A Disparity Foresight Briefing
Beyond Health Care Reform: Health and Equity in All Policies

October 20th, 2009

Meeting Summary

Introduction

On October 20, 2009 The Disparity Reducing Advances Project (DRA Project), in conjunction with the Congressional Black Caucus Health Braintrust, held its fourth Disparity Foresight Briefing on Capitol Hill. The subject of this fall's meeting was *Beyond Health Care Reform: Health & Equity in All Policies* and focused on factors outside healthcare which directly affect a person or a community's health, known as the Social Determinants of Health (SDOH). This is part of the "health equity movement" - like the anti-slavery movement, women's rights, civil rights, and environmentalism – the health equity movement will take a long time to develop.

Many of the issues surrounding the health equity movement lay in creating awareness and understanding of the true meaning of the movement. As a number of the speakers, and members of the audience, pointed out, health equity is not about healthcare, but rather about the lived environment of those who are disproportionately affected by poor health. Access to healthcare accounts for only 10-25% of the variance in health while 60% can be attributed to the social determinants of health, such as access to healthy food, safe communities and parks, and air quality. However, many people narrowly define health equity within the scope of healthcare. This meeting aimed to broaden that view by highlighting key issues which are not traditionally associated with health, but have significant health impacts, and to call attention to Health Impact Assessments (HIAs). The briefing also stressed the importance of using HIAs as a tool to assess the health impact of policies in the communities they affect.

The DRA Project and its Partners Network of over 65 organizations recently released two memos on the health equity movement (*The State of the Health Equity Movement* and *Health Equity Policies: A Review of the Recommendations*). These memos look at the recommendations being made in local, state, national and international efforts to achieve health equity. The DRA Project, a project of the Institute for Alternative Futures, is a multi-year, multi-stakeholder venture created to identify and accelerate advances which may lead to the reduction of healthcare disparities. The Disparity Foresight Briefing was held with support provided by Novo Nordisk. Details on the DRA Project partners, sponsors and reports are available at www.altfutures.com/draproject.

The panel comprised of leading experts from the fields of health disparities and prevention. Congresswoman Donna Christensen, Representative of the US Virgin Islands, Second Vice-Chair of the Congressional Black Caucus, and Chair of the CBC Health Braintrust, gave opening remarks. The panel consisted of Larry Cohen, Executive Director of Prevention Institute; Brian Smedley, Vice President and Director, Health Policy Institute at the Joint Center for Political and Economic Studies; and Adolph Falcón, Senior Vice President of the National Alliance for Hispanic Health. Clem Bezold, Chairman of the Institute for Alternative Futures and Program Director of the DRA Project, moderated the event.

Opening Remarks by Congresswoman Donna Christensen
The Disparities Foresight Briefing is the second formal event that the CBC Health Braintrust and the Institute for Alternative Futures have held together. The Congresswoman noted that she, along with all of the panelists and many in the room, have been working for a number of years to eliminate health disparities.

According to the Congresswoman, we're not far from where we were in 1985 when Health and Human Services Secretary Margaret Heckler issued a major report stating there were 66,000 excess deaths in the African American community due to health disparities. Today that number stands somewhere around 88,000. In this respect, we have not advanced and we may have actually gone backwards. This continued disparity has driven the Congresswoman to work with the Tri-Caucus to push the cause of health disparities to the forefront, including working tirelessly on the healthcare reform package to ensure that consideration of health disparities remains in the final bill.

Congresswoman Christensen also pointed out that Prevention Institute, the DRA Project and others are working to get prevention scored as part of the review of legislation by the Congressional Budget Office. Currently, scoring of legislative proposals does not adequately consider the potential savings from prevention, particularly the long term savings.

The Tri-Caucus has been working with the Congressional Budget Office and the Obama Administration to address the savings that are in healthcare reform, particularly HR Bill 3200. This bill includes both prevention and disparity elimination efforts, the savings from which could pay for the entire healthcare reform bill. Simply put, "the biggest impact that we will make on reducing healthcare costs is by making sure there is health policy in every policy."

