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COMMENTARY

Power, Politics, and Health: A New Public Health Practice Targeting the Root Causes of Health Equity

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Abstract *Purpose* Understanding the WHY, WHAT, and HOW of place-based work in maternal and child health (MCH) is critical to examining the components of the environment that shape health opportunity through the relationship between life expectancy and neighborhood residence. *Description* On September 18, 2014, during the CityMatCH Leadership and MCH Epidemiology Conference, Dr. Anthony Iton provided the Keynote Address focused on the root causes of health inequities. *Assessment* The address focused on issues of equity in California and initiatives designed to mitigate and prevent disparities, including the Bay Area Regional Health Equities Initiative framework. Dr. Iton presented information on how the framework translated into investment strategies and a policy and systems change approach to place-based work. *Conclusion* The field of MCH, because of its focus on supporting health during critical periods of development, is poised to play a significant role in reducing health inequities. Recognizing that human health suffers when low income communities are passive, disenfranchised and disorganized, in order to change this status quo, understanding that human capital is the greatest asset is the urgent challenge to the field of MCH.

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Significance

What is already known on this subject? Place-based public health initiatives are currently being implemented in communities throughout the United States. The socio-political, cultural, and built environments impact population health.

What this study adds? This keynote address provides concrete examples of community-based initiatives in Alameda County, California, that highlight the need for a consistent, place-based approach to program implementation.

Introduction

In Alameda County today, a White child born in the affluent Oakland hills will live on average 15 years longer than an African-American child born just miles away in East or West Oakland [1]. Alameda County is not unique in facing this health inequity, a difference in health that is unnecessary, avoidable, unjust, and unfair [2]; this pattern is consistent in many jurisdictions around the country [3]. Babies born in the U.S. today do not start life on level playing field.

People often think of babies as blank slates; that their futures have yet to be written. Knowing what we know about maternal and child health (MCH), this notion is largely false. Babies are the embodiment of their mother's life experience and the context in which she lived: her

home as a child, the street where she played, the neighborhood in which she grew up, the policies that allowed her to live there, the racism and discrimination she may have experienced, and the systems of privilege and oppression that structured the policies, political decisions, and institutional practices creating her neighborhood. While incubating in her mother's womb, the baby is exposed to her mother's stress levels, altering her physiology and her chromosomal expression. The baby's health at birth is both a measure of this inherited past as well as an ominous predictor of her future life chances [4].

This is not to say the baby's fate is preordained. Her personal decisions and behaviors will ultimately help shape her future. However, where the baby's family can afford to live when she's growing up, whether she will attend good quality schools, have family support to attend college, receive help with a down payment—these circumstances may have been decided prior to birth. In fact, the baby embodies not just the life of her mother, but also the history of this country, a place which shaped the baby's mother's experience. This history includes segregationist policies such as discriminatory zoning rules, redlining, and regressive taxation [5, 6] are examples of policies and practices determining where the baby's parents, their parents, and previous generations lived, what opportunities they had, what they were able to save, and what they could pass on to their children. The result of these policies and practices is the current reality of poor people and people of color disproportionately living in disinvested communities where residents lack access to health-promoting resources, including good schools, healthy food, safety, and strong social networks that allow for collective efficacy and voice in political decision-making.

Ultimately, the Life Course Perspective [4], often discussed in MCH, is about this history. It is this history that has resulted in the life expectancy differences we see by place—a culmination of differential experiences driven by race, socioeconomic status, and neighborhood conditions. The geographic clusters of health inequities that exist all over our nation represent the struggle over the allocation of scarce and precious social goods over time—the very definition of politics. Modern-day interventions that aim to reverse stark health inequities are therefore political; they must be about building power and sustaining an inclusive democratic process that challenges this history.

Addressing Root Causes: A Life Course Approach to Health Equity

The Framework for Health Equity (Fig. 1), adopted by public health departments in the San Francisco Bay Area as well as The California Endowment's (TCE) Building Healthy Communities (BHC) Initiative [7], acknowledges that we must broaden current public health practice beyond medical and health education to include systemic or "upstream" changes needed to create healthy neighborhood conditions where poor health clusters. This includes building power, improving policies, and changing the narrative about what produces 'health' in populations. Overlaying the Life Course Perspective on this framework, we understand that health is the product of one's opportunities and experiences over their whole life, largely driven by conditions during critical periods of development: during pregnancy, early childhood, and adolescence. Opportunities to play, to be safe from violence, to receive a high-quality education, to access healthy food, to have economic opportunities, and to be part of a strong and connected community are critical drivers of health.

