Moving upstream:

Working together to create *healthier* communities

A Report on a Statewide Policy Forum on Social Determinants of Health
Held on November 13, 2006

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February 2007

A message from Mark W. Banks, M.D.

Chair, Board of Directors, Blue Cross and Blue Shield of Minnesota Foundation
CEO, Blue Cross and Blue Shield of Minnesota

This past year has been a significant one for the Foundation. As we marked our 20th anniversary, we launched a series of programs and activities to fulfill our new purpose: *Looking beyond health care today for ideas that create healthier communities tomorrow.* We are drawing on our grantmaking experience and complementing the work of other Blue Cross and Blue Shield of Minnesota divisions by moving upstream, beyond the traditional health care arena, in recognition of the powerful influences of social, economic and environmental conditions on health, on the vitality of our communities and on the opportunities available to all.

A social determinants approach to health

Our work is building on the growing recognition that health is the result not only of genes, lifestyle and medical treatment. It is also determined by the day-to-day circumstances in which we live and work. Through new programs and partnerships in early childhood development, housing and the environment, we are investing in areas that promise long-term impact on the health and vitality of Minnesota communities and a means to close the health and opportunity gaps that affect many Minnesotans.

By its very nature, work on social, economic and environmental factors that determine health and quality of life is cross-sectoral. In embarking on this work, we recognize the importance of partnerships that bridge traditionally separate sectors, as well as the role that leadership and policy play in laying the groundwork for change. On Nov. 13, 2006, we hosted a policy forum — *Moving Upstream: Working Together to Create Healthier Communities* — designed to stimulate learning and dialogue on these issues among leaders representing Minnesota's health, environmental, early childhood, community development, housing, business and policy sectors.

The presentations by local and national experts and the discussion among participants over lunch, in lively question-and-answer sessions, and during breaks made for a rewarding day, one that we at the Foundation believe sets the stage for ongoing exploration and collaboration.

This report summarizes the information and themes covered during the forum. We hope it is of use both to those who attended the forum and to others interested in these issues. Further information is available through **www.bluecrossmn.com/foundation**.

To your health,

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Forum Summary

Keynote address
Paddling Upstream: Contributions of Social Determinants to Population Health

Ichiro Kawachi, M.D., Ph.D., *professor of social epidemiology, Harvard School of Public Health and director, Harvard Center for Society and Health*

Kawachi set the context for the day's agenda by linking patterns of health and disease in the United States to the social environment. While health care, genetics and lifestyle are also important determinants of health, Kawachi emphasized the need to take an "upstream" approach to health problems by focusing on changing societal influences.

Drawing on a recent comparative study of health in the U.S. and the United Kingdom, Kawachi looked at variations in health care, genetics, lifestyle and social environment as possible explanations for the greater incidence of diabetes, hypertension, heart attacks and stroke in the U.S. and for Americans' lower longevity. While differences in health care may contribute to the national differences, "health care alone is unlikely to explain the differences." Even the highest income Americans — those with access to health care — have a higher prevalence of diabetes and hypertension than the lowest-income English. "I'm not arguing against trying to achieve universal health care," Kawachi said. "That's extremely important. But even if we could achieve universal health care, that's unlikely to eliminate the health gap between Americans and others."

Similarly, Kawachi discounted lifestyle differences as a primary cause of the life expectancy and health differences between the two countries. People in England are heavier smokers and drinkers than Americans, and the dietary habits of the two countries look similar.

With a significant difference in body weight between the English and Americans, the prevalence of obesity is a prime suspect in health and longevity differences. But evidence from immigrant studies (the longer immigrants live in the U.S., the more their weight approaches the average weight of Americans) and the rapid progression of the obesity epidemic suggest that genetics is not the cause of national weight differences.

"Whatever the cause of obesity in America," Kawachi emphasized, "it's not because of the behavior of a few individuals who are unusually lacking in personal control. Everyone in this country is heavier than they ought to be." This leads to an important conclusion — there is an extraordinarily tight correlation between

average body mass index in a country and the prevalence of overweight and obesity. In other words, "the prevalence of risk depends on what the average person is doing," which in turn provides an important lesson for those interested in the social determinants of health: "If you want to prevent obesity, you need to 'cure the environment,' not the individual."

