Volume 5 / Issue 3
A Publication of
Turning Point: Collaborating for a New Century in Public Health

Winter 2003 / 2004

Transformations in public health

In This Issue

What Are Health Disparities?

Dorothy Bliss

One of the two overarching goals for the nation identified in *Healthy People 2010* is to "eliminate health disparities among Americans." A health disparity is a difference in rates of illness, disease, or conditions among different populations. It is a statistical description of persistent health differences that cannot be explained by individual characteristics or behaviors. In dictionary definitions, *disparity* not only means *difference*, but also *inequality*.

Although America has always been a "nation of nations," the past few decades have seen the American mainstream become conscious of and more deliberate about accepting and valuing diversity of all kinds. Classes for understanding and accepting diversity are taught in venues as different as Fortune 500 companies and elementary schools. We are experiencing a renewal of the understanding that our differences—different cultures, different life experiences, different points of view—make us strong as a nation.

When it comes to health status, however, persistent differences among groups of people are neither positive nor benign. Significant, persistent differences in health status of different populations signal that there are deeply rooted problems in American society: structural inequalities in our economic and social systems, racism and prejudice, and our approaches to health and health care.

American history has been a history of struggle for the right of all citizens to be free, to receive justice, and to live as equals. The determination to eliminate health disparities is grounded in these fundamental American principles.

Disparities data document problems

When the issue of health disparities came to national attention in 1990, the data to document disparities in many populations was sparse. The past decade saw a lot of effort go into improving the database for analyzing the issue of disparities. Much more information is available now, and suspicions have been confirmed: disparities in health status are found across the spectrum of American society.

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TurningPoint

From the Turning Point National Program Office

Taking a Systems Approach to Health Disparities

Bobbie Berkowitz, Director

During this past year I have had the pleasure of heading up the development of the *Center for the Advancement of Health Disparities Research* at the University of Washington School of Nursing (www.son.washington.edu/centers/hdc/). The Center, funded by the National Institute of Nursing Research, has been a logical extension of the progress Turning Point has made in understanding system-related factors that contribute to health disparities. For example, policy is a system variable that unites the challenges of age, race, and ethnicity with health disparities. Health care and public health operate in an environment whose highly complex economic system creates barriers to eliminating health disparities.

Race and racism also constitute important system variables that contribute to health disparities. Institutionalized racism is an especially important concept as it relates to the ability of racial and ethnic minorities to access health care, just as cultural competence in health care services is important to the quality of care that minority populations receive.

To understand the full range of factors that contribute to health disparities, we must look from the individual to the community, examining the associations between poor health and socioeconomic characteristics of the individual, their neighborhoods, community, and society. In the 1990s a number of studies were reported that proposed variables derived from societal influences that were thought to contribute to poor health. These societal influences included income inequality, socioeconomic position, race and ethnicity, and social capital. As a result of these studies, our understanding has been expanded about factors beyond disease and injury that affect how healthy we are as a society. Now, in the twenty-first century, with more than a decade of research on indicators related to societal influence on health, we are wondering how to intervene when the poor health outcomes are related to a lack of social capital or income inequality among minority populations.

Dr. David Satcher made the elimination of health disparities one of the top priorities of the nation during his tenure as the U.S surgeon general. He characterized health disparities as one of the major challenges of the public health system. He was wise to point out, however, that public health could not attempt the challenge alone. He regarded health disparities as a problem that would require a change in the structure of our health care system, including economic forces and health care delivery, and in particular more attention paid to those populations at highest risk of disparities.

The creation of partnerships to advance the elimination of health disparities is where Turning Point has made its greatest contribution. This issue of *Transformations* addresses a selection of these efforts. The authors have focused on those strategies aimed at the system, including policy, data systems, and organizational structures that are indeed critical to success.

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- Rural areas have the highest death rates for unintentional injury, especially motor vehicle injuries, and central cities in large metropolitan areas have the highest homicide rates.
- The rate of diabetes for American Indians and Alaska Natives is more than twice that for whites.
- Latinas have one of the highest rates of cervical cancer in the U.S.
- Lesbians are at greater risk for cancer than heterosexual women.
- Fewer than half of American elders of Asian heritage are vaccinated against pneumococcal disease, compared to 75 percent overall.
- The infant mortality rate of Americans of African heritage is double the rate for those of European heritage.
- Nearly two-thirds of low-income immigrants and refugees have no health insurance, compared to just over one-third of all low-income people.