The field of MCH, because of its focus on supporting health during critical periods of development, is poised to play a significant role in reducing health inequities and unlocking wasted human potential. Recognizing that human health suffers when low income communities are disenfranchised and disempowered, and that human capital is our greatest asset for changing this status quo, the urgent challenge to the field of MCH is recognizing that *building power is our imperative*. We must transform current MCH practice to incorporate building power as an organizing principle within our existing and new interventions, and we must lend our voices and support to existing efforts that explicitly focus on building power in communities. Efforts to address social determinants of health that lack this focus are likely to fail in ensuring an ongoing and sustainable process for change. *Without building power as the driving force behind MCH practice, we will falter in leveling the playing field, and fail to offer opportunities for success to all of our children.*

The Physiology of Power: Toxic Stress and Allostatic Load

Much progress has been made in recent decades to understand the physiologic mechanisms that link social conditions to health. In short, there are direct pathways—such as through differential levels of healthy food and environmental toxins in certain neighborhoods—and indirect pathways, through the body's response to chronic stress [8]. Day-to-day stress, wherein people have the resources to cope or control it, is common, and learning to manage it is important. It is the body's response to "toxic" stress that is strong, frequent, and prolonged which causes poor health [8]. The experience of repeated unrelenting stress leads to a disregulation of the stress response, called allostatic load. Allostatic load refers to the "wear and tear"

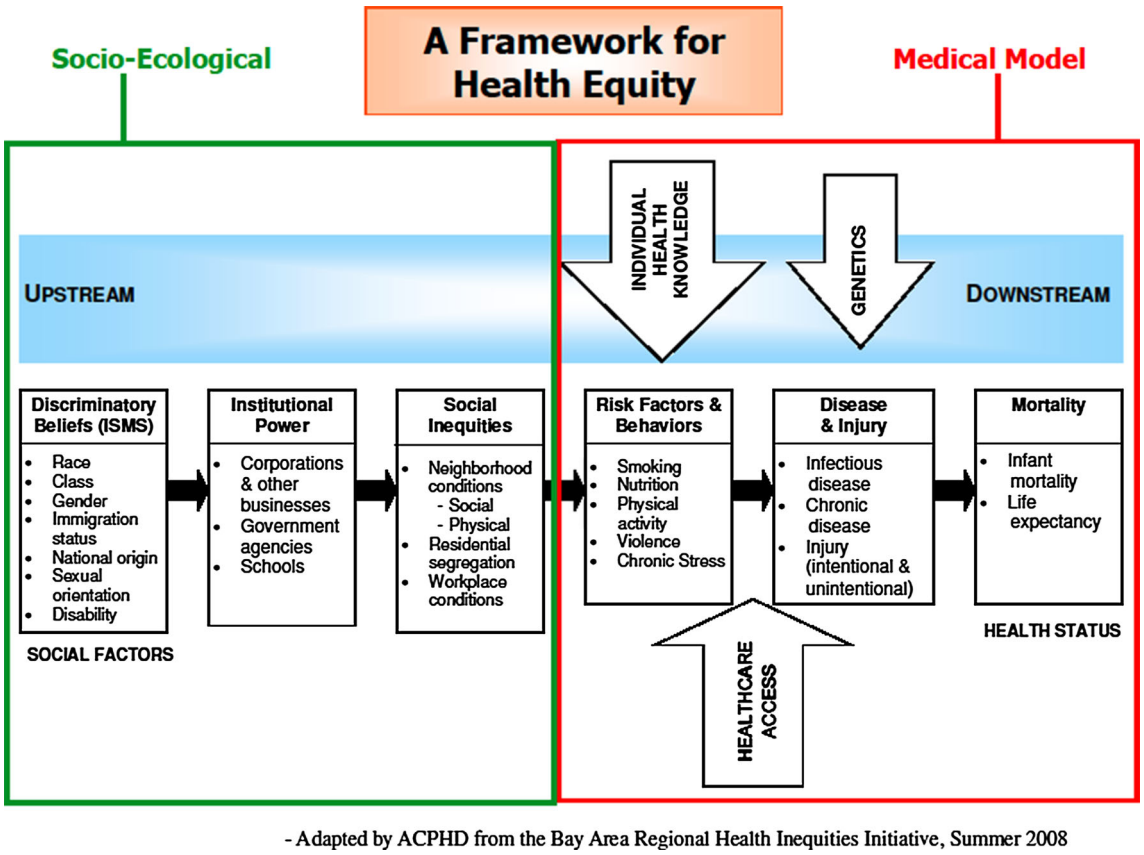

Fig. 1 A framework for health equity

that accumulates in the body's systems that in the long-term leads to biological as well as chromosomal damage [9] and increased likelihood of developing a range of diseases [10].