"Curing the environment," Kawachi explained, means taking an 'upstream' approach to health problems, focusing on changing societal influences, rather than a 'downstream' approach, which might focus on factors within an individual's control, such as diet and activity. An upstream approach to obesity prevention might involve changes in agriculture subsidies, transportation policies, and urban zoning. It might also involve restricting television advertising of food to children, creating national nutrition standards for meals served in childcare settings and working with the private sector to introduce healthier options in restaurants.

Health care, genetics and lifestyle change only take us so far. We need to move upstream, intervene early, work across different sectors and form public/private partnerships.
—Ichiro Kawachi

Policy changes such as these are very challenging. "The more upstream you go," Kawachi noted, "the more resistance you encounter from vested interests." However, there are several strategies available, including information (such as nutrition labeling); incentives (such as taxes and subsidies); regulation (such as expanding Federal Trade Commission authority to regulate food advertising and restricting the use of food stamps to purchase non-nutritious food); and litigation. Each of these strategies, in turn, brings its own difficulties. For example, nutrition labeling requires individuals to make a conscious health choice. Those who can will do so, but those who can't do not, thus widening health gaps.

The exploration of obesity is an example of "how far we can go with social determinants." This is an area where there's no one cause, no 'smoking gun.' Consequently, there is no one cure, no magic bullet: "As health problems have many causes and antecedents, the solutions cannot be of a magic bullet nature. We need a magic gun that sprays lots of magic bullets. We can't leave it to individuals and markets to solve the problem." In other words, we need government intervention and we need to "paddle upstream" to work with the producers of the obesity epidemic more than the consumers. And we need to find inter-sectoral solutions and improve people's environments by intervening early in life: "If we can stick to these three or four principles, we'll do better than we've done so far."

Synergies and synthesis:
Learning from cross-sectoral research

The morning panel discussion examined the research basis for work on social determinants of health, focusing on emerging research findings and policy implications related to health and early childhood development, the environment, affordable housing and racial justice.

Understanding the Long-Term Impact of Early Childhood Experience

Martha Farrell Erickson, Ph.D., *director, Irving B. Harris Training Programs, Center for Early Education and Development, University of Minnesota*

Erickson examined the long-term impact of early childhood experience. She began by summarizing research on the factors in early childhood that have a long-term impact on health, focusing especially on social and emotional development and the effects of early experience on brain development. For example:

❯ The brain goes through a "pruning" process, in which neural connections that are used are strengthened, so "use it or lose it" is an apt caution.

❯ Too much stress — from trauma or unmet needs, for example — results in an overproduction of stress hormones, which undermines neural connections and interferes in self-regulation.

❯ There are sensitive periods in early life when children are primed for specific kinds of development. Current research is examining unanswered questions about "plasticity" — that is, to what extent it is possible to compensate at later stages for development that didn't occur earlier.

Healthy development requires "solid foundations," including a sense of trust in others and in one's own power to solicit a caring response, the capacity to regulate emotion and behavior, the motivation and confidence to explore, and a rich, stimulating language environment. Each of these occurs within the context of early caregiving relationships with sensitive, warm, responsive adults. A secure attachment to such caregivers is a primary source of resilience for children, which can mitigate the effects of negative experiences, including loss and trauma. Children with insecure attachments are at increased risk for anxiety and lifelong conduct disorders. When the relationship with caregivers leaves children uncertain whether they will be protected or harmed, the risk of serious psychopathology increases.

Erickson concluded by outlining the factors that support or hinder young children in getting the early experiences they need for healthy development:

❯ Parental knowledge, skill, health and mental health

❯ Support systems, both formal and informal

- Accessibility, affordability and quality of early care and education, which can compensate for any lack of support in families
- Early screening, identification and intervention with children and parents at high risk or with special needs
- Broader community factors, including housing, neighborhood safety and transportation

environment

The Impact of Environmental Factors on Health: A Systems Approach

Ted Schettler, M.D., M.P.H., *science director, Science and Environmental Health Network*

Schettler spoke about the influence of the environment — understood broadly to include the natural, built and social environment — on health and on disease and disability. Taking a systems approach, he believes, can be more fruitful than isolating individual risk factors. This is particularly important in considering the vulnerability of young children, for whom the interaction of a variety of factors can profoundly affect development and have a lifelong impact.