One important recommendation that the Congresswoman gave the president during that meeting was to create an executive order to ensure that government agencies at the very least be required to include a health impact assessment (HIA) in their policies. At the very best, there should be a policy that would improve, or help to improve, the environment to better impact the health of communities. The Congresswoman invited everyone in the room to take part in this effort to talk to the White House. She noted that if the executive order did not happen, then they would look at ways to jumpstart the effort congressionally to consider health and equity in all policies. She pointed out that this is where we will see the greatest amount of savings, not just in money, but in lives.

Larry Cohen, Executive Director of the Prevention Institute

Larry Cohen is the founder and executive director of Prevention Institute, a non-profit national center dedicated to improving community health and well-being by taking action to build resilience and prevent problems *before* they occur. Prevention Institute moves beyond approaches that target individuals to those that create systematic, comprehensive strategies that alter the conditions that impact community health, with a particular focus on equitable health outcomes.

Cohen opened his remarks with an illustration of health disparities in the San Francisco Bay Area. An African American child born in the low-income area of East Oakland, and a white child born 10 miles away in the affluent West Oakland Hills have an average 15-year difference in life expectancy. Put another way, for every $12,000 difference in income, there would be a difference of one year in life expectancy.

The major determination of differences in health outcomes is not genetics, but rather the environment in which a person lives, works and plays primarily determines a person's health and life expectancy. Many people understand the link between the environment and safety in terms of toxins, pollution, air, and soil; however, the social environmental also plays a significant role in shaping health. The way our environment is constructed, the types of services and products we have access to, and how we get around all affect our wellbeing. The environment shapes norms, which affect our behaviors, and in turn affect our health and safety (e.g. smoking regulations in the workplace). Cohen introduced a series of pictures that capture the link between health and food, transportation, violence, and physical activity. According to the Institute of Medicine, "It is unreasonable to expect that people will change their behavior easily when so many forces in the social, cultural, and physical environment conspire against such change." For example, we are more likely to thrive in an environment where there are safe places to play and where there is access to healthy food.

Cohen called for taking two steps back from an immediate health concern to look at the underlying causes and the relationship between exposures, the environment, behaviors, and health - what he called Two Steps to Prevention. Currently, we focus on the treatment of injury and diseases, but medical care alone cannot reduce injuries and inequalities as healthcare services are not the primary determinant of health. Treating injuries and/or disease only treats one person at a time, rather than addressing the underlying cause of the injury or disease. Additionally, medical treatment often comes too late or cannot fully restore the sufferer's health.

One example he gave was automobile crashes, a leading cause of death and injuries. Taking a step back, it becomes clear that crashes are primarily caused by social behaviors, such as drinking and driving. To see the larger picture, take another step back to look at the environment that encourages drinking and driving – including widespread advertisements for alcohol as well as the emphasis on driving and the lack of viable public transportation. Looking at this broader view of behavior and the environment leads to different solutions which are focused on the community. Moving the focus from one person at a time allows for changes to be made on a larger scale in the environment.

There are key opportunities in the stimulus funding and in health reform to promote health, safety, and equity. Health reform will likely contain resources for community oriented primary prevention , including a Prevention Investment Fund, which would provide support for sustained investment in prevention throughout the nation, and support for prevention research that would continue to identify the most effective strategies for prevention and equity.

The Health Equity and Accountability Act of 2009 (H.R. 3090) incorporates key elements for promoting health equity and is directly relevant to heath reform, including elements such as:

- **Environmental Justice:** Reducing health disparities by strengthening Environmental Protection Agency efforts.
- **Health Empowerment Zones:** Funding and coordination of services for organizations in communities that disproportionately experience disparities in health status and healthcare.
- **Community-Based Practice:** Codifies the CDC's Racial and Ethnic approaches to community health programs.
- **Congressional Budget Office Scoring of Prevention:** Requiring the CBO to incorporate health care savings associated with clinical and community preventive services and programs when scoring legislation.

Community prevention strategies should focus on the Triple Bottom Line: health, environment and the economy. To help strengthen community prevention, community leaders should engage in intersectoral partnerships and multi-field collaborations. Cohen emphasized that the way to ensure prevention and equity outcomes is to consider health and equity in all policies. Prevention Institute developed for this Disparities Foresight Briefing a table that identifies key health and equity impacts in the major policy areas of transportation, healthcare, economic development, education, housing, violence prevention, and food/agriculture. The *Health and Equity Impacts* chart can be found in the Appendix below. Additionally, to achieve effective prevention outcomes, community members must be engaged in developing the strategies and solutions. Communities should also employ grassroots marketing, which includes training community members to educate their peers.