Policy makers use data for direction. Averages, however, can mask substantial differences between the majority population and minority populations. This means that approaches to health issues that are based on overall rates of diseases or conditions are at risk of perpetuating inequities; they may work for the majority yet not be effective for many who need significant health interventions.

The role of social and economic conditions

The picture of health disparities is a puzzle, a densely woven web of causes and effects. As information about health disparities has expanded, the new research shows that some of the more important factors related to health disparities are not traditional health issues. Income distribution, education, living conditions, social support, transportation, and employment all have a direct effect on health. And reduced health status, in turn, can negatively affect opportunities for social, educational, and economic success.

- **Income affects health.** The rich are healthier than people in the middle class, and middle class individuals are healthier than those who are poor, no matter their racial or ethnic backgrounds.
- **The effect of a large gap in income between the rich and the poor is felt by everyone in the community.** Disease and death rates are higher overall—not just for those at the lower end of the income spectrum—when the income gap is large between the rich and the poor.
- **Health is associated with having a sense of community safety and support.** Communities with greater civic participation and demonstrated concern for others have lower rates of violence and death.
- **Workplace quality affects health**. Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe, and there are ample opportunities for control, decision making, advancement, and personal growth.
- **Culture, religion, and ethnicity have important influences on health.** They affect perceptions and beliefs about health, illness, and healing and can influence decisions about whether and how to seek care. Culture, religion, and ethnicity are also closely linked to social support systems and community participation.

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- **Discrimination and racism play a crucial role in explaining health status and health disparities.** Racism can be expressed through restricted socioeconomic opportunities and mobility, limited access to medical care, and unequal treatment, residential segregation, and chronic stress.

Prejudice and stereotyping also influence health care. A recent report by the Institute of Medicine showed that, even among providers with a strong ethic of equal treatment, bias creeps into decision making because of inequities built into the structure of the health care system, such as the amount and types of information available and the nature of the health care encounter.

Can health disparities be eliminated?

The efforts of many in the past decade to identify and eliminate health disparities, reveal five key principles for making progress.

Expansion. More people, more ideas, more disciplines. The boundaries of the issue need to be expanded beyond traditional health agencies to include, for example, community planners, economists, and chambers of commerce. Many people are working on health disparities, but many more are needed. Smart people should pool their brainpower. Motivated people should inspire others. Those with resources should direct them to this effort and encourage others to do the same. An African proverb says, "Many spiders weaving their webs together can tie up a lion." Thousands of local efforts to eliminate health disparities can and will make a difference.

Engagement. Success depends not just on the number of people involved in designing solutions to health disparities, but on which people are involved. Engagement can make partners out of adversaries. Engagement can make cheerleaders out of passive spectators. True engagement means learning and "unlearning"—everyone around the table has something to teach and something to learn. Solutions that arise from a group of people bringing a multitude of perspectives that represent a full spectrum of the community, and eager to dive in, have a much better chance at success.

Equality. Health disparities cannot be eliminated while social and economic disparities remain. The strengths of communities, and not just the problems, need to be identified and reinforced. The ways in which we define individuals and institutions as legitimate need to be examined. Community wisdom is needed just as much as good data. Knowledge, resources, and decision-making authority need to be available to those who are close to the issues, can understand the nuances of a subpopulation, and can adapt to rapidly changing micro-environments.

Experimentation. This is no time to be singing the second verse, same as the first. The idea of experimenting—of trying something new, and not knowing exactly what your results will be—is basic science. At the same time, there needs to be some understanding that "failure" is a part of learning. New, successful solutions cannot arise unless there is acceptance that there may also be some new, unsuccessful ones.

Evaluation. Just as the results of an experiment are documented, so health disparities efforts should be prepared to measure both successes and failures. Every solution should have a core of measurable objectives to make it possible to learn from our efforts and to improve them as we go.

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Turning Point Member Profile

Teresa Wall

Every state has public health leaders they turn to who keep the promises of public health alive. In Arizona, one of the leaders to emerge in the past decade is Teresa Wall. Teresa began her career in public health in Arizona as a public health nurse for the Gila River Indian Community in 1985. After receiving an MPH in Health Administration at the University of Oklahoma, she returned to Gila River Indian Community to serve as executive director of the Department of Health Services. Teresa knew the importance of getting public health recognized as a separate entity from clinical medicine/primary care. Her dedication to this paid off. In 1997, the department's name was changed to the Gila River Indian Community Department of Public Health.