Children are more vulnerable because they are disproportionately exposed to environmental contaminants, more susceptible to environmental factors and have more time to develop environmentally triggered diseases. For example:

- On a pound-for-pound basis, children take in more air, food and water than adults, their gastrointestinal tracts are more permeable to nutrients and contaminants (calcium and lead are two examples), and their activities and environments differ from adults, providing exposures adults don't experience.

> In addition, their brains and respiratory, gastrointestinal, reproductive and immune systems are not fully developed for days, weeks, months or years after birth.

> Children in poverty are at increased risk on many fronts. Iron deficiency increases with poverty, as do exposures to stress hormones, asthma triggers, lead and other neurodevelopmental toxicants.

Social and environmental factors interact in complex ways to influence children's health. Iron deficiency, for example, leads to impaired IQ, auditory discrimination, and memory. Iron deficiency also increases the absorption of lead, transporting more lead into the developing brain, which affects IQ, learning, attention deficits, hyperactivity and impulsiveness. Interventions must address lead reduction, iron repletion and improved social circumstances collectively to have much benefit, but, even then, brain vulnerability outweighs plasticity. That is, "'catch-up' with remediation is not as effective as primary prevention."

What's needed is an ecological analysis and interventions that address multiple factors. —Ted Schettler

Why Move Upstream?

> What we're doing now is not working. The U.S. is in the bottom third of countries for average life expectancy, for example, despite spending more than any other country on medical care.

> Significant health disparities exist for portions of our population that cannot be explained by access to health care, lifestyle or genes.

> By addressing adverse social and environmental circumstances, we can ameliorate or even prevent many chronic health conditions. Chronic conditions not only drive the great majority of health care costs, they are a greater threat to U.S. population health than acute conditions.

> Research exists that can point the way to effective interventions — especially for children.

> Leaders and practitioners in many sectors — housing, environment, early childhood, community development, health, business, policy — recognize common cause and are interested in working together.

> An upstream focus on social and environmental conditions can make a difference in health, quality of life and access to opportunity for individuals and communities.

Community Effects on Health

Community conditions affect health and well-being, sometimes positively as protective factors, and sometimes negatively as risk factors. The following chart, presented at the forum by Pamela Thornton of the Health Policy Institute, Joint Center for Political and Economic Studies, illustrates protective and risk factors in a community's economic, social, physical and service environment. The chart is adapted from a 2002 PolicyLink report, *Reducing Health Disparities Through a Focus on Communities.*

Conceptual Framework of Community Effects on Health

	Protective Factors	Risk Factors
Economic Environment	• Living-wage jobs • Home ownership • Commercial presence	• Low-wage jobs/ unsafe conditions • Disinvestment
Social Environment	• Common cultural values • Social capital/social supports • Improving neighborhoods • Civic engagement	• Racism/language barriers • Lack of support & models • "Bad" neighborhoods • Hampered development

Physical Environment	• Policies/practices for clean,
	  healthy environments
	• Affordable, high-quality
	  housing, recreation
	  & safe workplaces
	• Police/fire protection
		• Exposure to toxics
		  & pollution
		• Exposures to lead paint,
		  pest infestation, etc.
		• Violence that breeds fear
		  and isolation

Services	• Accessible, culturally
	  sensitive health care
	• Quality support services
		• Lack of access; poor quality
		  health care
		• Unavailable services
		• Undependable/poor quality

Source: **www.policylink.org**

Brick by Brick: Building the Links Between Housing and Healthy Communities

David Jacobs, Ph.D., C.I.H., *research director, National Center for Healthy Housing*

Jacobs provided a brief history of the connection between housing and health in the U.S., examined lessons from the lead paint experience and discussed policy implications and thoughts about upstream work in primary prevention.

Among other important lessons, the lead paint experience illustrates the benefits of targeting interventions to those at highest risk. Today, it is relatively rare for people to die from lead paint exposure, but in the 50s and earlier, hundreds died of paint-induced lead poisoning. In 1990, there were 64 million houses with lead paint; by 2000, the number had dropped to 38 million. And between 1991 and 1994, 22 percent of African-American children living in housing built before 1946 were lead poisoned (compared to less than 10 percent of all children). Happily, disparities by race are now not statistically significant.

