2011 National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention

Health Equity Symposium:

Identifying Root Causes of Health Inequities: Using Data to Monitor and Improve Health

Tom Harkin Global Communication Center

Centers for Disease Control and Prevention, Atlanta, Georgia

August 3, 2011

Meeting Report

More than 300 people from across the Centers for Disease Control and Prevention (CDC) attended the 2011 National Center for HIV/AIDs, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) Health Equity Symposium in Atlanta, Georgia, on August 3, 2011. (See Appendix 1 for the symposium agenda.) The goal of the Symposium was to strengthen CDC's leadership role in advancing health equity by increasing awareness, engagement, and action to address the social determinants of health (SDH) and highlighting the role of data in informing and improving public health policy, practice, and research.

The Symposium, whose theme was "Identifying Root Causes of Health Inequities: Using Data to Monitor and Improve Health," featured special greetings from Congresswoman Donna Christensen, Delegate representing the U.S. Virgin Islands and Vice Chair of the Congressional Black Caucus; presentations from national experts on SDH; a question and answer panel discussion involving the audience and the previous speakers; a "CDC Call to Action" in which Dr. David Satcher, 16th U.S. Surgeon General and former CDC Director, called upon CDC staff and CDC partners to use data to address the root causes of health inequities; five concurrent workshops tailored to the needs of CDC staff working in research, surveillance, policy, and programs; and a scientific poster session showcasing SDH activities at CDC.

The Symposium was planned by the 2011 NCHHSTP Health Equity Symposium Planning Committee (Appendix 2), which consisted of 26 representatives from across CDC representing National Centers, employee workgroups, and scientific workgroups. Support for the Symposium was provided by the NCHHSTP Office of Health Equity and the NCHHSTP Program Collaboration and Service Integration Team.

CDC Welcome

Dr. Kathleen McDavid Harrison, Director of the NCHHSTP Office of Health Equity and Morning Session Moderator, called the meeting to order. Dr. Leandris Liburd, Director of the CDC Office of Minority Health and Health Equity, shared greetings from CDC Director Thomas Frieden and opened the day with a question first articulated by the World Health Organization (WHO): "Why treat people's illnesses without changing what made them sick in the first place?" (http://www.who.int/social_determinants/tools/multimedia/posters/en/index.html).

Dr. Liburd noted that (1) the influence of economic, social, and political factors on health outcomes is strong and has been well understood for centuries and (2) some U.S. population groups have benefitted more than others from overall progress made in preventing disease and premature deaths. In Dr. Liburd's view, the 2011 NCHHSTP Health Equity Symposium and the overwhelming turnout for the event send the message that CDC and its partners are committed to addressing these inequities by expanding knowledge, identifying intervention strategies, and developing tools to advance health equity.
Dr. Liburd shared her hope and expectation that the Symposium's learning objectives, which were outlined by the Symposium Planning Committee, would be met by the end of the day. These objectives were:

- To inspire participants to take action to address health equity
- To provide real-world examples of how public health policy makers, practitioners, and researchers use data to advance health equity, and

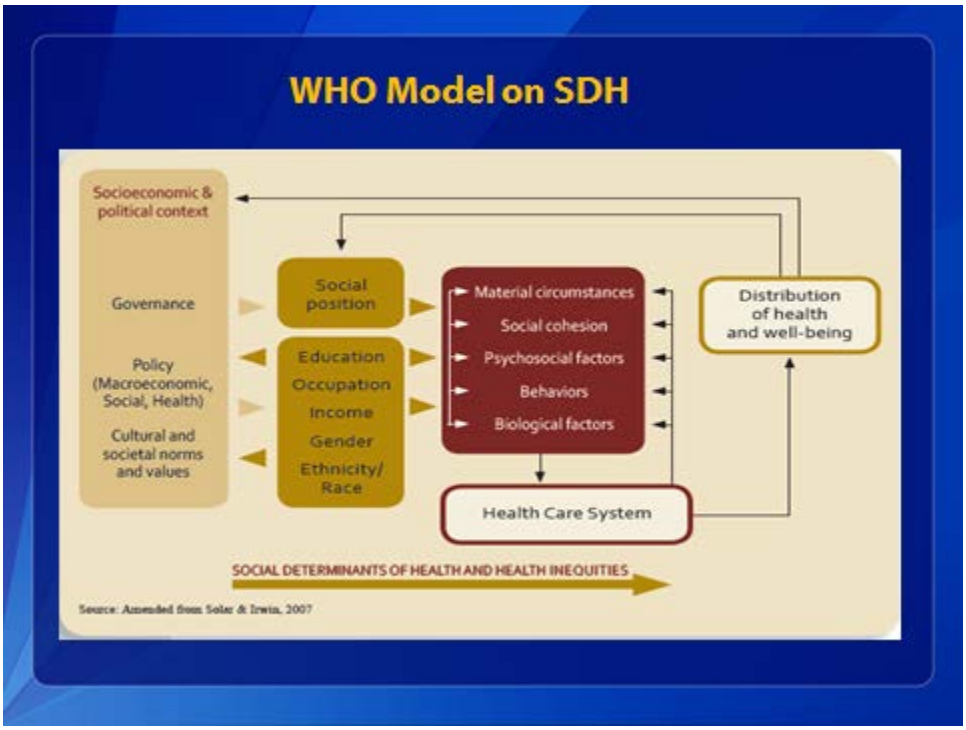
- To equip and motivate participants to apply SDH approaches in their work.

NCHHSTP Welcome

Dr. Kevin Fenton, NCHHSTP Director, welcomed participants and emphasized that SDH approaches to advancing health equity are critical to the work of NCHHSTP and CDC. He noted that, to improve the nation's health, it is essential to address *both* individual behavioral risk factors and the social and structural determinants of health that are beyond the control of individuals.