In her continuing support of public health, Teresa was instrumental in establishing the Gila River Turning Point Partnership in 1998, one of four local community Turning Point projects in Arizona, funded by the W.K. Kellogg Foundation through the National Association of County and City Health Officials (NACCHO). The initial emphasis of the Gila River Turning Point Partnership was to ensure the transition of the department from a medical model to a public health model that valued the health concerns of the Native American community and followed the core public health functions. In addition to the local Turning Point project, Teresa has been an active member of the Arizona Turning Point Project Steering Committee and helps ensure the Steering Committee always keeps in mind Native American public health issues.

Teresa's leadership in public health has led to significant steps for Gila River while at the same time serving as a model for other tribal nations within Arizona. One excellent example of this was the Shared Data Network, formed in 2001. Gila River was the first tribal nation in Arizona to establish a data-sharing agreement with the Arizona Department of Health Services. This has allowed improved monitoring of the health status of the Gila River Indian Community (GRIC). In addition, Teresa has worked with the leadership of Pinal County, the county in which part of GRIC is geographically located, to share data and coordinate public health services.

Teresa's leadership extends to the national level. She is a member of Turning Point's Public Health Statute Modernization National Excellence Collaborative and is effective in bringing Native American issues to the table. In addition, Teresa served on the Indian Health Service Roundtable Discussions on Public Health Infrastructure in American Indian and Alaska Native Communities, was elected to the NACCHO Board of Directors, and sits on NACCHO's Health and Social Justice Committee. One of Teresa's recent projects has been to participate in APHA's International Human Rights Committee, Health and Human Rights Curriculum Project Expert Task Force.

Although Teresa is being recognized here for her contributions, she insists, in the true collaborative fashion of Turning Point, that she "could not have done this without the help of many others who also have a passion for public health and the promise it holds for our communities." She says thanks to Merle, David, Vinny, Joe, Nancy, Susie, ALHOA, and NACCHO. And thank you, Teresa, for being part of Turning Point and public health.

Nominate Turning Point members to be profiled in future issues.

Policy Corner

Public health issues draw contradictory viewpoints and heated debate, sometimes between colleagues and partners who are nevertheless committed to working toward common goals. Turning Point's focus on building diverse partnerships to improve public health infrastructure gives us an opportunity to engage in dialogue on important topics. We invite readers to send us your thoughts on the policy statement below or go to our online Policy Corner and add your comments to the online discussion.

Policy Statement

The structure of the US economy virtually ensures that economic good times will worsen the already large income gap between the rich and the poor—leading to adverse effects on population health as well as to increased health disparities.

Responses

The standard for considering the health of a population is in relation to the health of other populations in the world. How healthy is that population compared to others? How big is the difference? Fifty-five years ago, the USA was one of the five healthiest countries in the world, measuring by life expectancy (average number of years lived). Now almost all the other rich countries and a few poor ones do better than we do. The gap between the rich and poor in a society (the range of hierarchy present) is the most important determinant of the quality of societal relations. Poverty is the greatest risk factor for poor health, and *relative poverty* is the key component in the psychosocial aspects of society that determine the quality of human relationships.

Perhaps fifty years from now, people will look upon this era and gasp at how we did nothing to avert nearly half a million deaths a year in the USA as a result of allowing relative poverty to persist. If the means to eradicate poverty exist anywhere in the world, they certainly do in the USA, the richest and most powerful country in history.

Stephen Bezruchka, MD, MPH
University of Washington, School of Public Health & Community Medicine

Recent evidence does suggest that income gaps increase with growth and, conversely, that increased redistribution reduces economic growth. At the same time, there is strong evidence that long-run economic growth drives improvements in population health. This alone suggests that long-run increases in the absolute standard of living are more important than relative income for population health. In contrast, several public health studies argue that the statistical association between income and inequality demonstrates that relative income is a more important determinant of population health than absolute income. However, subsequent research by economists has demonstrated that the association between inequality and health is spurious. Consequently, there is no credible evidence that inequality reduces population health.

The source of health disparities in the U.S. and elsewhere remains an open question. Many observers take the existence of such disparities across income groups, race, or other categories to be evidence of social injustice. However, the existence of disparities is not necessarily undesirable—for instance, if such disparities are generated by improvements in absolute well-being for all individuals (just as improvements in absolute standards of living for all may be accompanied by widening income disparities). In addition, policies that reduce health disparities have real economic costs that must be considered, and the accumulation of such costs may serve to reduce absolute well-being of the poor. Therefore, public policy should focus on improving the absolute well-being of the poor.