Cohen also focused on the importance of safety and violence prevention, stating that without safe communities, we can never have health equity. There are a number of things that cities can do to create safety within their communities. Cohen presented the UNITY Project's recommendations for community safety, including fostering high-level leadership and community engagement to provide

communications, programs, training and capacity building. The *UNITY RoadMap* also tells how to develop strategic plans, conduct evaluations, and seek funding.

Highlighting the fact that violence needs to be considered as a focus of health equity, Cohen pointed out the violence prevention aspects for key policy areas from the *Heath and Equity Impacts* chart he had drafted:

- Transportation – Safe, reliable methods of getting around (The Surface Transportation Act of 2009)
- Health Care – Preventative services that are responsive to community needs (Health Reform)
- Economic Development – Social networks and trust built on strong ties among persons and positions (American Recovery and Reinvestment Act of 2009 and The Livable Communities Act, S. 1619)
- Education – Students have safe, comfortable environments for learning (No Child Left Behind and Child Nutrition and WIC Reauthorization Act)
- Housing – Access to safe, affordable, available housing (The Livable Communities Act, S. 1619)
- Housing – Neighborhood look, feel and safety (The Livable Communities Act, S. 1619)
- Housing – Parks and open space for safe physical activity (The Livable Communities Act, S. 1619)
- Housing – Access to healthy foods (The Livable Communities Act, S. 1619)
- Housing – Access to services (The Livable Communities Act, S. 1619)
- Violence Prevention – Look, feel and safety (Youth PROMISE Act and other violence prevention efforts)
- Violence Prevention – Safe, clean accessible parks and open spaces (Youth PROMISE Act and other violence prevention efforts)
- Violence Prevention – Safe, reliable methods for getting around (Youth PROMISE Act and other violence prevention efforts)
- Violence Prevention – Students have safe, comfortable environments for learning in school (Youth PROMISE Act and other violence prevention efforts)
- Food – Neighborhood access to health, fresh, affordable and culturally appropriate foods (Farm Bill and Child Nutrition and WIC Reauthorization Act)

As a final example, Cohen told the story of a library in Salinas, California, which implemented its own anti-violence measures. Noting that there is a strong connection between literacy, safety and educational success, Cohen described how the chief librarian eliminated the need for children to present identification in order to obtain a library card. She then took the next step and handed out library cards to every child at a local school. Two weeks after distributing the cards, the number of books checked out of the library tripled. Seeing the power of this act, Cohen asked her to make it a national initiative. To Cohen, this was an excellent example of safety prevention and illustrates how one shift in thinking can change community policy and norms.

Brian Smedley, Director of Health Policy Institute at the Joint Center for Political and Economic Studies

The Joint Center Health Policy Institute recently released a report titled *The Economic Burden of Health Inequalities in the United States*. The report calculated the economic cost of health inequities in terms of both costs to the medical system and lost productivity due to time off work and fewer years of productive life, among other factors. Over a four-year period between 2003 and 2006, the report found that the United States was spending $50 billion on direct medical costs a year due to health inequities.

Smedley went on to say that, factoring in indirect medical costs, the total cost of health inequities during this time period was $1.24 trillion.

A key challenge to moving "upstream" to address health inequities, he noted, is that in the United States we equate medical care with health status. Yet there are several neighborhood factors that influence health both directly and indirectly. Many of the negative environmental factors affect people of color disproportionately, setting them up from a very young age for poor health. A number of studies have shown that a child's neighborhood, school and family environment are primary factors in a child's health and development. Yet many children of color live in highly segregated neighborhoods and attend segregated schools. Some of these neighborhoods, Smedley noted, resemble the level of segregation found in apartheid-era South Africa, and are associated with poor cognitive, health and life outcomes. The lack of access to "opportunity neighborhoods" or "opportunity schools" is associated with racial/ethnic segregation, and can't be accounted for by income differences alone.