Dr. Fenton reminded participants that SDH are complex and overlapping, directing participants' attention to the WHO Model on Social Determinants of Health (Figure 1), which illustrates the dynamic interactions among SDH and individual level characteristics within any population and gives prime importance to the factors that describe an individual's place in the social hierarchy and their ability to navigate that hierarchy. The model takes into account the critical roles of the healthcare system and the socioeconomic and political context (e.g., governance, policies, and cultural and societal norms and values). Dr. Fenton noted that sexual orientation, although not in the WHO model, is a key determinant of position in the social hierarchy for Lesbian, Gay, Bisexual and Transgender populations around the world and therefore should be included in models of SDH.

Figure 1. THE WHO MODEL ON SOCIAL DETERMINANTS OF HEALTH.



Source: Discussion paper for the Commission on Social Determinants of Health (http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf) (amended from Solar O, Irwin A (2007) A *Conceptual Framework for Action on the Social Determinants of Health*).

Per Dr. Fenton, NCHHSTP is committed to a continued leadership role in addressing SDH and health equity in all of its activities, including research and surveillance, communication and marketing, policy, prevention programs, capacity building, and partnership activities. The *NCHHSTP 2010-2015 Strategic Plan* (http://www.cdc.gov/nchhstp/docs/10_NCHHSTP%20strategic%20plan%20Book_semi%20final508.pdf includes a health equity goal: to "reduce health disparities in HIV/AIDS, viral hepatitis, STDs, and TB by promoting health equity." Dr. Fenton noted that NCHHSTP's strategic plan is aligned with:

- The WHO report *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health* (http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf)
- White House health initiatives, including the *National Prevention Strategy* (http://www.healthcare.gov/center/councils/nphpphc/strategy/report.pdf) and the *National HIV/AIDS Strategy* (http://www.whitehouse.gov/sites/default/files/uploads/NHAS.pdf),
- The Department of Health and Human Service (HHS) *Healthy People 2020* initiative (http://www.healthypeople.gov/2020/default.aspx)
- The Institute of Medicine (IOM) report *For the Public's Health: The Role of Measurement in Action and Accountability* (http://www.nap.edu/catalog.php?record_id=13005)

Dr. Fenton also pointed out some of NCHHSTP's recent accomplishments in the area of SDH:

- Hosting the first (2010) Health Equity Symposium at CDC that reviewed the roles of science, policy, and communications in addressing SDH.
- Publication of a White Paper on SDH in 2010. This policy document outlines NCHHSTP's strategic vision for reducing health inequities related to HIV/AIDs, Viral Hepatitis, STDs, and TB (http://www.cdc.gov/socialdeterminants/docs/SDH-White-Paper-2010.pdf).
- Publication of a special supplement of the peer-reviewed journal *Public Health Reports* in 2010 entitled *Social Determinants of Health in the Prevention and Control of HIV/AIDS, Viral Hepatitis, Sexually Transmitted Infections and Tuberculosis* (http://www.publichealthreports.org/archives/issuecontents.cfm?Volume=125&Issue=10).

Per Dr. Fenton, ongoing work at NCHHSTP related to SDH includes preparation of new guidance and training materials with SDH definitions, measures, indicators, and data sources; creation of an SDH strategic communications plan; inclusion of language related to SDH and health equity in all NCHHSTP

funding opportunity announcements (FOAs); and continued engagement of new partners in SDH policy development.

Finally, Dr. Fenton announced the release of a second special *Public Health Reports* supplement focused on data systems and their use in addressing SDH (http://www.publichealthreports.org/issuecontents.cfm?Volume=126&Issue=9).. The publication of this peer-reviewed supplement is one of the activities and commitments outlined in NCHHSTP's White Paper on SDH.

Opening Remarks: America Healing

Dr. Gail Christopher, Vice President for Program Strategy at the W.K. Kellogg Foundation (http://www.wkkf.org/), addressed a challenging topic: the enduring effects of racism on health. She characterized racism as a "wound in the heart of our nation" that has never completely healed

The WHO Model of the Social Determinants of Health (Figure 1) includes ethnicity and race. Dr. Christopher remarked that our unique history in the U.S. makes it particularly difficult to successfully address these factors as determinants of health, noting that, for 300 years, the U.S. explicitly based human value on skin color, with some people regarded as less than human. Dr. Christopher pointed out that, despite a civil war and a civil rights movement, that belief system has never been expunged; it is still embedded in science, religions, government policies, and in the way we communicate. She considers the clearest evidence of this to be the persistence of residential racial segregation in the U.S., which, in major metropolitan areas, is comparable to segregation in South Africa at the peak of apartheid.[1, 2, 3] Today's

[1]Massey DS. Segregation and stratification: a biosocial perspective. *The Dubois Review: Social Science Research on Race*. 2004(1):1-19.
[2] Iceland J, Weinberg DH, Steinmetz E. 2002. *Racial and Ethnic Residential Segregation in the United States: 1980-2000*. U.S. Census Bureau, Census Special Report, CENSR-3, Washington, DC: U.S. Government Printing Office.

residential segregation is not the cumulative result of individual personal choices. Rather, Dr. Christopher observed, it is the consequence of a long history of laws, policies, attitudes, and beliefs that enforce racial bigotry.

Dr. Christopher shared that the mission of the R.W. Kellogg Foundation is to strengthen communities in order to create conditions that propel the most vulnerable children in the U.S. to success. *America Healing*, the Foundation's racial equity initiative, resulted from a "20-year journey" by the Foundation's Board of Directors, who, Dr. Christopher said, eventually came to realize their mission required honest engagement with the pervasive unconscious belief in racial hierarchy.

Dr. Christopher reminded the audience that most children born in the U.S. today are children of color; many of them experience "double jeopardy" because they grow up non-white in low-income families residing in segregated low-resource neighborhoods.[4] *America Healing* helps communities address these and other symptoms of the "wound" of racism. Dr. Christopher noted that the Foundation understands that people are the force for change in democracies and that civic engagement is therefore critical. It supports more than 400 grantees around the country who share a heartfelt commitment to racial equity that often stems from acknowledgement of injustice.

