

# UNNATURAL CAUSES

is inequality  
making us sick?

## **CCLHO Semi-Annual Spring 2008 Conference**

*Anthony Iton, MD, JD, MPH*

Director and Health Officer

Alameda County, April 30, 2008

# Unnatural Causes: Is Inequality Making Us Sick?

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- A very different portrait of health than we are used to seeing in the media.
- **Prediction:** You will feel overwhelmed with the scope, scale and profundity of the issues raised *AND* their implications for you as a PH official and as an American.

UNNATURAL  
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# Unnatural Causes: Is Inequality Making Us Sick?

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- The ideas addressed in this film, while by no means new, speak to the very nature of how our society is organized and the avoidable health consequences that are “STRUCTURAL” in nature.



# Unnatural Causes: Is Inequality Making Us Sick?

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The film unveils the essence of the on-going political and social debate in this country about: what ideals we really stand for, how we set and balance our priorities, and how we translate these core notions into social and economic policies that ultimately determine who benefits and who bears the burden.



# Structural Tensions

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- Individualism vs. Community
- Profit vs. Social Responsibility
- Competition vs. Collaboration
- Free-trade vs. protecting jobs & workers
- “Race-neutrality” vs. addressing the legacy of systematic discrimination, land confiscation, and human slavery
- Preserving privilege vs. striving for equity
- Unrestrained capitalism vs. democracy



# Central Question For PH Practitioners

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How committed are WE to the principles of social justice?

How does that commitment translate to our PH practice?

# HP 2010

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## Goal 1: Increase Quality and Years of Healthy Life

- The first goal of Healthy People 2010 is to help individuals of all ages increase life expectancy *and* improve their quality of life.

## Goal 2: Eliminate Health Disparities

- The second goal of Healthy People 2010 is to eliminate health disparities among segments of the population, including differences that occur by gender, race or ethnicity, education or income, disability, geographic location, or sexual orientation.

# Public Health Mandates

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TITLE 17. PUBLIC HEALTH  
DIVISION 1. STATE DEPARTMENT OF HEALTH SERVICES  
CHAPTER 3. LOCAL HEALTH SERVICE  
SUBCHAPTER 1. STANDARDS FOR STATE AID FOR LOCAL  
HEALTH ADMINISTRATION  
ARTICLE 2. PROGRAM  
1276. Basic Services

The health department *shall* offer at least the following basic services to the health jurisdiction which it serves:  
... i) Services directed to the social factors affecting health, and which may include community planning, counseling, consultation, education, and special studies.