With more power comes more resources to cope with stressors. In the landmark Whitehall studies conducted among civil service workers in the United Kingdom, even marginal changes in power provided benefits to health [11, 12]. The findings suggested that power in the smallest unit allows one to have control over one's own life. On a collective scale, power determines political agendas and the allocation of resources that impact health.

A New Public Health Practice: The BHC Initiative

BHC is a 10-year, $1 billion initiative launched by TCE in 2010 to transform 14 of California's communities most impacted by health inequities into places where all people have an opportunity to thrive [13]. BHC employs five drivers of change to ensure an inclusive and democratic process that will sustain the momentum of building healthy conditions beyond the tenure of the project itself. Below we share the drivers of change, how they have been applied to East Oakland's BHC site, and then consider what it takes to forge a new MCH practice to achieve health equity:

BHC Drivers of Change

(1) *People Power* Resident leadership and organizing is foundational for people to influence the policies and politics that shape the environments in which they live. In addition, challenging systems and institutions to change their decision-making structures to include authentic community participation is critical for sustained change.

(2) *Youth Leadership Development* Supporting motivated and activated youth leaders in reaching their full potential and serving as leaders is essential in the movement to create healthy and just communities. BHC also aims to make it a norm within local systems and institutions to include active participation by youth in decision-making.

(3) *Enhanced Collaboration and Policy Innovation* Aligning unlikely partners—key systems, community-based organizations, and residents working in diverse arenas such as land use, education, law enforcement, social services and health—around a

shared vision for healthy communities is essential to maximize resources and drive critical policy and systems changes over time.

(4) *Leveraging Partnerships and Resources* Leveraging public and private sector resources from foundations to corporations to policymakers will multiply the value of TCE's direct investment many times over and ensure sustainability.

(5) *Changing the Narrative* BHC is working on a new narrative about community health and prevention—one that recognizes the environmental, political, and economic determinants of health and moves the dominant frame from one focused on personal responsibility and exclusion to one focused on collective action and inclusion. Instead of just medical care and individual behavior, we want people to hear 'health' and think of parks, grocery stores, and good schools.

East Oakland BHC

In East Oakland, the drivers of change have been applied to develop the following strategies:

- *Building Authentic Resident Power and Voice* Residents are organizing Neighbor Nights to build community and celebrate the arts, culture and history of East Oakland; residents are supporting families experiencing violence and trauma; a youth leadership board awards mini-grants to young people for community projects and helps plan other engagement opportunities; and young men and women are representing East Oakland at statewide activities convened by TCE.
- *Creating Innovative Health Protective Policies* The Land Use Work Group is advancing multiple efforts to create healthier neighborhoods by creating Healthy Development Guidelines—a proposed set of planning guidelines that would require any new development projects to consider health-related impacts on residents and the environment.
- *Creating A New and Inclusive Narrative* Meaningful work for a living wage is health protective. Low-income communities of color, particularly men, have been systematically dislocated from the labor force and other opportunity structures for several decades. The Economic Opportunity Work Group is focused on projects that create real jobs with livable wages and benefits. The Health Careers Pipeline is a project to facilitate job training and placement in allied health careers. Work For All was a regional summit that brought residents and organizations together for a deep discussion on creating an inclusive economy for groups such as youth, the formerly incarcerated, and immigrants.
- *Collaborating to Transform Systems* The East Oakland BHC Health Access Work Group is breaking down traditional silos to create new partnerships with untraditional partners like immigrant rights groups and formerly incarcerated populations to support insurance enrollment. Its subcommittees are focused on data collection and analysis to inform future policy change efforts to assist the uninsured.

A New MCH Practice: Moving from Here to There in Alameda County

As has been previously described, transforming MCH public health practice requires attention to organizational change, cross-sector partnerships, and addressing social determinants of health in program design [14, 15]. In addition, a new MCH practice must incorporate attention to power along a spectrum from the individual to the collective. How do we build on current MCH practice to incorporate attention to power?