In Dr. Christopher's view, current challenges include documenting the health impact of discrimination and exclusion and measuring our progress toward racial equity. She stressed that we must hold ourselves

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(http://www.census.gov/hhes/www/housing/housing_patterns/papertoc.html); Wilkes R, Iceland J. 2004. Hypersegregation in the Twenty First Century. Demography 41(1): 23–361. http://www.ncbi.nlm.nih.gov/pubmed/15074123)

[3] Glaesar EL, Vigdor JL. 2001. Racial Segregation in the 2000 Census: Promising News. Center on Urban and Metropolitan Policy, The Brookings Institution (http://www.brookings.edu/es/urban/census/glaeser.pdf)

[4] Acevedo-Garcia D, Osypuk TL,McArdle N, Williams DR. Towards a Policy-Relevant Analysis of Geographic and Racial/Ethnic Disparities in Child Health. Health Affairs, 27, no 2 (2008): 321-333 (http://www.ncbi.nlm.nih.gov/pubmed?term=Acevedo-Garcia%20D%2C%20Osypuk%20TL%2C%20McArdle%20N%2C%20Williams%20DR)

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accountable as a nation and "connect the dots" to elucidate the mechanisms by which SDH, including the chronic stress that comes from having one's humanity and equality denied, predispose us to disease. There is a fundamental need to be included in society, observed Dr. Christopher. When this does not occur, it has a negative impact on one's body and its functions. In her view, clinicians and other health professionals have a critical role to play in helping the field of public health bring to light the effects of chronic stress that not only enhance vulnerability but also increase the likelihood of becoming ill or not overcoming illness. She stated that a major challenge for the future is putting "the human body right into the heart of the SDH framework."

Dr. Christopher shared that she is often asked how we will know that the racial divide in the U.S. has been overcome. Her answer is that we will know we have been successful when physical characteristics that signify race no longer predict educational and economic outcomes for children.

Institute of Medicine Reports on the Social Determinants of Health

Dr. Steven Teutsch, Chief Science Officer at the Los Angeles County Public Health Department, is the former CDC employee after whom the Prevention Effectiveness Fellowship is named (http://www.cdc.gov/pef/). In his presentation, Dr. Teutsch reviewed the rationale for moving away from an exclusively biomedical orientation approach to health and adopting a comprehensive approach that encompasses SDH. He emphasized that changing our approach to health begins with measurement, citing the adage that "what is measured gets done." Dr. Teutsch expressed his view ~~that,to~~that, to move forward, we must measure SDH in surveillance and health monitoring systems in a way that drives action and holds people accountable.

He then summarized the highlights of two Institute of Medicine (IOM) reports sponsored by the Robert Wood Johnson Foundation:

- *For the Public's Health: The Role of Measurement in Action and Accountability* (http://www.nap.edu/catalog.php?record_id=13005) and
- *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (http://www.nap.edu/catalog.php?record_id=13093).

Dr. Teutsch, Vice Chair of the IOM Committee that developed these reports, also announced the upcoming publication of a third report that addresses public health financing.

Dr. Teutsch stressed that America is not getting the best value for its healthcare dollar. He noted that, when each country's per capita healthcare spending is plotted against life expectancy at birth, most industrialized countries fall on a curve, indicating a correlation between spending and health. However, the U.S. is an outlier. Extrapolating from the amount spent on healthcare in 2003, U.S. life expectancy should have been 81.4 years, when, in fact, it was 77.5 years.[5] Furthermore, observed Dr. Teutsch, the current level of health in the US, which most Americans agree is sub-optimal, should cost in the range of $700 billion to $1.2 trillion less than it does now. Dr. Teutsch noted that open-ended, poorly controlled spending on medical care in the U.S. siphons resources from other societal goods—such as education and housing—that could provide greater value and lead to improved population health.

Turning to the IOM reports, Dr. Teutsch highlighted recommendations from *For the Public's Health: The Role of Measurement in Action and Accountability* that call for:

- *Better measures of population heath*. The report indicates that HHS should support the development of a "core, standardized set of indicators that can be used to assess the health of communities, a core, standardized set of health-outcome indicators for national, state, and local use, and a summary

[5] *Overcoming Obstacles to Health*, Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America (2008). Figure 14, Page 39 (http://www.rwjf.org/files/research/obstaclestohealth.pdf) .

measure of population health that can be used to estimate and track health-adjusted life expectancy for the United States."[6]

- *Increased awareness of social and environmental determinants of health*. Per the report, HHS should "produce an annual report to inform policy-makers, all health-system sectors, and the public about important trends and disparities in the social and environmental determinants that affect health." [7]
- *Better tools for decision-making.* To elucidate the complex relationships among the social, economic, and environmental causes of poor health, the report indicates that HHS should (1) "coordinate the development and evaluation and advance the use of predictive and system-based simulation models to understand the health consequences of underlying determinants of health and (2) use modeling to assess intended and unintended outcomes associated with policy, funding, investment, and resource options." [8]

Per Dr. Teutsch, the second IOM report, *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges*, urges legislatures and government agencies to use existing legal tools (e.g., taxation, spending, direct regulation, deregulation, and litigation) to address the leading causes of poor health. The report recommends that:

- Federal and state governments "develop and employ a Health in All Policies (HIAP) approach to consider the health effects—both positive and negative—of major legislation, regulations, and other policies that could potentially have a meaningful impact on the public's health."[9] Per the report, as part of this effort, governments should evaluate health effects and costs before and after enactment of laws, regulations, and other policies.

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[6] *For the Public's Health: The Role of Measurement in Action and Accountability* (http://www.nap.edu/catalog.php?record_id=13005), page 6.
[7] *For the Public's Health: The Role of Measurement in Action and Accountability* (http://www.nap.edu/catalog.php?record_id=13005), page 7.
[8] *For the Public's Health: The Role of Measurement in Action and Accountability* (http://www.nap.edu/catalog.php?record_id=13005), page 9.
[9] *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (http://www.nap.edu/catalog.php?record_id=13093), page 9.