Jeffrey Milyo, Assistant Professor
University of Chicago, Harris Graduate School of Public Policy

Add your comments to the discussion of this topic by going to our online Policy Corner at *www.turningpointprogram.org/web_log/weblog_index.html.*

Deadline: March 16, 2004

More Responses to the Policy Corner Statement in the Summer 2003 issue.

Policy Statement: *What role should public health play in pursuing policy initiatives to reduce childhood obesity? (The debate about soda vending machines in schools, as one example of such policy initiatives.)*

The school environment is not the sole source of children's excess calories. It is, however, a venue parents and public officials can both affect and direct, by voicing concerns to school boards and legislators and by exercising local political power. For example, Texas public schools have ousted soft drinks, despite potential decreases in revenue. Other school districts, including Seattle, have scaled back on beverage contracts.
Ellen J. Fried, JD, MA, Adjunct Clinical Assistant Professor
New York University Dept. of Nutrition, Food Studies, and Public Health

Removing candy and soda machines from schools would reduce children's access to sugar, but it would not address the need to educate individuals and empower them to make choices for themselves that will result in a positive lifestyle and promote emotional, spiritual, and physical health. Thus, the approach must be multifaceted, involve members of the target audience in the development of the strategies, and be culturally anchored.
Carlos Quezada-Gomez, PsyD, MBA, Director, Wellness Center
San Carlos Apache Tribe

The debate about childhood obesity and soft drinks provides another example of the delicate balance between individuals' right to choose and our role in collective action on behalf of the community. With that caution, taking steps to inform parents about children's diets and the need for exercise while also working collaboratively to increase the safe options for activity and food choices makes sense.
Kristine Gebbie, DrPH, RN, FAAN
Columbia University, School of Nursing

Vending machines remind us of the power of interventions that do not require the individual to change behaviors. But those who have tried cutting the cord to the TV set only to find the kids going next door to catch their favorite junk shows have learned that fundamental behavior change requires positive personal alternatives as well!
Hugh Tilson
University of North Carolina at Chapel Hill, School of Public Health

Vending machines provide an important source of revenue for many of Virginia's school districts. Facing accumulating budget shortfalls, few school administrators are willing to relinquish a revenue stream that they can use to fill in the gaps left by inadequate funding. We recognize that until children are educated about the connection between nutrition and good health and schools are offered a viable financial alternative to vending machine revenue, the notion of removing their vending machines will not meet the stated objectives.
Stephanie Kellner, Jeff Lake, and Jeff Wilson
Virginia Turning Point State Partnership

Instead of focusing on the individual issues, I think Public Health organizations need to work on addressing the underlying issue. They need to help kids see that they have the power to decide what they want on their own and that they don't need other things, such as peer groups and advertisers, to tell them what to think.
Ebie Bialek
Junior at Bethesda-Chevy Chase High School

These comments have been edited for length.

To read the full comments, go to the online Policy Corner at www.turningpointprogram.org/web_log/weblog_index.html.

APHA Speaks to Health Disparities

Georges C. Benjamin

This year the American Public Health Association (APHA) reaffirmed that its top three policy priorities are ensuring access to care, rebuilding the public health infrastructure, and eliminating health care disparities. Among the many things APHA is working on this next year, two concerning our efforts to eliminate health disparities deserve special mention: the 2004 National Public Health Week and the California Campaign to Eliminate Racial and Ethnic Disparities in Health.

Moving from statistics to solutions

Each year, the APHA serves as the organizer of National Public Health Week (NPHW). This week-long activity is designed to educate policy makers, the public, and public health practitioners about the issues related to the year's theme. The 2004 National Public Health Week is April 5-11.

This year's theme, *Eliminating Health Disparities: Communities Moving from Statistics to Solutions*, is of particular importance, because communities across the country are struggling to find ways to address this persistent health problem. The presence of these disparities in health outcomes have been demonstrated in numerous studies and show significant differences among racial and ethnic groups, various age groups, gender, and sexual orientation.

A nationwide approach to eliminating health disparities has yet to emerge, but many organizations like the APHA are working to tackle this tough problem with innovative solutions. For Public Health Week 2004, APHA will collect and highlight a variety of solutions to inspire others who work in the health and public health fields and want to eliminate these disparities in their communities. APHA believes it is time to move from statistics that measure and help us define the problem to solutions that ensure equitable and quality care for all.

