Wisconsin Center for Health Equity

Having the best health care in the world, how can it be that the U.S. is not as healthy as most developed countries, and has such large differences in health among various groups?

Some experts, using data from the Centers for Disease Control, estimate that only 10% of good health is a result of health care. Much of the remainder has to do with social and economic factors, including income, education, racism, and related factors such as child-care, housing, vocational training, unemployment, literacy, social support, community violence, transportation, built environment, and food security and accessibility. *These "upstream determinants of health" must be addressed in order to achieve health and reduce health inequities.*

What are Health Inequities? According to one definition, "The term 'health disparity' is used to indicate any difference in health between groups of people. Some disparities, such as those due to innate biological differences, are unavoidable. However, a 'health inequity' is a disparity which is avoidable, which is often the result of social or economic conditions or policies, and which, therefore, represents an unfair or unjust disparity."[1]

Vision

To create a society where all people have an equal chance to be healthy.

Mission

To improve the social and economic conditions that contribute to health equity through education, civic capacity building, and public policy.

Upstream Health Determinants: Milwaukee as a Model for Change

Milwaukee is an ideal location to start an innovative Center to address these upstream determinants of health that are responsible for health inequities. The nation's 22nd largest city, Milwaukee ranks 7th worst among US large cities in Infant Mortality, 7th worst in Teen Birth Rate, and 2nd worst for Sexually Transmitted Diseases – and has large disparities in these health outcomes among differing racial and socioeconomic groups. Not coincidentally, among U.S. large cities Milwaukee has some of the nation's worst poverty, child poverty, violence, unemployment, and high school drop-out rates.

Most of these upstream factors require policy-level interventions, rather than individual-level interventions. This makes them ideal to be addressed by a Center for Health Equity working at the intersection of communities, service providers, advocacy groups, and the government agencies that can examine and address needed policy changes.

Our Center for Health Equity is only the second such center in the nation to be founded at a local health department (Louisville was the first). With input from a number of key advisors (*e.g.,* the State Health Officer, the County Director of Health and Human Services, leaders from community-based agencies, and a nationally-known researcher on the social and economic determinants of health), we have laid the groundwork for a powerful and effective Center.

Although the burden of health inequities is largest in urban areas, *inequities affect every area of the state.* Further, effective policy solutions will often require a statewide focus. Thus the Center will be based in Milwaukee but will work to reduce health inequities across the entire state.

To achieve our vital mission, the Wisconsin Center for Health Equity will engage:

- Elected Officials
- Policy-makers
- Healthcare Sector Leaders
- Public Safety Officials
- Business Leaders
- Education Sector Leaders
- Community-based Organizations
- Faith-based Organizations
- Other Key Leaders
- The People of Wisconsin

[1] http://www.pophealth.wisc.edu/uwphi/publications/brief_reports/brief_report_v01n05.pdf

The Wisconsin Center for Health Equity: A New Paradigm for Public Health

Most people, including many public health professionals, believe that there are two main approaches to improving health and reducing health disparities: reduce unhealthy behaviors and increase access to healthcare. While policy development is one of three official "core public health functions," the traditional local public health approach has been: 1) target a vulnerable population, or a disease and its related risk factors, 2) supply health education and health promotion programs based upon behavioral models and learning theories, and 3) try to improve access to healthcare.

However, we now know that good health requires not only healthy behaviors and access to medical care, but also attention to a broader set of factors that lie outside the individual and outside the capacities of both medical care and traditional public health.

As Figure 1 indicates, the overarching social structure and policy environment produces powerful effects on individuals and groups that account for much of the large group differences in health outcomes that we experience.

Therefore, public health must learn to influence the policy environment in multiple areas with which it has been relatively unfamiliar. Of course, public health should continue its traditional roles, including promoting healthy behavior and access to healthcare. But public health must now add to its repertoire the skills, competencies, tools, and methods to address the broad policy and systems environment that so strongly influences health.

The key actions are:

1. Form alliances with government and non-government partners, private sector organizations, health professionals, and civil society more broadly (including trade unions, political parties, community organizing-advocacy groups, popular movements and alliances).
2. Identify the social and economic policies and systemic arrangements that can increase or decrease health inequities, and explain the evidence that links public health problems to the social determinants of health.
3. Build the civic capacity of communities to understand and change the policies and systems underlying health inequities, and partner with communities to secure needed policy changes.