- "State and local governments create health councils of relevant government agencies" that engage stakeholders in the development of an "ongoing, cross-sector, community health improvement plan informed by a HIAP approach." [10]
- "HHS ~~convene~~convenes relevant experts to enhance practical methodologies for assessing the strength of evidence regarding the health effects of public policies as well as to provide guidance on evidentiary standards to inform a rational process for translating evidence into policy." [11]

Dr. Teutsch concluded by noting that this series of IOM reports can help the public health system secure the necessary measurement tools, authority, and resources to address the social and environmental determinants of health.

Where You Live Matters: A Local Perspective on Health Equity

Dr. Anthony Iton, Senior Vice President, Healthy Communities, California Endowment (http://www.calendow.org/) provided compelling data on the health effects of living in low-resource communities. Dr. Iton noted that access to healthcare is important yet insufficient to eliminate health disparities because "where you live matters."

Dr. Iton recounted how his group used death certificates from Alameda County, California to examine trends in life expectancy at birth among African Americans and whites, finding that the life expectancy gap between these two groups increased from 2.3 years in 1960 to 4.9 years in 1980 and 7.8 years in 2005, with whites consistently having higher life expectancy.[12] Dramatic differences in life expectancy were identified

[10] *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (http://www.nap.edu/catalog.php?record_id=13093), page 10.
[11] *For the Public's Health: Revitalizing Law and Policy to Meet New Challenges* (http://www.nap.edu/catalog.php?record_id=13093), page 11.
[12] *Source*: Alameda County vital statistics files, 1960-2005. Community Assessment, Planning, Education and Evaluation (CAPE) Unit of the Alameda County Public Health Department. [Correct?] Note: Individuals were identified as African-American or white, regardless of Latino or non-Latino origin.

between adjoining census tracts in Alameda County [13], comparable to differences observed between low-income and high-income countries. Similar results were found in Baltimore, Maryland;[14] Los Angeles County, California;[15] and Cuyahoga County, Ohio.[16] Dr. Iton's group further observed that life expectancy at birth tended to be correlated with household income at the census-tract level, with every $12,500 in income "buying" a year of life expectancy in the San Francisco, California area.

Dr. Iton emphasized that SDH are not randomly distributed. Rather, they are concentrated in communities, and entire communities have "health trajectories." Per Dr. Iton, "high-trajectory" neighborhoods, with associated life expectancies of 80 years or more, put residents on a pathway toward good health. These neighborhoods have financial and social resources and resiliency factors, such as good schools, parks and playgrounds, jobs that pay a living wage, and housing that is safe and secure. "Low trajectory" neighborhoods—characterized by inferior housing and schools, low-paying jobs, and high levels of crime—put residents on a pathway toward poor health. These neighborhoods tend to be racially and economically segregated and are often located near sources of toxicity and pollution. They also have high concentrations of payday lending facilities and liquor stores and low concentrations of playgrounds and full-service grocery stores.

In Dr. Iton's view, past discriminatory housing policies explain the clustering of poor health in Alameda County today. Between 1926 and 1950 (the "era of racial covenants"), the property deeds in some Alameda County neighborhoods included legal restrictions that prevented sales to persons not of Caucasian race. By the time these restrictions were invalidated, segregated patterns were already well-

[13] *Source*: Alameda County vital statistics files, 1999-2001. Community Assessment, Planning, Education, and Evaluation (CAPE) Unit of the Alameda County Public Health Department
[14] Baltimore City Health Department. *Neighborhood Health Profiles*: http://www.baltimorehealth.org/neighborhood.html.
[15] Office of Health Assessment and Epidemiology, Los Angeles County Department of Public Health. *Life Expectancy in Los Angeles County. How long do we live and why? A Cities and Communities Health Report. July 2010.* Figure 5, page 6. (http://zev.lacounty.gov/pdfs/Life-Expectancy-Final_web.pdf)
[16] Cuyahoga County Board of Health ,2010 Annual Report. Page 8. (http://www.ccbh.net/annual-reports)

established. Moreover, neighborhoods where African Americans and other minorities were legally compelled to reside received little public or private investment. Superimposing a 1937 "redlining" map of the City of Oakland—which graded neighborhoods in terms of investment worthiness—with census data maps for 1940, 1950, and 1960, demonstrates that African-Americans populated the neighborhoods considered least desirable to investors.[11]

Dr. Iton holds that, to undo the legacy of segregation and eliminate the health disparities it has engendered, it is necessary to (1) examine and change policies that create "low trajectory" neighborhoods, (2) engage individuals living in these neighborhoods in crafting new solutions that rebalance social, political, and economic power and resources at the local level, and (3) change the narrative we tell about health—to use public health data to tell compelling stories that help us understand how policies affect social conditions which, in turn, lead to a downstream "cascade of disease."

Talking About Health Disparities

Dr. Drew Westen, Professor of Psychology at Emory University, spoke about finding a common language that will expand American's views about what it means to be healthy. He suggested that CDC and the public health community could use this language to talk about health disparities in ways that make sense to policy-makers and the public.

Dr. Westen described three principles of effective messaging. The first principle is to know which "associative networks" are activated during communication. Dr. Westen observed that certain words trigger associations, images, and emotions that occur outside of our conscious awareness. For example, terms like *uninsured*, *Medicaid recipients*, and *entitlements*, can evoke the feeling of "us" versus "them" among the group known to pollsters as "white swing voters."[17] The second principle is to use messages

[17] Swing voters are the members of the U.S. electorate that are most likely to change their vote in response to media messages. In *The Swing Voter in American Politics* (Mayer, W. G. (2008). Washington, DC: Brookings Institution

whose emotional impact has been tested and confirmed. Many acronyms, for example, do not do well in this type of testing. The acronym SCHIP, which stands for the State Children's Health Insurance Program, has no emotional resonance and does not convey the idea that people who work for a living should be able to take their kids to the doctor. The third principle is to tell a compelling, memorable story that resonates with the public and with policy-makers. Dr. Westen noted that stories provide motivation and frameworks for absorbing complex ideas.