Segregation has a number of negative effects on health and human development by concentrating poverty, as well as excluding and isolating communities of color from the mainstream sources of success such as adequate schools and safe places to play. Segregation also restricts socio-economic growth and opportunity by placing non-whites into neighborhoods with inadequate public schools, fewer employment opportunities and smaller returns on real estate. This is not just a matter of poor income. Smedley points out that African Americans are more likely to reside in poorer neighborhoods regardless of income level.

The pernicious effects of segregation are passed down through the generations. The same piece of real estate purchased in a low income or segregated community is not worth as much as a piece of property bought in an integrated or high income neighborhood. When this property is passed down to children, it has a lower value in the low income community, and is one of the major reasons there is a tremendous wealth gap between whites and people of color. It is also a major predictor of health disparities.

African Americans are five times less likely than whites to live in areas with super markets, and African Americans and Hispanic neighborhoods have fewer parks and safe places for physical activity. Additionally, low income communities are more likely to be exposed to environmental hazards than upper and middle income neighborhoods. As an example, 56% of residents in neighborhoods with commercial hazardous waste facilities are people of color, even though they comprise only about a third of the United States population. Compounding the issue is the fact that it costs residents of poor communities more for the same consumer products than in higher income neighborhoods, adding a "Poverty Tax" to people in poor communities.

Smedley argued that evidence suggests doing five things:

- Focus on prevention, particularly on the conditions in which people live, work, play and study
- Look to multiple strategies across sectors
- Sustain investment and long term policy agendas
- Implement place-based strategies such as investments in communities
- Focus on people-based strategies such as increasing housing mobility options

There are also a number of place-based strategies that communities can take to become healthier. These strategies include improving food and nutrition options through incentives for farmers markets and grocery stores, and placing regulations on fast food and liquor stores. Communities can also structure land use and zoning policy to reduce the concentration of health risks and institute Health Impact Assessments to determine the negative or positive health consequences of new housing, transportation, labor and education policies. Additionally, communities can improve their air quality by

relocating bus depots from areas near homes and schools, expand the availability of open space and address disproportionate environmental impacts through Brownfield redevelopment.

The Health Policy Institute started a program called Place Matters which works in a number of communities across the country to build their capacity to address the social and economic determinants of health. The program arms leaders with data to enable them to identify and measure conditions and provide evidence-based strategies to promote health. Some examples of where Place Matters has implemented strategies to improve community conditions for health include:

- **Bernalillo County (NM)** – analyzing land use policies to address the disproportionate burden of environmental pollutants on minority and vulnerable communities, raising awareness of the cumulative impact of multiple environmental and social stressors on the health of the community.
- **King County (WA)** – educating and mobilizing community leaders to engage in discussions about racism, discrimination and privilege in order to raise awareness about their relationships to health inequity, and to build support for a robust policy agenda developed through a collaborative stakeholder engagement process.
- **San Joaquin Valley (CA)** – seeks to reduce motor vehicle injury and fatalities by raising public and policymaker awareness of inadequacies in the area's transportation infrastructure, particularly in low-income migrant worker communities.

Smedley concluded his remarks by stating that this is not just a public health issue, and the public alone cannot solve this. It must be multi-sector and engage other stakeholders and policymakers. Quoting from the World Health Organization Commission on the Social Determinants of Health report from 2008, "[I]nequalities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social and economic forces. Simply put, the bottom line of this report is that these health inequities are avoidable and the result of policies and practices." We can take WHO's statement as inspiration as we, in the U.S., create health and equity for all.

Adolph Falcón, Vice President for Science and Policy for the National Alliance for Hispanic Health

Adolph Falcón briefly described the work of the National Alliance for Hispanic Health, which focuses on community based solutions and providing services to over 15 million Hispanic patients. He advocated for a health reform agenda which focuses on good/healthy food, physical activity, clean air, clean water and an understanding of the social determinants of health.

Factors that Falcón addressed include the lack of community recreational spaces and the link between this lack and reduced physical activity in communities of color. Creating or promoting open spaces for physical activity has been shown by the CDC to increase the number of physically active residents by 25%. Hispanics and non-Hispanic Blacks are 8.6 times and 3.3 times, respectively, more likely to live in neighborhoods without recreational facilities than their non-Hispanic white counterparts.