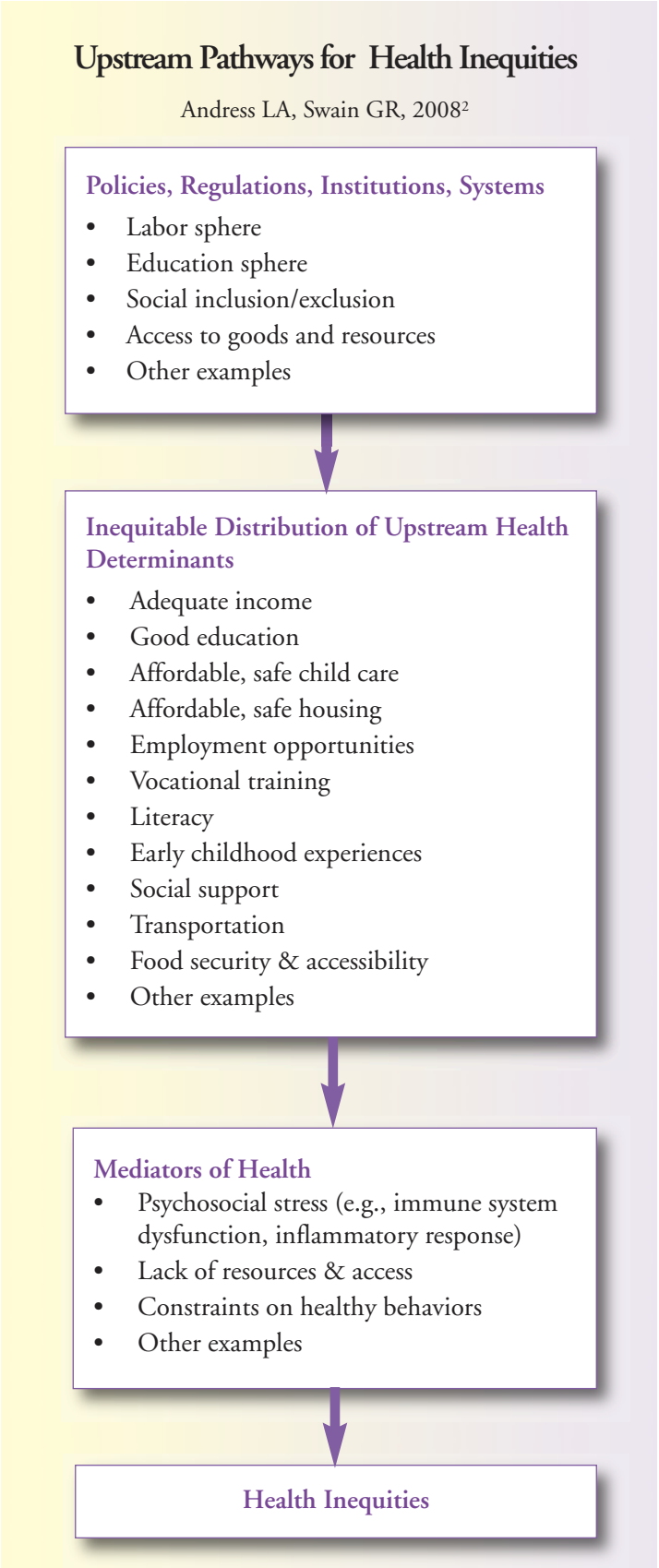

Figure 1

[2]Adopted from Tackling Health Inequities Through Public Health Practice: A Handbook for Action. Hofrichter (Ed), National Association of County & City Health Officials, Washington DC, and the Ingham County Health Department, Lansing MI, 2006, p. 245.

How Is this Approach Different from Traditional Public Health?

The conventional approach that public health has taken to address health inequities uses a health disparities frame defined mainly as minority and ethnic health. This approach focuses on increasing access to care and improving health behaviors as its main interventions for these targeted groups. This approach is not sufficient because it excludes other populations that experience health inequities due to socioeconomic status, and because it fails to address the overarching policy environment which so strongly influences and constrains individual health behaviors.