Each year APHA creates comprehensive planning, organizing, and outreach materials to advance the issue. During the 2004 event, APHA will highlight solutions to different types of health disparities. A searchable disparities database is being created to enable individuals to identify model programs suitable for replication in their communities. APHA is actively seeking participants for Public Health Week. Further information is available at www.apha.org.

Working on health disparities in California

For the past two years APHA has been working with the California Department of Health Services and a coalition of California-based public health organizations to develop a strategic approach to eliminating racial and ethnic health disparities in California. The campaign aims to help guide future statewide efforts to address disparities through prevention and intervention. The working group identified two overarching goals: 1. Prevent the development of illness and injury by fostering healthy behaviors, healthy community environments, and institutional support of good health outcomes, and 2. Reduce the severity of illness and injury by providing high-quality health care for all. The group also identified critical pathways to achieving health and looked at ways to engage other stakeholders in achieving the campaign's goals.

Find the California Campaign's report at www.preventioninstitute.org/healthdis.html or www.apha.org.

Georges C. Benjamin, MD, FACP, is executive director of the American Public Health Association.

Working on Health Disparities: Infrastructure for State Agencies

Jill Hunsaker

It is well documented that in the United States, racial and ethnic minorities suffer from a disproportionate burden of disease, disability, and death. American Indians, African Americans, and Latinos/as have rates of poorer health outcomes that are, on average, between two and six times greater than the majority population. Public health agencies have begun to recognize their leadership obligation to improve minority health and reduce disparities, although many states lack the necessary infrastructure to produce an effective response. The Colorado Turning Point Initiative (CTPI) has been working to develop this type of state-level infrastructure to addressing health disparities in Colorado.

According to the federal Department of Health and Human Service's report, *Assessment of State Minority Health Infrastructure and Capacity to Address Issues of Health Disparity*, "Infrastructure appears strongest when it is supported at the core by a statewide minority health organization, statewide task forces, strategic plans specifying minority health objectives, and legislation." Colorado has also discovered that necessary infrastructure includes minority health surveillance systems, community partnerships, and an ethnically representative public health workforce.

Infrastructure development

A statewide minority health structure—most commonly known as an Office of Minority Health—appears to be key to the foundation of state efforts because it affords dedicated staff time to focus on the issue and operates as a point of contact for the public. Many of these offices track and report health status and health behaviors by race and ethnicity. Doing this is another vital form of infrastructure. In order for states to address health disparities, they must first be able to measure and document them. In Colorado, CTPI coordinates data collection programs to provide a standardized comparison of health indicators by race and ethnicity. This information is then published in a report for distribution to local health departments and community-based organizations. CTPI also promotes the over sampling of minority persons for health behavior surveys, such as the Behavioral Risk Factor Surveillance System.

Another critical piece of infrastructure is a qualified, multicultural public health workforce, including diversity at the management level. This type of staff improves the likelihood of culturally relevant services and the creation of policies that are beneficial to communities with health disparities. For Colorado's health department, CTPI is leading an assessment to determine system improvements for hiring, promoting, and retaining a diverse workforce.

The importance of community relations cannot be overstated. There is no way for a health department to do this work alone. In fact, health departments may be most successful in a supporting role for community-based organizations. Once relationships are developed, a department may be surprised to hear constructive feedback about how it has traditionally served communities of color. Feedback in Colorado has raised the issue of using Caucasian staff to conduct focus groups with minority persons, for every different disease area funded. According to one community leader, "Communities of color prefer a

Communities of color prefer a coordinated response by public health professionals who look like them.

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Changing Behaviors Through Social Marketing

Economic and political barriers contribute greatly to the disparities between the health of majority and minority populations in the United States, but some health disparities can be prevented or controlled through behavior change. Behavior change, however, can be difficult to motivate, especially when the established behavior is the most convenient alternative. Behavior is even harder to change when the behavior is pleasurable in the short run and the potential risk is long-term.

To motivate behavior change in these "hard sell" situations, some public health professionals have adapted techniques developed by successful marketers of commercial products. The adapted approach, called *social marketing*, involves lowering the barriers, or costs, that members of an at-risk group associate with a health behavior change and emphasizing the benefits of the desired behavior that group members find really meaningful.