Air and water pollution also play big roles in the poor health of minority communities. Mexican Americans are 3 times more likely to be exposed to herbicides than non-Hispanic whites. Water pollution disproportionately affects Hispanics who actively fish for recreation and as a food source. Many members of these communities are unaware of the high levels of mercury contamination in the water they fish and the fish that they eat.

However, it is also important to note the powerful, positive force community can have on health. Hispanic communities are much more likely than others to be uninsured, overweight and have diabetes, yet they have better life expectancies than other racial/ethnic groups. There may be a

powerful, underlying factor influencing the health of these communities. Culture can be playing a positive, protective role in these communities, but health research rarely looks at the role of the family and culture in well-being.

The National Alliance is working with the National Institutes of Health and the National Hispanic Health Institute on a $61 million dollar study on Hispanic health. The study will work with 16,000 people over 6 years with the goal of identifying the prevalence and risk factors for disease, disorders and other conditions in U.S. Hispanic communities. The study is finding that, as Hispanic communities adopt North American norms, they are also shortening their life spans. Falcón worries that after the next generation, we will no longer be able to say that Hispanic Americans have the highest life expectancy rates. He also encourages us to look at not only what is going wrong in these communities, but more powerfully, what is going right, to find the lessons this offers for life in these communities.

Falcón then turned to the environment, saying that we are often missing the mark in our analysis. Often, he says, we think about the environment in terms of air, water and plants, but we rarely look at it in terms of humans. There is not enough data on air pollution in poor communities, for example. Most data about poor air quality conditions is gathered from stationary platforms that are seldom located in African American or Hispanic communities. To increase this data, the National Alliance for Hispanic Health created cell phone-sized air quality censors, fostered a relationship with Google Earth, and gave them to kids to collect the data while they walked from home to school. The information was displayed on Google Maps showing the environmental risks that they face in their communities.

Falcón also announced the ¡Vive Tu Vida! Block party which the National Alliance for Hispanic Health and the Health Foundation for the Americas has been holding since 2007. The event offers opportunities for physical activity, sports and most importantly, health screenings. Over the course of the three years that this event has been held, it has brought in over 25,000 participants, with 86% attending with their families. The Block Party typically starts at 9 am and goes until 5pm, but participants begin to line up as early as 7 am to get a health screening. Falcón pointed out that this shows that people are willing to put in the time, they just don't have access to adequate or affordable healthcare options. He also noted that the screenings do not close until everyone has been seen.

Falcón then addressed a number of recommendations and objectives that the National Alliance for Hispanic Health had created to address health in policies outside healthcare. These recommendations parallel the health impacts of policies identified in the Prevention Institute table in the Appendix. These include:

Good Food to Eat

- Tailoring food subsidies to healthy food goals
- Child and Adult Care Food Program standards
- WIC and Food Stamp use in Farmer's Markets
- Tax Incentives for supermarkets in "food deserts"

Places to Play

- Targeting of stimulus to recreational spaces
- Link Community Development Block Grant to plan requirement for community recreational space
- Incorporate safe places to play into community oriented policing services

Clean Air and Safe Water

- Revamping clean air and water monitoring to include community-based monitoring
- Expand human health monitoring of EPA
- Support ATSDR program for linkages between city and state health and environmental departments.

Understanding the Social Determinants

- Include Congresswoman Christensen's amendment on disaggregation of data under health reform legislation
- Mandate annual compliance report from NIH on the inclusion of racial and ethnic minorities in the research it funds.
- Move from disparities to "best outcomes for all" model that recognizes the positive role of culture and community in health outcomes.

Finally, Falcón stressed the importance of having Hispanic young people enter the more challenging fields of science, technology, engineering and math (STEM) and announced a new $4 million initiative to give scholarships for students entering these fields.

Questions & Discussion

Question:

There is impressive work going on in communities around the country, but it seems to be a patch work of things. What is it going to take to get a national strategy?