While "we still have a long way to go," Jacobs noted the many barriers to resolving lead paint hazards that existed before the 1990s, including no health-based exposure standards for paint, dust or soil; no standard inspection or abatement protocols; no trained workforce or occupational standards; no concerted public education; no laws regarding disclosure of known hazards; and no funding to address hazards in low-income, privately owned, high risk housing. Unfortunately, this situation is still true of other contaminants.

Looking to the future, "we need to talk of the economic costs as well as the health consequences" of inaction. However, the will to take action, even when the benefits outweigh the costs, is affected by "who benefits and who pays."

From a building owner's perspective, for example, "it's irrational to make a health investment in housing because the market doesn't value it." Those concerned about public health need to ensure that consumers understand "the price of making such investments and the cost of not making them." If we are not successful in doing this, the costs are transferred to the education sector or the health care sector.

The bottom line is that substandard housing and community disinvestment is not sustainable, not affordable, not healthy. — David Jacobs

Jacobs also noted that other housing-related diseases can, in fact, be mitigated by housing changes, citing research on asthma, carbon monoxide poisoning, radon, environmental tobacco smoke and fatal injuries: "Better housing quality means better health." Several local, national and international innovations are promising, including the Green Communities initiative; research on the use of green building practices in the renovation of Worthington, Minn.'s Viking Terrace Apartments, to evaluate health outcomes of improved ventilation, radon testing and other housing changes for low-income residents; and the U.S. signing of the 2004 declaration of the Fourth Ministerial Conference on Environment and Health, committing "within the limits of our national mandates, to taking action to ensure that health and environmental dimensions are placed at the core of all housing policies."

In concluding, Jacobs called for partnerships across sectors: "We don't have to wait for people to get sick before we do something," he said. The bottom line is that "substandard housing and community disinvestment is not sustainable, not affordable and not healthy."

Moving Upstream: Naming and Addressing the Impacts of Racism on Health

Camara Phyllis Jones, M.D., M.P.H., Ph.D., *research director on social determinants of health, Centers for Disease Control and Prevention*

Jones began by providing an overview of the causes of health disparities. While disparities arise because of differences in quality of care received within the health care system and differences in access to health care, including both preventive and curative services, the bulk of the problem comes from differences in "life opportunities, exposures and stresses that result in differences in underlying health status." One of the major forces creating health disparities and the uneven distribution of resources is racism, which Jones defines as a system of power, not an individual character flaw or a personal moral failing.

It is "a system of structuring opportunity and assigning value, based on the social interpretation of how we look. It unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and saps the strength of the whole society through the waste of human resources."

Jones discussed three levels of racism: institutionalized, personally mediated and internalized. Institutionalized racism results in differential access to goods, services and opportunities by race. Examples include housing, education, employment, income, medical facilities, clean environment, information, resources and voice. This differential access, which explains the association between socioeconomic status and race, occurs through structures, policies, practices and norms such as educational funding through property taxation.

Minnesota has such good health status, but the inequity piece is important.
—Camara Jones

Personally mediated racism involves differential assumptions about the abilities, motives and intents of others by race, including prejudice and discrimination. Examples include police brutality, physician disrespect, shopkeeper vigilance and teacher devaluation. Both institutional and personally mediated racism can occur through acts of omission and commission and can be unintentional as well as intentional. Internalized racism involves the acceptance by stigmatized races of "limitations to our full humanity," including negative messages about abilities and intrinsic worth. Examples include self-devaluation, resignation, helplessness and hopelessness.

Jones concluded by emphasizing the importance of the social environment, how racism grows from initial preference to the perpetuation of inequity and the compelling need to address institutional racism. Potential policy strategies in education include re-examining funding of public schools based on local property taxes and setting 100 percent high school graduation as a public health goal. Within the justice area, policy ideas include creating pathways from prison to work and re-enfranchising former felons.

At some point, you give yourself permission to think that change is possible.
—Winona LaDuke

The national perspective: Models and tools from across the country

Building on the research findings shared in the morning panel, afternoon panelists addressed how to put what is known about social determinants of health into practice, exploring models, challenges and results. The three presentations allowed forum participants to develop a better picture of what this work can look like.