The social marketing process

Social marketing is a systematic, data-driven planning process that begins by using epidemiological data and other background information to define a health problem and pinpoint groups at disparate risk. Then members of the at-risk groups (and those who influence them) are asked for their perspectives on the health problem, its associated risk behavior, and healthier behavior. Preferences for sources of health information are solicited, and opportunities to try out healthier behaviors are identified. Health messages, services, and products are tailored to appeal to the target audience, and finally, these "offerings" are market-tested prior to distribution.

Using such a rigorous process is clearly warranted when the health of most Americans improves but identified groups are left behind. Uncovering health disparities during initial problem analysis can justify spending program resources on those hardest hit. Subsequent audience research can deepen understanding of the special barriers to change that minority groups face. Finally, the process of designing and implementing social marketing programs can provide empowering participation and training opportunities for members of the affected community.

Successful social marketing projects

Social marketing has already been successfully applied to health problems that have had a disparate effect on minority groups. One project, for example, focused on Latino children in New York City who drank whole milk at higher than average rates, placing them at risk of obesity.

Social marketers assessed the availability of low-fat milk in the community, and conducted focus groups and interviews with local consumers and merchants to explore perceptions of the product. The research uncovered the fact that Latino shoppers believed that low-fat milk had been thinned by adding water. Taste tests, promotional events, and mass media spots promoted the benefits of low-fat milk to institutions and consumers, and the product was successfully substituted for whole milk at some daycare centers and schools. Tallies of discarded milk cartons indicated that children's use of low-fat milk doubled in campaign schools, while there was no change in comparison schools.

Find more examples of social marketing projects in *Social Marketing and Public Health: Lessons from the Field* (www.turningpointprogram.org/Pages/smc_lessons_from_field.pdf), a product of the Social Marketing National Excellence Collaborative.

Social marketing is not a quick fix. It involves months of research on, planning for, and testing of campaign offerings. It also means maintaining a focus on one health area, perhaps at the expense of other important health needs, in order to have a real chance of being effective. Public health professionals must change many of their own behaviors in order to adopt this kind of disciplined approach to program planning. The habit of doing something feasible quickly in the face of fleeting opportunities or great need dies hard. Nonetheless, persistent health disparities are undeniable evidence that public health professionals must find ways to harness the full potential of approaches such as social marketing.

This article was written by members of the Social Marketing National Excellence Collaborative.

Turning Point Talks Public Health at APHA

What better place to share innovations in public health and disseminate tools and resources than at APHA's annual meeting? Public health meetings abound, but only APHA brings together tens of thousands of people from diverse backgrounds, but who are all concerned with public health, to one place with one overarching agenda—learning together about what works in public health. Turning Point has long participated as a presenter at APHA, but this year we kicked our participation up a notch, presenting in more sessions and exhibiting not one, but *two* Turning Point booths. The result of these efforts? More people learned about what can be achieved through partnership building, collaboration, public health planning, and system change.

Interested visitors kept staff busy describing the projects and products at the Turning Point exhibit at the APHA annual conference.

Sessions shared both the work of the National Excellence Collaboratives and the state partnerships. In one session participants learned of Nebraska's transformation, in which Nebraska Turning Point has been the impetus behind an enormous increase in local level capacity. Other sessions provided information on efforts to understand health disparities in Illinois and to support collaborative leadership development in tomorrow's leaders in Minnesota. In addition, staff from the National Network of Public Health Institutes discussed the role of institutes in building community capacity, and a session of contributed papers by the Turning Point National Program Office staff shared the experiences of the entire Initiative and drew conclusions about the effect of Turning Point partnerships on preparedness and sustaining system improvements.

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Involving Communities in Health Disparities Work

Kim S. Kimminau

The minority health disparities work of the Turning Point project in Kansas has two core goals. The first is to assess the data available that could help determine the extent to which disparities in health and health status exist for racial and ethnic minorities in Kansas. Although a variety of public and private organizations have, in the past, tried to assess disparities on a number of health and health-related issues, no centralized attempt to organize population-based disparities data had been undertaken. Kansans have been hampered by the absence of a resource that presents what is both known and not known about health issues of minorities. Furthermore, a state-level view of health disparities from a public health perspective had not been completed.

The second core goal is to involve minority communities across the state directly in health disparities and data issues. In particular, by involving communities in examining their own relevant population data, we hoped to drive system changes in how data should be collected, and how they could and should be used. We reasoned that communities deal with the outcomes of disparate health care and health access in a variety of ways but rarely make use of data as a performance management tool for assessing the effectiveness of their programs aimed at reducing or eliminating health disparities.