Smedley:

Much of the action and choices are local, but there is a need for strong Federal leadership. There are some Federal opportunities that can be promoted, such as REACH from CDC, though that needs more resources. There may be opportunities in the stimulus package for that.

Cohen:

I'm strongly in agreement with that. We worked with the Institute for Alternative Futures two and a half years ago on a couple of papers related to equity and prevention. The second one had a funny premise, that being "what if someday people asked for a strategy, will we be ready, and what needs to be done?" We equated this health equity movement to the Marshall Plan or the Manhattan Project. It requires strategy that is both larger and more focused in order to achieve health equity in this nation. Again, there are a lot of really good initiatives, such as REACH or Place Matters, as Brian mentioned, or a number that have been funded by Strategic Alliance in California.

Falcón:

One of the things that we're committed to is that every child should be within 10 minutes of a safe place to play. We're working with the US Soccer Foundation on a commitment to build something in every community that wants it. We have seen that, as a supermarket transforms a community, so does a safe place to play.

Question:

Studies have shown that the longer a migrant is here in the United States, the unhealthier they are. I think we need to think of three or four things that are attainable and get the groups both here and others to agree to push for those in legislation.

Falcón:

True, access to fresh fruits and vegetables are closely linked to childhood obesity, and that's a solvable issue that can be resolved through tax and zoning efforts aimed at eliminating food deserts. All the data shows that culturally, there is a better diet, but we are learning bad health habits as we adopt North American norms. We, as Hispanics, also consistently see negative information about ourselves as a people. When we talk about this in our community, we are happy to hear something positive about our cultural practices, and how that can positively affect our health. But you can't expect someone with no car and who is living miles away from a super market to routinely access healthy foods.

Cohen:

We need to look at recreation and transportation. The *Health and Equity Impacts* table is only in draft form right now, and we would love your input. But I don't want the notion of low hanging fruits to make us feel like safety is too hard. If airports are safe, our communities should safe. It's achievable now, and cheaper than prison.

Question:

Where is health planning in this whole process? Where are the financial incentives to take health seriously? I don't see it in the healthcare reform bills, or Healthy People 2020. What can we do to make this more real?

Smedley:

Thank you for continuing to bring to our awareness of ourdisconnect around the continual need to have a broader set of goals and objectives surrounding health and equity. As one example of our myopia around this issue, many folks in this room are aware of the problems surrounding CBO scoring of prevention, but many don't understand what prevention means. This allowed critics of investing in prevention to narrowly cast it as medical prevention, such as screenings and immunizations. Ours is a more holistic approach that will lead to savings.

Question:

We tag on all these notions of violence onto health reform, but the reality is, Larry, we can't take one step back; we have to have a trickledown effect to reach individuals and communities. Domestic violence spreads across all areas of health concerns, and has a measurable impact on health. How do we take these broader policies and initiatives and put them in the back yard of the American home?

Cohen:

Earlier this year I was invited to a White House meeting on gangs, and I was the only person in the room representing the health sector. It is critical that the health sector be there because no one *really* gets primary prevention. The good news from this White House meeting is that these groups, police, mayors, etc., are saying that they can't do it alone. They need the health sector involved. They also acknowledged that we need to

go back and find some positive strategies. The farthest back they went was prison re-entry programs. There are a variety of strategies to ensure that people are less likely to re-enter prison, including incentives and monitoring them very carefully. But this is an approach that takes people in trouble, puts them in prison where they learn all the terrible things we don't want them to know, and then we work with them only after they get out. We need resources much earlier on, and focus on changing the community and the environment. It's clear that locking people up doesn't work. It makes more sense to spend that money earlier. It's only a question of attention and political will.

Question:

How do we increase awareness in communities of color or underserved communities that they are at an increased risk of poor health?

Smedley:

There are two things that you're asking with this question, that being awareness and empowerment - empowering communities. We need to amplify their voices to make sure that the 535 members of Congress hear them. It's ironic that 5 out of the Gang of 6 working on healthcare reform come from states that are overwhelmingly white. They do not reflect the demographics of the country. As I said earlier, the health status of people of color increasingly defines the nation's health status. Political pressure needs to be applied, so they are compelled to do the right thing not only because of the data, but because of the politics of it.

