting industries. The explanation is discriminatory siting and licensing decisions and the failure to enforce laws and regulations.
 9. See Richard Hofrichter and Rajiv Bhatia (eds) *Tackling Health Inequities through Public Health Practice: Theory to Action* (New York: Oxford University Press, 2010).
 10. Baker Salisbury, Elaine O'Keefe, and Jennifer Kertanis, "Measuring Social Determinants of Health Inequities: The CADH Health Equity Index," in Hofrichter and Bhatia, Note 9.