Dr. Westen went on to describe the results of a study, conducted with support from the Robert Wood Johnson ~~Foundation, that~~Foundation that used polls, surveys, and focus groups to test and refine SDH messages. The study found that 84% of Americans tend to view their health as something largely under their control and for which they have to take personal responsibility. After reading a series of SDH messages (including the ones in Box 1), the percentage of people who acknowledged social factors as major influences on health increased by 31%. Dr. Westen pointed out that the messages (1) use colloquial, values-driven, emotionally compelling language, (2) identify a problem and offer potential solutions, (3) mix conservative and progressive values, and (4) avoid triggering negative associative networks among some who might otherwise not be open to SDH messages.

Press.), Mayer notes that "the perception that blacks are not swing voters probably derives from the fact that, in every recent [U.S.] presidential election except 1992, at least 80 percent of blacks voted for the Democratic candidate." However, he also notes that, in both the 2000 and 2004 presidential elections, a non-trivial proportion of black people were non-supportive of or lukewarm about the Democratic candidates.

Box 1 - Speaking about Social Determinants of Health in a Compelling Way

Where Health Begins:
America leads the world in medical research and medical care, and for all we spend on health care, we should be the healthiest people on earth. Yet on some of the most important indicators, like how long we live, we're not even in the top 25, behind countries like Bosnia and Jordan. It's time for America to lead again on health, and that means taking three steps. The first is to ensure that everyone can afford to see a doctor when they're sick. The second is to build preventive care like screening for cancer and heart disease into every health care plan and make it available to people who otherwise won't or can't go in for it, in malls and other public places, where it's easy to stop for a test. The third is to stop thinking of health as something we get at the doctors' offices but instead as something that starts in our families, in our schools and workplaces, in our playgrounds and parks, and in the air we breathe and the water we drink. The more you see the problem of health this way, the more opportunities you have to improve it. Scientists have found that the conditions in which we live and work have an enormous impact on our health, long before we ever see a doctor. It's time we expand the way we think about health to include how to keep it, not just how to get it back.

Health Equity:
People have a personal responsibility to take care of themselves and their health. But it isn't right when things outside our control—like where we're born or how much money we make—affect our health. In the entire city of Detroit—an area of nearly 150 square miles—there are dozens of "convenience stores" but only five grocery stores. An apple a day may keep the doctor away, but you have to be able to buy an apple. And it isn't easy to get exercise if you have to work three jobs just to get by, or if you can't easily get affordable daycare for your kids. We're not just talking about the rich versus the poor. On average, middle class Americans live shorter lives than those who are wealthy, and that's not right. Money can't buy happiness, and it shouldn't buy health. We have to take responsibility for our lives and decisions. But all Americans should have an equal opportunity to make the decisions that allow them to live a long, healthy life, regardless of their level of income, education, or ethnicity.

In his presentation, Dr. Westen emphasized that, whenever we speak about health disparities and SDH, we activate associative networks in our listeners (for example, networks related to race, ethnicity, and class). In his view, understanding that and following other principles of effective messaging can "make all the difference in the world" in communicating with policy-makers and the public.

Panel Discussion: Challenges and Opportunities for Advancing Health Equity

Dr. Fenton (Director, CDC NCHHSTP) invited members of the audience to ask the panel members—Congresswoman Christensen; Dr. Christopher (Vice President for Program Strategy, W.K. Kellogg Foundation) ; Dr. Iton (Senior Vice President, Healthy Communities, California Endowment); Dr. Liburd (Director, CDC OMHHE); Dr. Teutsch (Chief Science Officer, Los Angeles County Public Health Department); Dr. Westen (Professor of Psychology, Emory University); and Dr. Fred Karnas (Senior

Advisor to the U.S. Secretary for Housing and Urban Development)—about challenges and opportunities for addressing social determinants of health. Responses to some key questions are summarized below.

Looking at racism in ourselves and our institutions

Regarding a question about raising awareness of unconscious racism in ourselves and our institutions, Dr. Christopher observed that racism has infected everybody in this country. In her view, each of us must undertake an individual journey to heal and undo the subconscious thoughts and messages that influence our judgments and behaviors, and every organization in America should take the opportunity to do this type of work at an institutional level. Dr. Christopher recommended White Men as Full Diversity Partners as a resource for organizations (http://www.wmfdp.com/#).

Dr. Iton recalled that early in his career he disregarded advice about the need to look inside himself before addressing community issues. Over the years, he came to realize that it is essential to simultaneously do "inner work" and to engage with the community.

Dr. Westen shared his view that we need to rethink how we talk about racism. He believes that we need to move away from, "Is he or is he not a racist for having said X, Y or Z?" and help people become aware of their unconscious racism and prejudice.

Dr. Fenton noted that NCHHSTP has recognized the need to look internally, remarking that NCHHSTP has begun a program of diversity training for all staff members that will encourage them to challenge and address the preconceptions that influence decision-making.

How race and income affect access to health

A member of the audience commented on data presented by Dr. Teutsch showing a strong correlation between income and longevity regardless of race or ethnicity. The audience member commented that,

even for wealthy African Americans, race remains an important factor in the quality of medical care they receive and the health outcomes they experience. Dr. Teutsch agreed that many interrelated factors, including race and ethnicity, determine medical care quality and health outcomes.

Individual-level vs. community-based approaches

In response to a question about whether individual and group-level interventions can promote health equity and address SDH, Dr. Christopher noted that we do not have the luxury of focusing only on community-level and structural interventions. Dr. Christopher stated that, for people who have experienced oppression, the problem is both systemic and personal. She believes that, while we are working on changing the system, we also need to provide individuals with tools and resources to protect and improve their health at the individual level.