Work and Strategies of the Health Policy Institute, Joint Center for Political and Economic Studies

Pamela L. Thornton, M.S.W., Ph.D., *Health Policy Institute, Joint Center for Political and Economic Studies*

Thornton outlined the Health Policy Institute's efforts to translate work on health disparities into practice. Established in 2002 as a division of the Joint Center for Political and Economic Studies, the Institute is committed to building a "Fair Health" movement that "gives people of color the inalienable right to access and opportunity for healthy lives." Broad strategies include connecting with policymakers, community organizations and academic institutions and convening commissions to work on targeted areas.

The Institute's Place Matters Initiative is an ambitious five-year project designed to help communities of color identify policy objectives and activities to redress the upstream social conditions associated with health inequities. The initiative will focus on political representation, neighborhood disinvestment and environmental hazards. Additional initiatives work to reduce African-American infant mortality rates and improve life choices for young men of color.

One of the Institute's major partnership activities is a four-hour PBS series — *Unnatural Causes: Is Inequality Making Us Sick?* — scheduled to air in the fall of 2007. The Institute believes the series and accompanying public education will be a catalyst for national debate about the underlying causes of racial inequalities in health.

Healthy Homes and Early Learning: Addressing Social Determinants of Health in Seattle and King County

Jim Krieger, M.D., M.P.H., *chief epidemiologist, Seattle/King County Department of Public Health, and clinical associate professor of medicine and health, University of Washington*

Krieger discussed work in the Seattle/King County area on housing and early learning, describing several programs supported by cross-sector partners. "Addressing social determinants of health requires partnership," Krieger emphasized. "No one sector has all the resources."

The Seattle/King County Healthy Homes Project uses community health workers to assess home environments of low-income children with asthma and to work with families to develop and implement an environmental action plan. Outcomes for children include reductions in symptoms and in use of hospitalization and emergency departments. "Asthma provides a great example of the relationship between housing and health," Krieger said. "Exposure to triggers is a major cause of asthma and makes it worse. And substandard housing increases exposure to asthma triggers."

A program to build 1,600 affordable, healthy housing units on the site of existing, substandard housing is a collaboration among the resident council, architects, the public health department, the housing authority and the University of Washington. The site will include a network of open spaces and trails, spaces for social interaction, community gardens, access to transit and local availability of healthy food. Some of the units will include enhanced features so they can function as "breathe-easy homes" for children with asthma. The plan is to evaluate the health

outcomes for these children, assessing the benefit of the new homes over interventions that provide asthma education to residents of existing homes.

Policy can play a critical role in creating healthy homes and communities. Among the policy steps local communities and/or public health departments can take are:

❯ Disseminate guidelines for healthy homes construction and renovation

❯ Update local housing codes

❯ Advocate for healthy and affordable housing for low-income families

❯ Train housing inspectors, advocates, designers, builders, contractors, public housing agencies

❯ Help public housing tenants with asthma obtain appropriate units

Addressing social determinants of health requires partnership. No one sector has all the resources.

—Jim Krieger

Krieger went on to describe local work on early childhood development, which included a review of the literature to build a common knowledge base, partnership to build a policy agenda, creation of a system to track school readiness and to mobilize community action based on readiness gaps and provision of services such as home visits by public health nurses. Local partners developed policy recommendations and action priorities in five areas — nurturing relationships, family resources, childcare/early education, neighborhood and early intervention. Additional Seattle-area early childhood initiatives include use of the Early Development Instrument to measure school readiness for groups of children in specific geographic areas and the White Center work on school readiness, which includes home visits, case management and high-quality early learning.

Krieger concluded by summarizing common factors in addressing social determinants of health:

❯ Focusing on the feasible

❯ Convening multiple sectors

❯ Developing partnerships

❯ Learning each other's language

❯ Integrating efforts

❯ Recognizing that projects unfold over many years

❯ Evaluation

Health Impact Assessment: A Tool for Mobilizing Research and Understanding About the Upstream Determinants of Health

Brian L. Cole, Dr.P.H., *project manager, health impact assessment group, University of California, Los Angeles, School of Public Health*

Cole provided an overview of health impact assessment (HIA), an underutilized tool for mobilizing research and understanding about the upstream determinants of health. HIAs provide a means of "exploring different scenarios and discussing how to maximize health benefits." Features include a focus on public policy decisions and population health outcomes, a multidisciplinary process, consideration of a wide range of evidence and use of a structured framework.