The Alameda County Public Health Department (ACPHD) has recently undertaken efforts to transform MCH practice. A first step ACPHD has taken is to create a staff culture that encourages clients' individual agency and sense of control over their lives. Trainings have been conducted on race, power, and privilege to create more awareness of how they operate on interpersonal and institutional levels. In addition, programs have been altered or started to build upon the knowledge and self-determination of clients and residents, including the following:

ClubMom

This project of ACPHD's Healthy Start Initiative is a non-traditional model of health education for African American women at risk for adverse birth outcomes. This model challenges the current paradigm of providers as experts and encourages knowledge sharing among clients in a group setting. The goal of the project is to positively change the context in which young African American mothers make decisions around their health and related behaviors to include social support, health information, knowledge of resources, and health-seeking motivation. The program blends health promotion with life skills development, for example repairing credit, navigating going back to school while receiving public assistance, and understanding one's intimate relationships.

MCH Client "Asset-Building Grants and Loans Pool"

This program, supported by the California Wellness Foundation, builds on the self-determination of current program

clients and is premised on the idea that access to flexible capital opens up opportunities for people to move toward economic and social mobility. This program will offer small-dollar grants and loans to be used flexibly for education, childcare gaps, small business development, and other client-identified needs. The program is being designed now based on lessons from ACPHD's long-standing mini-grants programs, the Family Independence Initiative's resource bank [16], and international microfinance models.

Best Babies Zone

In 2012, ACPHD launched one of three sites of a new project led by the University of California, Berkeley called the Best Babies Zone Initiative (BBZ). This place-based project, funded by the W.K. Kellogg Foundation, the California Wellness Foundation, and TCE, is focused on a 7 by 12 block area of East Oakland and has the goal of achieving community transformation to ensure a healthy future for the neighborhood's children. Strategies to reach BBZ's goals include:

- *Resident leadership* Resident leaders in the area are implementing "small win" solutions to issues that matter to them with the support of a program called the East Oakland Innovators as well as through a mini-grants program.
- *Building a vibrant local economy* A local community market is lifting up local entrepreneurs, providing small business supports, and creating a unique opportunity to buy local goods and services to keep money circulating in the local economy.
- *Early childhood hub* A dynamic partnership of government agencies and local organizations are growing an early childhood center in response to resident concerns over the lack of safe places to take young children. Program offerings include playgroups, fatherhood support groups, and resident-led parenting groups.
- *Home visits* All pregnant women and babies born in the area are offered a home visit from a nurse or case manager.

Making the Case: Using Data as a Call to Action

Data play a critical role in the movement toward health equity. Research is critical to reveal health inequities and their underlying causes. In the last decades, social epidemiologists have helped redefine health as a socially patterned process that develops over time and through generations—separate from medical care and subject to forces outside of individual bodies and wills. There is growing conversation in the field to develop a more practicable social epidemiology [17, 18]. Research that accounts for historical context [19] in patterns of health over space and time will be especially valuable to understanding the social processes underlying health development.

Local level data revealing the spatial patterns of health outcomes and correlations to income, housing, education, and other important social determinants of health can be used in a call to action to develop cross-sector partnerships, policy analysis, and innovative solutions [20]. Public health departments and epidemiologists can also partner with local organizations to lend data expertise and a credible voice to policy advocacy efforts [21]. Data also plays a critical role for the thoughtful evaluation of innovative public health approaches that intend to address root causes. It is essential that these evaluations are sensitive to context and process, and have appropriate time frames for change. Given that inequities developed over time, we must expect their undoing to take time as well.

Conclusion

The World Health Organization asserts that any action to address health inequities is a political process that must engage "both the agency of disadvantaged communities and the responsibility of the state" [22]. It is time as public health professionals that we turn our gaze toward this challenge. Attempts to address health disparities will fail unless we acknowledge that changing our practice is inherently political and potentially controversial. The evidence is before us and we must not hesitate. Take action today: whether it is reflecting on your power in relation to the communities you serve, implementing dialogues in your organization on how to incorporate power-sharing with those you serve, or designing new programs designed to build collective power for change. The current reality of health inequities driven by race, income and place did not emerge overnight, nor will efforts to undo them happen overnight, but today we must begin.

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