Dr. Iton suggested that it may be possible to slowly and incrementally transform individual-level interventions into community-based activities. His hope is that, over time, the paradigm in which health professionals provide services to passive recipients can be changed to include people coming together to share experiences and develop their own community-level solutions.

Dr. Teutsch commented that we need to apply multi-component interventions that address health equity issues at multiple levels, citing interventions to improve immunization rates as an example. He observed that, even when the goal is to immunize individuals, improving rates depends on targeting the clinician, the patient, and others; ensuring access to vaccine; and implementing an effective communication plan—in other words, intervening in a comprehensive way.

Measuring wealth and other SDH

A member of the audience referred to a recent study by the Pew Research Center indicating that wealth gaps between racial/ethnic groups in the U.S. reached record highs during the recent recession

(http://pewresearch.org/pubs/2069/housing-bubble-subprime-mortgages-hispanics-blacks-household-wealth-disparity). She asked for advice about language and data that CDC can use to discuss and measure wealth. Dr. Fenton then asked the panel to think even more broadly about how CDC should change the way it collects and uses data on SDH.

Dr. Iton noted that, although dramatic inequalities in wealth cannot be remedied in the short- or intermediate- term, other forms of wealth can help communities thrive; when people are socially connected and feel that they are part of something larger than themselves, they have "community-level wealth" that can be health-protective.

Dr. Teutsch noted that, although measures of social wealth and wealth creation simply don't exist, the business sector has developed potentially helpful economic measures. He suggested that we must decide what we most need to know about communities and develop standardized measures accordingly.

Dr. Christopher urged CDC to develop a cadre of leaders who understand SDH issues and are committed to measuring, monitoring, and improving SDH. She suggested that leaders in health equity develop an irrefutable business case supporting SDH approaches as critical to the viability and effectiveness of CDC, noting that "the data are there" to tie SDH to the CDC's mission of protecting the nation's health. In her view, one of the next steps is to pull together the measurement resources that are already available.

Take- home messages from panel members

Dr. Fenton closed the panel discussion and the events of the morning by requesting one-minute summaries from each of the panelists (presented here):

- Dr. Liburd noted that CDC can foster social cohesion by employing community-based, participatory approaches in its work. CDC has more work to do in articulating a prevention

framework that speaks to the real lives of people in the communities it serves. Nevertheless, CDC clearly possesses the capacity to achieve this.

- Dr. Christopher also stressed the importance of social cohesion. In her view, what is needed now is the capacity to empathize and demonstrate caring for others. She suggested that CDC must, as an organization, become more united in its determination to both promote racial healing and social cohesion and address SDH as part of its mission of protecting the nation's health.
- Dr. Iton considers it essential to focus on helping communities harness their own power and develop new leaders, particularly among youth. Dr. Iton also voiced his firm belief that investments to improve education and other social determinants of health can have more impact on health than investments in healthcare.
- Dr. Teutsch stressed the importance of both developing better measures of SDH and finding ways to communicate to the public about these measures so that we have a common understanding of the major factors that influence health and are able to monitor our progress in advancing health equity.
- Dr. Westen emphasized that the way we talk about SDH as scientists and public health professionals can backfire when we speak to the public. When addressing topics that trigger "associative networks" related to race and ethnicity, anything that turns an "us" into a "them" is unhelpful.

CDC Call to Action

In the afternoon, Dr. David Satcher, Director of the Center of Excellence on Health Disparities and the Satcher Health Leadership Institute at Morehouse School of Medicine (http://www.msm.edu/research/research_centersandinstitutes/SHLI/aboutUs.aspx), delivered a "Call to Action" to address SDH. Dr. Satcher, who served as Surgeon General and Assistant Secretary for Health (1998-2001) and as CDC Director (1993-1998), shared that he is no stranger to calls for action, having

previously issued calls to action on suicide prevention (1999), promotion of sexual health and responsible sexual behavior (2001), and prevention of obesity (2001).

Dr. Satcher began by sharing formative experiences from his early life that led him to focus on health disparities and health equity as an adult. He grew up in rural Alabama in the 1940s and 1950s, a time and place where social exclusion based on race was the norm. At the age of two, suffering from whooping cough and pneumonia, he was denied admission to the only nearby hospital because of his skin color. Dr. Satcher attended Morehouse College in Atlanta, GA at the height of the civil rights movement. He became president of the student body at Morehouse and chairman of the student committee on human rights. He entered medical school in 1963 with the understanding that it was not enough simply to practice medicine: it was necessary to change medicine and improve access to care.

Later in life, Dr. Satcher came to understand that the social justice for which he fought as a student has a direct impact on health. He shared a recent experience of speaking at a National Association for the Advancement of Colored People (NAACP) symposium on medicine and health for African Americans (http://www.naacp.org/blog/entry/americas-family-doctors). In that presentation, Dr. Satcher focused on the need for new partnerships and alliances, emphasizing the importance of the NAACP's work (for social justice, education, and the creation of jobs) in the effort to address SDH. Dr. Satcher believes that we have arrived at an exciting new day in terms of how we think about health equity and partnerships for health equity, making the 2011 NCHHSTP Health Equity Symposium both critically important and well-timed.

Dr. Satcher asserted that the CDC is well-positioned to address questions regarding the role of measurement in addressing SDH and to move the U.S. toward a public health system that takes into full consideration the social determinants of health. He reminded Symposium participants that the "enduring public health approach" (which focuses on "fulfilling society's interest in assuring the conditions in which people can

be healthy"[18]) is broad enough to accommodate increased commitment to addressing SDH. Dr. Satcher described the public health approach as asking and answering the questions: "What is the problem, what is its cause, and how can we intervene?" He noted that, in the case of health inequities, the problems are extremely complex and difficult to measure; they require understanding how resources are distributed in society and how social factors affect people's ability to access them.