HIAs focus on the likely impacts of a specific policy (e.g., tax cuts) by examining the "proximate effects" of the policy (e.g., increased family income, decreased government revenue), the intermediate outcomes on determinants of health (e.g., education, housing, funding for publicly subsidized health care, etc.) and health outcomes (e.g., mortality, injury/disease rates, years of healthy life, etc.). An HIA might produce a product, such as a report or a policy brief, or a process, such as community forums.

Health impact assessments can be used to:

❯ Influence decision-makers

❯ Highlight potentially significant health impacts

❯ Assess how proposals will affect the most vulnerable

❯ Facilitate inter-sectoral working and public participation

❯ Promote sustainable development

❯ Encourage a greater appreciation of public health in the policy-making process

In considering a policy proposal or proposed program, an HIA might ask questions about potential health effects, significance of the health benefits, equitable distribution of benefits and risks, impact on current disparities in health risks and conditions, health consequences of current policies and the cost/benefit balance of specific elements.

Health impact assessments may not have all the information we need, but a decision is going to be made and we want to bring health to the table. We want policymakers and stakeholders to make informed decisions about health impacts. —Brian Cole

Experience in other fields has provided important lessons for HIA practice. Environmental impact assessments (EIA), for example, have successfully engaged the public, but the EIA process is time-consuming, expensive and often litigious. EIAs also tend to produce long and complex documents and to focus on projects, not policies.

Strong consensus supports the following as necessary steps in conducting a health impact assessment:

❯ Screening – determining if an HIA should occur

❯ Scoping – determining what to do and how to do it

❯ Impact assessment – determining health hazards and considering evidence of impact

❯ Reporting and review – producing a coherent, usable synthesis of findings from the analysis for target audiences (e.g., policymakers)

❯ Evaluation and monitoring – determining whether the HIA has influenced the decision-making process (and the subsequent proposal) and monitoring the implementation of the proposal to ensure that any recommendations that decision-makers agreed to actually occur

Increasing capacity in the U.S. to use health impact assessments will require addressing technical and institutional obstacles. Promising strategies to do this include: creating a repository or clearinghouse for HIAs as well as prototypes, shortcuts for local agencies and training and technical assistance; linking universities, health departments, and legislative analysts; highlighting best practices; and creating broad supporting policy (not mandates).

How Do We Move Forward with an Upstream Approach?

As Ichiro Kawachi commented in the question and answer period following his keynote address, "One of the limitations we face in the social determinants field is that no one has a magic formula for how to invest." Despite the absence of such a formula, a number of strategies, guidelines and recommendations for moving forward emerged during the forum's closing panel discussion, as well as in sessions throughout the day, including:

❯ Work across sectors, in new ways

❯ Understand the importance of childhood and early intervention

❯ Target interventions to those at highest risk

❯ Address racism

❯ Understand the impact of poverty and the structural factors perpetuating problematic conditions

❯ Consider rural as well as urban needs

❯ Take a community focus, looking to communities to identify needs and priorities

❯ Connect with others doing similar work

❯ Begin with what's feasible

❯ Leverage work already under way

❯ Move on multiple fronts

❯ Use policy as a tool for systems change

❯ Communicate effectively — making health inequities visible, explaining the costs of inaction, focusing on specific, definable issues — to build public understanding and policy support

❯ Identify promising programs, tools, approaches as well as barriers and potential threats

❯ Plan for sustainability at the start

❯ Address the health care crisis as an opportunity for integrating upstream solutions

❯ Strengthen the connection between the health care sector and a social determinants approach

If all we do is worry about how to contain costs for interventions after health problems have occurred, we've already lost the battle.
—Jan Malcolm

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Panel discussion:
Setting the course for policy change
Healthier Communities — What Will It Take?

Jan Malcolm, *CEO, Courage Center, and former commissioner of health, state of Minnesota*

Malcolm set the context for a discussion among speakers and panelists on the policy changes needed to support an upstream approach. Producing healthier communities will take changing the conversation from the current focus on access, quality and cost-effectiveness of health care services to a fundamentally different way of talking, Malcolm explained: "If all we do is worry about how to contain costs for interventions after health problems have occurred, we've already lost the battle."

Instead, we need to broaden our focus to look at what really produces health status gains at the population level. "Unless we start talking of the social and economic determinants of health," Malcolm said, "we will never make meaning-ful progress in controlling the cost of health care or getting commensurate gain for the population." We need to ensure that the public and policymakers are aware — and outraged — by facts like these:

❯ The U.S. spends 50 percent more per capita on health care than any other country, yet ranks 37th overall in the World Health Organization's analysis of national health systems.