Falcón:

One of the things that came out of our initiative to map air pollution was that our kids got together with community groups and bought a hybrid van to take legislators through the neighborhoods were these kids live. The legislators were not aware of the negative health effects of the pollution until they saw the neighborhoods where the data came from. These toxic tours lead to the development of community spaces including the redevelopment of water-ways into "blue-ways" in that community. We are now negotiating with legislators to put highways underground and putting parks above ground. There's no one solution, but these health-focused solutions have a more lasting impact.

Question:

Do you know of any ways that those in this room who want to make sure that their focal and coordinating points can help ensure Healthy People in a trans-agency groups working with HHS or the White House take into consideration the health impacts of all policies? Things like tackling the IOM tracking of the ARQH report and making progress towards the plans laid out in that report.

Cohen:

It's not going to come from just one of us. Although we've had these discussions before, I do believe momentum is growing. Right now we need a meta-strategy, such as identifying: is it CBO scoring? Is it pushing on the Health Reform bill? It's probably too late there to include equity. What do we need to do on a local level, or build on a community level? We also need to look at where academic research can advance the work Brian did on economics with *[The Economic Burden of Health Inequalities in the United States](.)*. This is important not just for low income people, but also for people who

need to be persuaded and whose paradigms need to be shifted. We should begin working on those points that need to be pushed on.

Bezold:

This is like the Civil Rights movement, it's that significant. I want to say to Larry that I heard your call to do a planning meeting. Since we have not yet found a funder for it, the DRA Project, Prevention Institute and relevant colleagues should go ahead and have the meeting.

In terms of the *Healthy People 2020* as a focus for the national strategy, that is not the right place for this, though ironically the Healthy People 2010 process is one of the reasons I started the DRA Project. As we've said, the health equity movement is the next civil rights movement and as Larry said, it needs a combination of the Marshall Plan and the Manhattan Project. It reflects society changing its mind as we did with slavery, women's rights, civil rights and the environment. Equity is next, and that includes health equity. The cases of "society changing its mind" are often preceded by major statements of goals that are unachievable at the moment in which they are stated, but visionary, non-the-less. *Healthy People 2010* made such a statement. One of the two overarching goals is "the Elimination of Health Disparities." That is an historic statement.

In the mid-1990's I had the honor to work as a consultant to Surgeon General Satcher when that goal was set. I was facilitating a meeting of the Secretary's Council (HHS Secretary) and the group had a draft of the language to "eliminate health disparities" for HP2010. The Secretary's Council did not think it was possible to achieve this goal, but it was the right one to have. The language to "eliminate health disparities" became one of the overarching goals of the Federal Government. Obviously we have not eliminated health disparities in this decade, but Healthy People 2010 put the US on record as aspiring to do that. I started the DRA Project to accelerate advances that would help achieve this goal.

Question:

Health is affected by a large number of policies, but it goes unconsidered. There's a movement afoot to push the Health Impact Assessments and the best report that any of us can find is by the Partnership for Prevention which worked with the UCLA Center for Health Impact Assessment to create a report for Congress and agencies to implement Health Impact Assessments.

Ripley Forbes from Partnership for Prevention is here today, so I wanted to ask you, Ripley, given that your organization has done a great report on Health Impact Assessments and how Congress and agencies can conduct HIAs, what reactions have you seen, and would you adjust your recommendations?

Ripley Forbes:

We haven't received as many calls of interest from Congress as we had hoped, but the good news is that Senate Bill 1679 includes a provision for setting up HIAs at the CDC in the Environmental Health Center. HIAs are a powerful and useful tool when used, but right now we don't have a great many people, at least in this country, who use them on a regular basis. However, if we did them more often it would make it easier for community leaders to make the decisions that optimize health, such as building a road in a different location that has a lower impact the community's health.

The Transportation Prescription report is a tremendous resource. It basically lays out the direct and indirect effects of transportation policy on health. Next year Congress is going to be deciding the Transportation Bill, and that's the place to start, but

it needs to be more than just HIAs, we need to get money to communities to actually do HIAs themselves. Unless communities actually have an assessment were they can quantify the impact on health, necessary policy and construction changes won't be made.