Our task was to work at both ends of the health disparities spectrum: at the level of local delivery of services in communities and the level of population-based data sources that monitor population health. We wanted local communities to drive the content and nature of the data chosen to describe the state's minority health profiles. If minority communities felt that socioeconomic indicators were useful in explaining the source or cause of a disparate health condition, we wanted to respect that view and incorporate it into the population data activity. Likewise, as we investigated a variety of data sources, we wanted to make sure local communities had a valid and well-informed resource in helping understand the completeness or limitations of the data itself.

We wanted local communities to drive the content and nature of the data chosen to describe the state's minority health profiles.

Accomplishing the work

The theoretical framework chosen to accomplish this research project includes the notion that to achieve population health, we must move beyond clinical interventions in high risk individuals and populations—in other words, focusing on the "tails" of the population's disease continuum and distribution is insufficient. The entire population must be focused on in order to achieve gains in health. This perspective forces us to examine a wide variety of variables that contribute to the fact that minority populations lag behind (or constitute a differentially high proportion of the trailing "tail" of the overall population's distribution). Such variables include cumulative disadvantage, socioeconomic issues, social networks, and the toll of social factors on biological and physiological systems. This broader perspective is certainly challenging. How, for example, does one capture the effect of stress on a cardiovascular system when it is compounded by years of disadvantage for a minority individual? Clearly, measuring blood pressure is more straightforward.

This perspective drove the selection of a participatory research model in guiding the Kansas project. The key elements of this model are that 1) it is research through collaboration, 2) it requires a researcher-community exchange relationship, and 3) the research process is as important as the outcome. We found the collaborative element of the model particularly attractive, given the goals of the Turning Point project in Kansas. Seeking to break down the barriers between researcher and subject and affording all participants access to the production of knowledge encouraged what is referred to in the participatory research literature as "authentic participation." In a field such as public health, what better core value than this could be extended to the research process?

The minority health disparities project in Kansas has found that including the perspectives of communities—their values, issues, suspected causalities of health conditions, and views of health—has enriched the process of using data to affect minority health immensely.

Kim S. Kimminau is senior vice president with the Kansas Health Institute.

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Another goal of the presentations was to share the products of the National Excellence Collaboratives. A national satellite broadcast presented the Turning Point Model State Public Health Act to colleagues across the nation. The Information Technology Collaborative presented the results of their survey of current information technology capabilities and perceived needs in local health departments. The Social Marketing Collaborative rolled out CDCynergy–Social Marketing, a new tool for planning, managing, and evaluating social marketing programs. If an APHA attendee was at a loss for what session to attend to learn about all the products of the Turning Point Collaboratives, one session summarized the entire suite of products. The sessions at APHA were well attended and drew fantastic audience participation through questions and comments.

A new facet of participation at APHA's annual meeting were our exhibits, which were on display for the duration of the meeting. The main Turning Point booth gave attendees an opportunity to try out CDCynergy–SOC, acquire copies of the Turning Point products, and learn about what is being done to improve infrastructure in their state or any Turning Point state across the country. The Public Health Statute Modernization National Excellence Collaborative also had a booth featuring their Model State Public Health Act, which was available there in both print and CD formats.

People who had long known of Turning Point stopped by to say hello, and others approached and asked for the low-down on the initiative. In the end, many were surprised and delighted to hear what we are achieving, and many more took home materials to share with their co-workers. Turning Point members and staff who worked at the booth perfected the art of describing Turning Point in one minute and learned a lot about the challenges of states across the nation, which share many of the concerns of the Turning Point states. Next year, we look forward to polishing our comfy shoes, printing more brochures, and bringing Turning Point to APHA once again.

[Continued from p 4—Disparities]

If you are unwell, or if my life is cut short because of disease or disability, we both lose. When we help each other succeed in health and in life, we both win. Though the issues are complex, the math is simple. The costs of not eliminating health disparities are much too high to ignore. At the same time, the benefits—for all of us—of making sure that every person has the same opportunity for health are huge.

Dorothy Bliss is a community planner in the Office of Public Health Practice at the Minnesota Department of Health.

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coordinated response by public health professionals who look like them." The federal Office of Minority Health asserts that strong links and partnerships between minority health entities, minority communities, and the state health department are factors that help determine state-level success in addressing minority health issues.

A final piece of necessary infrastructure is a state plan to reduce health disparities, with goals, objectives, and performance measures that are developed in collaboration with partners. Not only does this promote links and coordination, but it also increases credibility among policy makers and funders, who tend to focus on outcomes.