❯ We rank about 25th on life expectancy.

❯ Our comparative ranking on infant mortality (now at 28th) has fallen in recent decades.

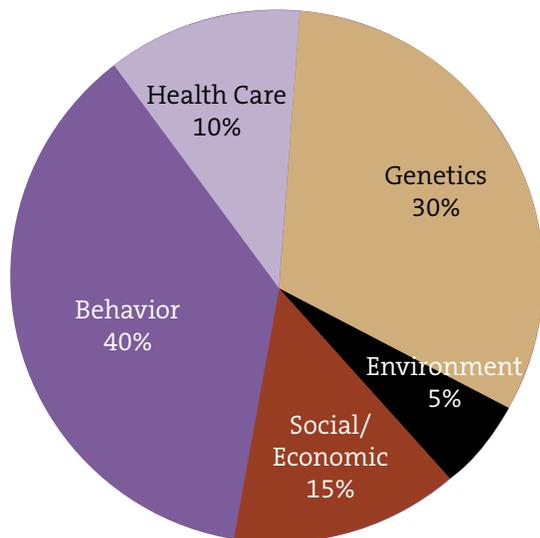❯ The only measure in which we rank No. 1 is life expectancy at age 80.

Malcolm also outlined the public health perspective:

❯ Health policy should maximize population health status at a manageable cost.

❯ Chronic conditions drive the great majority of health costs and are a greater threat to population health than acute conditions.

❯ Almost all chronic conditions can be significantly ameliorated, or even prevented altogether, if we work upstream to address causes and not just treatment after the fact.

❯ Prevention must be much more central in funding and in policy decisions.

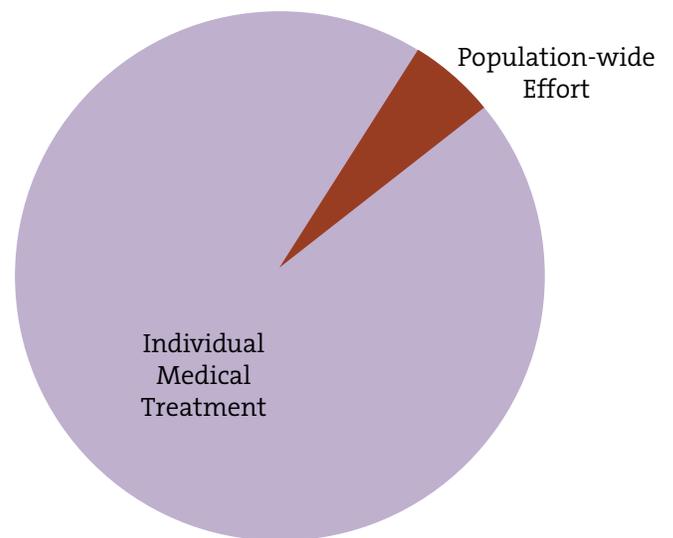❯ The non-medical determinants of health need much more focus.

Unfortunately, the significance of social, economic and environmental conditions for health is not reflected in our health investment decisions.

policy

Health determinants

Health Care 10%

Genetics 30%

Behavior 40%

Environment 5%

Social/ Economic 15%

How do we invest?

Population-wide Effort

Individual Medical Treatment

Health Expenditures

Source: Centers for Disease Control and Prevention

Answering the question of how to "get more health for the money," Malcolm noted that we must put a higher priority on prevention: "Yes, we need greater individual responsibility, but we have to also understand the kinds of environmental and social forces that surround individual choices." One opportunity is to enlist the clinical community in the effort to "better balance our health investments." Unless that happens, "we'll keep on banging on the health care system for failure to produce better results," results that are out of its reach.

To get better results, this country must embrace what certain other countries seem to understand — that education, housing, transportation, community development and income policies are also health policies. "We need to make the health care reform conversation and this conversation merge," Malcolm said. "These things are not afterthoughts. They have to be at the beginning and at the center of every health reform conversation we have."