Question:

There's a tricky issue with the HIAs, because, as with the Environmental Assessments, they can get narrow very quickly. This Briefing is focused on health and equity in all policies, which you and Prevention Institute promote. The World Health Organization released a report recently which looks at the history of HIAs, calling for a greater focus on equity. They point out that over the 20 year history of HIAs, equity has been mostly left out. So Larry, I'd be curious, given this context, in encouraging HIAs, do you have any cautions or additions you would recommend in conducting HIAs?

Cohen:

California is just one place where Environmental Impact Assessments have a bad name because they add a lot of bureaucracy and complications. We need to be really careful that, with HIAs, we make sure that they don't become an obstruction, but are used as a tool to help focus attention on the ways that health needs to be in all policies. People don't understand this notion yet, and HIAs can be used to illustrate how health is related to all policies. What should different in the environment and how we could achieve this? HIAs can be used to construct bridges between health and other policies, and that's the point of the *Health Equity* table. Once people get it, HIAs becomes a critical tool.

Question:

The Robert Wood Johnson Foundation, along with The Pew Charitable Trusts, announced the launch of their [Health Impact Project](#) today. My question is: do you have a toolkit or a website for people who are interested in doing that work?

Forbes:

There's not a toolkit because it's far more complicated than that, but it takes a variety of expertise and knowledge on equity and social determinants, which is why the Senate has language about training and creating an assessment infrastructure to make this more routine.

Bezold:

Richard Hofrichter at [NACCHO](#) argues that HIAs can be formal or informal, expensive or inexpensive and recommends Rajiv Bhatia's work at the [San Francisco Program on Health Equity and Sustainability](#). The SFPHES works to support San Franciscan's urban health, social and environmental justice by integrating local governments and community efforts and provides guidance for conducting HIAs.

Cohen:

We also staff a group out of our office that is doing some of this work, called the [Healthy Places Coalition](#). The Coalition advances public health involvement in land-use and transportation planning to ensure that all neighborhoods in California promote the opportunity to live a healthy life. It consists of practitioners from the planning, public health, parks and recreation, and other related fields, community advocates, academics, and concerned individuals committed to social and health equity from around the state.

Appendix: Health and Equity Impacts

Sector	Key Community Health and Equity Factors		Potential Legislative Vehicles
Transportation	o *Safe, reliable methods for getting around* o Injury prevention o Neighborhood walkability	o *Air quality* o Economic development o Access to services	The Surface Transportation Act of 2009
Health Care	o *Health care access and quality* o *Cultural and linguistic competence of care* o *Emergency response that is timely and appropriate*	o *Preventive services that are responsive to community needs* o Investment in prevention and wellness o Healthy facilities o Healthy workforce o Public health infrastructure	Health Reform
Economic Development	o *Racial justice: equitable opportunities and services for all* o *Job opportunities and local ownership* o *Social networks and trust built on strong ties among persons and positions*	o *Neighborhood look, feel, and safety* o *Neighborhood access to healthy, fresh, affordable, and culturally appropriate foods* o *What's sold and what's promoted*	o American Recovery and Reinvestment Act of 2009 o The Livable Communities Act (S.1619)
Education	o Students have safe, comfortable environments for learning in school o Access to quality preschool education	o Opportunity for physical activity in school o Access to healthy foods in school	o No Child Left Behind o Child Nutrition and WIC Reauthorization Act
Housing	o *Access to safe, affordable, available housing* o *Neighborhood look, feel, and safety* o *Parks and open space for safe physical activity*	o *Safe, reliable methods for getting around* o *Access to healthy foods* o *Access to services* o Neighborhood walkability	o The Livable Communities Act (S.1619)
Violence Prevention	o *Look, feel, and safety* o *Safe, clean, accessible parks and open spaces* o *Safe, reliable methods for getting around*	o Students have safe, comfortable environments for learning in school o *Access to services*	Youth PROMISE Act and other violence prevention efforts
Food (Agriculture)	o *Neighborhood access to healthy, fresh, affordable, and culturally appropriate foods* o *What's sold and what's promoted*	o Food is produced, processed, and transported in a way that protects natural resources and supports local and regional economies	o Farm Bill o Child Nutrition and WIC Reauthorization Act