Colorado has found that state health departments must be intentional in their efforts to improve health within minority communities by first developing the necessary infrastructure to mount an effective response. This must be done in partnership with affected communities. Upon attaining this foundation, states can work more effectively toward the Healthy People 2010 goal of eliminating health disparities.

Jill Hunsaker, MPH, is director of the Colorado Turning Point Initiative.

Ready to shake up your New Year?

Contemplating how to design your next health intervention program to achieve better results? Wondering what *collaborative leadership* really means and why there is such a buzz about it in public health? Interested in getting the latest and greatest materials on initiating performance management in your work? You have arrived at the right place!

Social Marketing is being incorporated into health promotion programs and has led to increased grant funding when cited as a methodology to be used in these programs. Check out the Social Marketing Collaborative's *Social Marketing Resource Guide* for a primer on understanding and using social marketing principles. When you're ready to implement social marketing, turn to *Social Marketing and Public Health: Lessons From the Field*, for 12 case studies of social marketing in action.

To jumpstart your search for information on collaborative leadership, look no further! The Turning Point Leadership Development National Excellence Collaborative embraces collaborative leadership and has produced a literature review, *Collaborative Leadership and Health: A Review of the Literature,* to help you navigate the maze of information on this increasingly important subject. And to help you increase your collaborative leadership skills, look for the *Collaborative Leadership Training* series, soon to be released by the Leadership Development Collaborative.

Visit our Web site (www.turningpointprogram.org) for the latest publications from the other Collaboratives.

The popular materials from our Performance Management Collaborative are now available through our partner, the Public Health Foundation and will appear in their Spring Catalog. To view the catalog, visit http://bookstore.phf.org.

Resources on Health Disparities

Information on health disparities abounds in print media and on the Web. Here is a sampler of Web sites, books, and meetings to get you started.

Web sites

Population Health Forum (http://depts.washington.edu/eqhlth/)
The Population Health Forum's mission is to raise awareness and initiate dialogue about the ways in which political, economic, and social inequalities interact to affect the overall health status of our society. Its goals are to promote knowledge and advocate for action in service of a healthier society.

Inequality.org (www.Inequality.org)
This site is a treasure of information on all aspects of hierarchy and inequality.

Community Coalition for Environmental Justice (www.ccej.org)
This grassroots organization looks at environmental issues often incorporating health disparities.

Comprehensive Annotated Bibliography on Racial and Ethnic Disparities
(www.phrusa.org/research/domestic/race/race_report/bibliography.html)
By Physicians for Human Rights, this site presents a variety of materials on health care related to ethnicity.

Books

The Spirit Catches You and You Fall Down. Fadiman, A. (1997). Farrar, Strauss and Giroux: New York.

The Health of Nations: Why Inequality Is Harmful to Your Health. Kawachi, I. and B.P. Kennedy (2002). New Press: New York.

Health and Social Justice: Politics, Ideology and Inequity in the Distribution of Disease. (Ed.) Hofricter, R. (2003). Jossey-Bass: New York.

Social Epidemiology. (Eds.) Berkman, L. and I. Kawachi (2000). Oxford University Press: New York.

The Society and Population Health Reader: Income Inequality and Health. (Eds.) Kawachi, I., B.P. Kennedy, and R.G. Wilkinson (1999). New Press: New York.

Dates to Note

May 11-13, 2004. Turning Point Conference "States of Change." The Turning Point Initiative will share accomplishments, stories, and products of the 23 Turning Point states with health officials and local, state, and federal public health colleagues from across the nation, in Denver, Colorado. Join us!

For more information on this meeting go to: www.turningpointprogram.org or contact Marleyse Borchard at borchard@u.washington.edu, telephone: 206-616-8410.

June 14-16, 2004. The Public's Health and the Law in the 21st Century conference. Atlanta, GA. www.aslme.org.

July 14-17, 2004. NACCHO Annual Meeting. St. Paul, MN. www.naccho.org.

September 28- October 1, 2004. ASTHO Annual Meeting. St. Paul, MN. www.astho.org.

November 6-10, 2004. APHA Annual Meeting: Public Health and the Environment. Washington, DC. www.apha.org.

Transformations in Public Health is a publication of the *Turning Point: Collaborating for a New Century in Public Health* initiative. The goal of this initiative is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies can respond to the challenge to protect and improve the public's health in the 21st century. The University of Washington School of Public Health and Community Medicine serves as National Program Office for the initiative.

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