We must understand that education, housing, transportation, community development and income policies are health policies.
—Jan Malcolm

First Steps in Developing a Policy Agenda

In support of our commitment to improving community health and quality of life, one of the Foundation's new initiatives focuses on policy development. We take a broad view of policy work and know that public education and communication are critical to the understanding and public will necessary for effective policy at all levels. Helping specialists and the public develop common concepts and language is particularly important in new areas. We believe the Foundation can play a role in stimulating dialogue among researchers, leaders in many fields and the public about what makes a healthy community. The discussion and learning at the November 2006 forum, building on work already under way both locally and nationally, is a first step in that direction.

Reflections and Next Steps

While the challenges of this work are great, so are the opportunities. In reviewing forum proceedings and comments from participants, we believe the following emerge as significant opportunities:

❯ Discovering ways to work together across sectors

❯ Building awareness of promising models, activities and tools

❯ Focusing on producers of negative determinants of health

❯ Starting early in life, with attention to children

❯ Intervening in the social environment

❯ Exploring the potential of health impact assessment

❯ Building on the work already under way in Minnesota around housing, early childhood development and the environment

❯ Paying close attention to community readiness and interest in change

These are good starting points for ongoing discussion and productive collaboration, and set the stage for defining plans and policies that will place Minnesota on a course to becoming the healthiest state in the nation for all its citizens.

Going forward, the Foundation will continue to work on the social conditions that determine health. We are committed to children, to the creation of healthy communities and to serving as a catalyst for discussion, cross-sector partnership and leadership. **We welcome your comments and suggestions and look forward to ongoing connection with all those interested in "working together to create healthier communities." Please contact us at (651) 662-3950 or toll free at 1-866-812-1593 or by e-mail at foundation@bluecrossmn.com.**

Upstream Health Leadership Award

The forum provided an opportunity to inaugurate the Foundation's health leadership award, created to highlight the effectiveness of leadership and concrete work on upstream community conditions that determine health and well-being.

Mark W. Banks, M.D., CEO, Blue Cross and Blue Shield of Minnesota, and board chair, Blue Cross and Blue Shield of Minnesota Foundation, presented the inaugural leadership award to Winona LaDuke, Native American environmental activist, in recognition of her leadership of the White Earth Land Recovery Project. LaDuke founded the project in 1989 to recover and restore the original Anishinaabeg land base for sustainable agriculture and to preserve the culture, heritage and health of the Anishinaabeg people. Along with the award, the Foundation provided a $15,000 grant to help further this important work.

"As a physician, I believe in the importance of prevention," Banks said. Noting that LaDuke refers to herself as a "social doctor," Banks said, "We should all aspire to be social doctors as we go forward."

As she accepted the award, LaDuke said, "As individuals and collectively as a community, we're interested in the process of becoming healthy and recovering ourselves." To do this, "we can't just put a program in. We have to look at the structural issues of how to make a community healthy," including the sacred and spiritual ties to land and language. Under LaDuke's leadership, White Earth successes have included sturgeon restoration, exploration of wind energy as a means to combat mercury in the reservation's lakes from coal-fired power plants and local food processing. "It's a psychological thing," LaDuke explains. "At some point you give yourself permission to think that change is possible."

The purpose of the Blue Cross and Blue Shield of Minnesota Foundation is to look beyond health care today for ideas that create healthier communities tomorrow. By addressing key social, economic and environmental conditions that determine health — beyond genes, lifestyle and access to health care — we work to improve community health for the long-term and close the health gap that affects many Minnesotans. The Foundation has awarded $20 million since it was established 20 years ago.

Current Foundation initiatives include:

- **Growing Up Healthy:** Kids and Communities, a statewide grantmaking initiative that helps communities work across sectors in new ways to create an environment that nurtures the healthy growth and development of children from birth to five.

- **Healthy Together:** Creating Community with New Americans, a statewide grantmaking initiative to reduce health disparities for immigrants by building social connectedness and relationships between newcomers and broader communities.

- **Critical Links,** which promotes training and use of community health care workers to reduce health disparities by race, ethnicity and foreign-born status.

- **Leadership recognition and development,** designed to develop, train, recognize and support leaders who can effectively work across sectors to help create healthier Minnesota communities.

- **Public awareness and policy support,** designed to build understanding and support for social, economic and environmental policies that promote health.

Thank You

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Gretchen Musicant, *Minneapolis Department of Health and Family Support*

Chuck Slocum, *Minnesota Business for Early Learning*