Dr. Satcher emphasized the importance of measuring SDH and the impact of public health interventions, noting that willingness to measure one's progress and report back to partners and stakeholders is a sign of integrity. He reminded the audience that measurement alone is insufficient: measurement should lead to the design and implementation of health policies and intervention programs that are consistent with science, and this process requires determination and long-term efforts by many committed partners.

In Dr. Satcher's view, sustainability of efforts to address health inequity is also critically important. He suggested that sustainability has three components: a reputation for excellence and integrity, availability of adequate resources, and involvement of partners, observing that public health is growing increasingly dependent upon partnerships, and these partnerships can be more important than financial resources, particularly when resources are scarce.

Dr. Satcher concluded his call to action by quoting John Gardner, who served as U.S. Secretary of Health, Education, and Welfare in the 1960s and said that "life is full of golden opportunities carefully disguised as irresolvable problems."

After his presentation, Dr. Satcher answered a number of questions from the audience:

[18] Institute of Medicine report: *Future of Public Health*, 1988 (http://www.iom.edu/Reports/1988/The-Future-of-Public-Health.aspx)

- In response to a question about aligning CDC's disease-specific resources and programs with efforts to address SDH, Dr. Satcher suggested that CDC redefine health problems in a more holistic way that includes SDH, and that CDC build new coalitions and bring together teams of people who can address SDH.
- When asked how to ensure that medical and nursing education incorporates an SDH perspective, Dr. Satcher suggested working with accreditation groups rather than individual schools. He stressed the importance of admitting students with broader backgrounds, encouraging students to work in the community, and exposing students to other disciplines, such as social work.
- Regarding a question about the importance of partnering with others, Dr. Satcher shared his hope that, in the future, a leader will be defined as someone who possesses the ability to partner. He noted that the Satcher Leadership Institute defines leaders as those who are open to learning from others.
- In response to a question about American individualism and SDH, Dr. Satcher voiced his belief that the individualistic approach that characterizes life in the U.S. can promote isolationism. He observed, however, that this does not preclude the building of partnerships. For example, he noted, lack of U.S. Government support for the WHO Commission on SDH indirectly led to several U.S.-based foundations becoming deeply involved in its work.
- When asked how to convince decision-makers to consider the health impacts of policies and projects, Dr. Satcher stressed the importance of identifying mutual benefits. He provided the example that the education sector may become more interested in improving nutrition in schools when the positive impact on academic performance has been clearly demonstrated.

Workshops Providing Practical Tools for Promoting Health Equity

The Symposium included five concurrent afternoon workshops focused on incorporating SDH approaches and SDH data into various areas of public health work.

SDH 101: A Primer on Social Determinants of Health , presented by Ms. LaTonya Chavis Keener, Coordinator of the Racial and Ethnic Health Disparities Action Institute (http://www.cdc.gov/Features/DisparitiesInstitute/) at the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), provided basic knowledge on SDH, including key terms and concepts, and covered SDH approaches for advancing health equity through public health programs and partnerships.

Addressing SDH by Influencing Policy and Program Planning Activities was presented by Dr. Leandris Liburd, Director, CDC Office of Minority Health and Health Equity; Mr. Arun Skaria, Senior Advisor for Program Integration, Office of the Director, NCHHSTP; and Ms. Jo Valentine, Associate Director for Health Equity, Division of STD Prevention (DSTDP), NCHHSTP. Workshop presenters discussed the following approaches to integrating SDH approaches into projects: advancing the health equity goals of Healthy People 2020 (http://www.healthypeople.gov/2020/default.aspx), implementing the NCHHSTP Program Collaboration and Service Integration (PSCI) strategy to improve provision of preventive services (http://www.cdc.gov/nchhstp/programintegration/), and incorporating SDH approaches into funding opportunity announcements.

Using Public Health Legal Research to Drive Policy Development and Improve Health Equity, presented by Mr. Evan Anderson from Temple University and Mr. Stan Lehman from the Division of HIV/AIDS Prevention (DHAP) in NCHHSTP, considered the use of public health law research in developing national and local health policies. The workshop drew upon joint work by the Public Health Law Research Program at Temple University and the Policy Office of DHAP, and it provided practical information on the role of laws and policies as determinants of health and as tools for advancing health equity.

Measuring, Monitoring, and Linking Social Determinants of Health Variables to Health Outcome Variables was presented by three NCHHSTP scientists: Ms. Mi Chen and Dr. Zanetta Gant from DHAP, and Dr. Matthew Hogben from DSTDP. This workshop focused on the need for public health and social science research to elucidate the complex relationships among SDH variables. It introduced key SDH variables and suggested ways to link them to health outcomes to improve surveillance of health inequities.

Practical Solutions for Identifying Social Determinants of Health and Measuring Health Disparities, presented by Mr. Chip Allen, Health Equity Coordinator, Ohio Department of Health, and Dr. Sam Harper, Assistant Professor, McGill University, introduced tools and techniques for measuring health inequities within communities and for using that information in public health planning, decision-making, and research.

Scientific Poster Session

Forty posters were presented during a lunchtime scientific poster session and exhibited throughout the day. All posters reflected work conducted at CDC or with CDC involvement to measure health disparities and inequities and/or promote health equity through SDH approaches. Abstracts accepted for the poster session were submitted by authors from:

- The National Centers for:
  - HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP)
  - Birth Defects and Developmental Disabilties (NCBDDD)
  - Chronic Disease Prevention and Health Promotion (NCCDPHP)
  - Injury Prevention and Control (NCIPC)
  - Immunization and Respiratory Diseases (NCIRD)
- The Center for Global Health (CGH)
- The Office of Surveillance, Epidemiology, and Laboratory Services (OSELS)

- The Office for State, Tribal, Local, and Territorial Support (OSTLTS)
- The National Institute for Occupational Safety and Health (NIOSH)

Reflections on the Day

Dr. Ana Penman-Aguilar, Chair of the 2011 NCHHSTP Health Equity Symposium and Acting Senior Health Scientist in the NCHHSTP Office of Health Equity[19], noted that the Symposium's purpose was to bring the entire agency together to foster greater awareness, engagement, and action on health equity and social determinants of health. In the view of Symposium planners, public health practice and policy must be grounded in data that reflect root causes of inequities. For this reason, the Symposium focused on the role of data in informing and shaping public health policy, practice, and research.