Public Health Practices	Traditional Model (examples)	Equity Model[3] (examples)
Problem Areas	Focus on threats to the community through surveillance of cases, the promotion of healthy behaviors, and treating diseases to prevent complications or transmission.	Additional focus on societal systems, policies, and practices that result in the inequitable distribution of upstream health determinants.
Primary Interventions	Most effort focused outside of the policy sphere, such as nursing home visits, restaurant inspections, immunizations, communicable disease management, health education & encouraging healthy behaviors, and screening for early disease or risk factors. Policy efforts often narrowly focused, e.g., motor vehicle laws, food and occupational safety laws, family planning, fluoridation of drinking water, anti-smoking measures, use of tobacco settlement funds.	Institutional commitment to upstream interventions, in addition to (not in place of) traditional interventions. Staff devoted to policy development and analysis, and to collaboration with others who are addressing social determinants of health. Include the influence of key upstream health determinants (see Figure 1) in all of the essential public health services. Skills for, and commitment to, Community Civic Capacity Building.
Collaborative Work	Typically with healthcare providers, and with community groups representing marginalized community members (often for research or for input in setting departmental health priorities).	Development of a transparent, inclusive structure that supports true community partnerships. Expansion of partnerships to groups that deal with human rights, civil rights, and social advocacy. Dedication of some resources to neighborhood mobilization and community organizing to work on issues related to the self-interests of a community.

Figure 2

[3] Andress, 2008; Traditional public health practices versus health equity practices. Adapted and modified from 1) the Bay Area Regional Health Inequities Initiative, Internal Capacity Committee, Standards and Competencies: http://www.barhii.org/programs/standards.html ; and 2) A Dialogue-Based Tool for Assessing/Describing the Social Justice Orientation of a Local Health Department, April 2008, Doak Bloss at dbloss@ingham.org, Ingham County Health Department

Strategies for Health Equity

Examples of strategies that the Wisconsin Center for Health Equity will employ to meet its vision and mission include:

- Identify baseline level of local and statewide understanding of the actual determinants of and contributors to health.
- Educate the public about the upstream determinants through various strategies, including linking prominent health issues (e.g., breast cancer, HIV/AIDS, infant mortality, etc.) to their related, underlying, upstream determinants.
- Encourage physicians, other clinicians, and public health professionals to support "thinking upstream" at both a community level and a policy level.
- Promote increased civic capacity – directly, and by collaborating with existing groups which already engage in civic capacity building efforts – to build community members' sense of both individual efficacy and social inclusion, as well as their ability to influence policy change.
- Develop a competitive community grant-giving program to assist and strengthen local organizations who are already working on issues that impact health equity.
- Prepare the community to support and promote policy changes to improve the "upstream determinants environment."
- Develop and support a prioritized list of key policy initiatives (for example, early childhood education) that are most likely to result in improvements in the upstream determinants of health.
- Support Health Impact Policy Assessments, and serve as a "watchdog" to assure that policy-makers understand the health impacts of their proposals.

The Wisconsin Center for Health Equity is at the forefront of those who are working to demonstrate an expanded public health approach, and to improve public health's effectiveness, so that as a discipline, and as a nation, we finally reach our goal: a society where all people have an equal chance to be healthy.

Model for the Future

Our long-term staffing model calls for a Director, Associate Director, two Community Organizers, a Social Epidemiologist, a Data Specialist, a Policy Analyst, a Grant-writer / Fundraiser, and a Communications Specialist.

These positions are essential as we (1) develop our education strategies for policy-makers and the general public; (2) execute interventions to improve community civic capacity by partnering with existing community-based organizations; and (3) work to increase the implementation of social and economic policies that will improve health and reduce health inequities.

We are grateful to Columbia St. Mary's hospital system and the UW Madison RWJ Health and Society Scholars Program for providing crucial "seed funding" for the Center. However, to implement our strategies, achieve our mission, and to develop a model that will be transferable to other areas of the country, additional funding is essential.

Improving the social and economic conditions that contribute to health inequities is a bold and vital mission that will take dedication and perseverance to accomplish. Ultimately, the Wisconsin Center for Health Equity will be recognized as a pioneer and a model in leading the US toward achieving health equity.

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