Dr. Penman-Aguilar summarized important ideas discussed at the Symposium and called attention to two over-arching themes that were voiced by Symposium speakers, including speakers from outside CDC: CDC has a critical role in leading the effort to advance health equity, and partnerships are key. Synthesizing the remarks of CDC speakers and speakers from outside CDC, Dr. Penman-Aguilar offered that, to move us forward, CDC could intensify its efforts to work in partnership with other organizations and other sectors to:

- Identify and address root causes of health inequities;
- Promote a comprehensive approach to health that combines individual-level and SDH strategies for improving health and preventing disease;
- Develop standardized ways to measure and monitor progress in reducing health disparities;
- Make the "business case" for SDH approaches;
- Employ community-based, participatory approaches whenever possible; and

[19] Dr. Penman-Aguilar is currently the Associate Director for Science, CDC Office of Minority Health and Health Equity.

- Develop effective ways to communicate with the public and policy-makers about health equity and SDH.

Dr. Kevin Fenton closed the Symposium by sharing an experience he had earlier in the day, when he participated in a press briefing during which he discussed the increasing incidence of HIV/AIDS among young black men who have sex with men (MSM). Inspired by the day's events, he spoke to journalists about social determinants of health, focusing on the lives of young black MSM and the underlying factors that lead to elevated rates of new HIV infections.

Dr. Fenton reminded participants that "this work matters," and that lives depend on our ability to engage in open conversation about the social determinants of health, including education, poverty, racism, and discrimination. He urged participants to reflect on the day's presentations, challenge themselves and their institutions, and act in partnership to advance health equity.

Appendix 1 SYMPOSIUM AGENDA

2011 NATIONAL CENTER FOR HIV/AIDS, VIRAL HEPATITIS, STD, AND TB PREVENTION HEALTH EQUITY SYMPOSIUM:

Identifying Root Causes of Health Inequities: Using Data to Monitor and Improve Health

Centers for Disease Control and Prevention
Tom Harkin Global Communication Center
August 3, 2011, Atlanta, Georgia

AGENDA

8:00 a.m. – 8:30 a.m.	Registration/Check-in
8:30 a.m. – 8:35 a.m.	Morning Session Moderator - *Dr. Kathleen McDavid Harrison* *Director, Office of Health Equity, NCHHSTP* *U.S. Centers for Disease Control and Prevention*
	CDC Welcome - *Dr. Leandris Liburd* *Director, Office of Minority Health and Health Equity* *U.S. Centers for Disease Control and Prevention*
8:35 a.m. – 8:45 a.m.	NCHHSTP Welcome - *Dr. Kevin Fenton* *Director, NCHHSTP* *U.S. Centers for Disease Control and Prevention*
8:45 a.m. – 9:00 a.m.	Opening Remarks - *Dr. Gail Christopher* *Vice President for Program Strategy* *W.K. Kellogg Foundation*
9:00 a.m. – 9:30 a.m.	Briefing on Institute of Medicine Report: *For the Public's Health: The Role of Measurement in Action and Accountability* *Dr. Steven Teutsch* *Chief Science Officer* *Los Angeles County Health Department*
9:30 a.m. – 10:00 a.m.	State/Local Perspective *Dr. Anthony Iton* *Senior Vice President, Healthy Communities* *California Endowment*
10:00 a.m. – 10:20 a.m.	Break
10:20 a.m. – 10:50 a.m.	Communications Perspective *Dr. Drew Westen* *Professor of Psychology* *Emory University*

10:50 a.m. – 11:20 a.m.	Federal Partner Briefing *Dr. Fred Karnas* *Senior Advisor to the United States Secretary for Housing and Urban Development* *U.S. Department of Housing and Urban Development*
11:20 a.m. – 12:30 p.m.	Panel Discussion - Moderated by *Dr. Kevin Fenton* *Director, NCHHSTP* *U.S. Centers for Disease Control and Prevention*
12:30 p.m. – 1:45 p.m.	Meet and Greet Luncheon and Poster Session
1:45 p.m. – 2:30 p.m.	CDC Challenge/Call to Action *Dr. David Satcher* *16th Surgeon General of the United States* *Director, Satcher Health Leadership Institute* *Director, Center of Excellence on Health Disparities* *Morehouse School of Medicine*
2:30 p.m. – 2:45 p.m.	Break
2:45 p.m. – 4:15 p.m.	Concurrent Workshops: SDH 101: A Primer on Social Determinants of Health *Ms. LaTonya Chavis Keener* Addressing Social Determinants of Health by Influencing Policy and Program Planning Activities *Dr. Leandris Liburd; Mr. Arun Skaria; Ms. Jo Valentine* Using Public Health Legal Research to Drive Policy Development and Improve Health Equity *Mr. Evan Anderson; Mr. Stan Lehman* Measuring, Monitoring, and Linking Social Determinants of Health Variables to Health Outcome Variables *Ms. Mi Chen; Dr. Zanetta Gant; Dr. Matthew Hogben* Practical Solutions for Identifying Social Determinants of Health and Measuring Health Disparities *Mr. Chip Allen; Dr. Sam Harper*
4:15 p.m. – 4:30 p.m.	Reflections on the Day *Dr. Kathleen McDavid Harrison* *Director, Office of Health Equity, NCHHSTP* *U.S. Centers for Disease Control and Prevention*

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