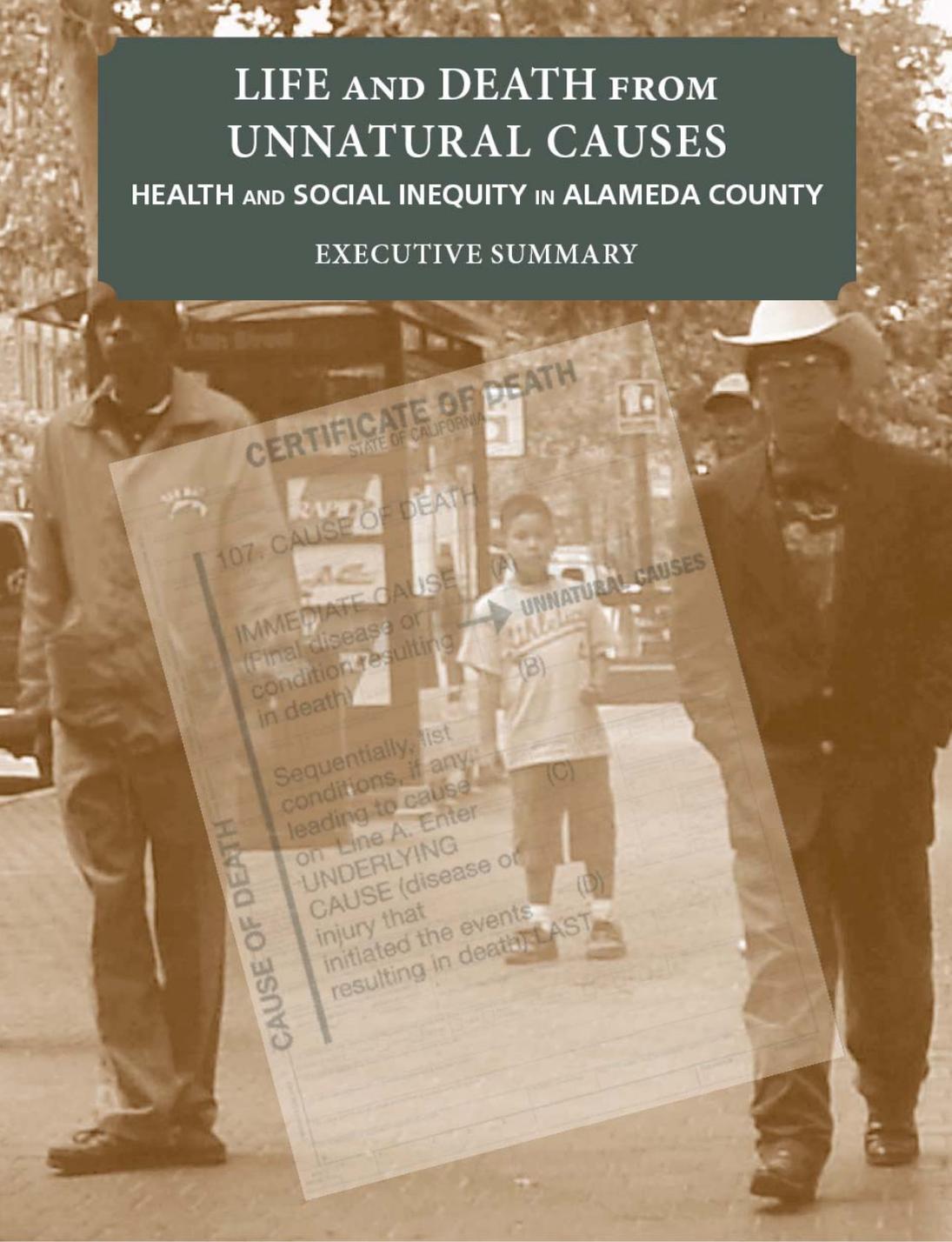
Lifting Up What Works  
**PolicyLink**

# LIFE AND DEATH FROM UNNATURAL CAUSES

## HEALTH AND SOCIAL INEQUITY IN ALAMEDA COUNTY

### EXECUTIVE SUMMARY

**Why Play?**  
Building a



# Eight America Disparities across Race and County

Christopher J. L. Murray<sup>1,2,3</sup>, Sande Terrell J. Landiorio<sup>3</sup>, Majid Ezzati<sup>1,2\*</sup>

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**Competing Interests:** The authors have declared that no competing interests exist.

**Academic Editor:** Thomas Novotny, University of California, San Francisco, United States of America

**Citation:** Murray CJL, Kulkarni SC, Michaud C, Tomijima N, Bulzacchelli MF, et al. (2006) Eight America Disparities: Investigating mortality disparities across races, counties, and race-counties in the United States. *PLoS Med* 3(9): e260. DOI: 10.1371/journal.pmed.0030260

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**Abbreviations:** BRFSS, Behavioral Risk Factor Surveillance System; NCHS, National Center for Health Statistics; SES, socioeconomic status

\* To whom correspondence should be addressed. E-mail: mezzati@hsph.harvard.edu

## ABSTRACT

### Background

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### Methods

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# The Fall and Rise of Mortality: 1960–2002

Nancy Krieger<sup>1</sup>, David H. Rehkopf<sup>1,2\*</sup>, Jarvis T. Chen,<sup>1</sup>

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**Citation:** Krieger N, Rehkopf DH, Chen JT, Waterman PD, Marcilli E, et al. (2006) The fall and rise of US inequalities in premature mortality: 1960–2002. *PLoS Med* 3(2): e46. DOI:10.1371/journal.pmed.0050046

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**Abbreviations:** CI, confidence interval; IRD, incidence rate difference; IRR, incidence rate ratio; NCHS, National Center for Health Statistics; PAF, population attributable fraction

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**Abbreviations:** BRFSS, Behavioral Risk Factor Surveillance System; NCHS, National Center for Health Statistics; SES, socioeconomic status

\* To whom correspondence should be addressed. E-mail: msjid\_ezzati@hsph.harvard.edu

## ABSTRACT

### Background

Debates exist as to the magnitude of income decrease. We accordingly shrink—in a context of 42 year period.

### Methods and Findings

Using US county mortality data from the 1960–2000 decennial censuses among persons under 75, we found that mortality rates in the lowest and highest mortality counties increased by 14% and 19%, respectively, between 1960 and 2000. This increase was most pronounced among persons of color.

### Conclusions

The observed trends in population health imp our job to understand

*The Editors' Summary of this*

# The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality Disparities in the United States

Majid Ezzati<sup>1,2\*</sup>, Ari B. Friedman<sup>2</sup>, Sandeep K. Culkarni<sup>2,3</sup>, Christopher J. L. Murray<sup>1,2,4</sup>

**1** Harvard School of Public Health, Boston, Massachusetts, United States of America, **2** Initiative for Global Health, Harvard University, Cambridge, Massachusetts, United States of America, **3** University of California, San Francisco, California, United States of America, **4** Institute for Health Metrics and Evaluation, University of Washington, Seattle, Washington, United States of America

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**Competing Interests:** The authors have declared that no competing interests exist.

**Academic Editor:** Thomas Novotny, Center for Tobacco Control Research and Education, United States of America

**Citation:** Ezzati M, Friedman AB, Culkarni SC, Murray CJL (2006) The reversal of fortunes: Trends in county mortality and cross-county mortality disparities in the United States. *PLoS Med* 3(4): e66. DOI:10.1371/journal.pmed.0050066

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**Abbreviations:** COPD, chronic obstructive pulmonary disease; NCHS, National Center for Health Statistics; SD, standard deviation

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## ABSTRACT

### Background

Counties are the smallest unit for which mortality data are routinely available, allowing consistent and comparable long-term analysis of trends in health disparities. Average life expectancy has steadily increased in the United States but there is limited information on long-term mortality trends in the US counties. This study aimed to investigate trends in county mortality and cross-county mortality disparities, including the contributions of specific diseases to county level mortality trends.

### Methods and Findings

We used mortality statistics (from the National Center for Health Statistics [NCHS]) and population (from the US Census) to estimate sex-specific life expectancy for US counties for every year between 1961 and 1999. Data for analyses in subsequent years were not provided to us by the NCHS. We calculated different metrics of cross-county mortality disparity, and also grouped counties on the basis of whether their mortality changed favorably or unfavorably relative to the national average. We estimated the probability of death from specific diseases for counties with above- or below-average mortality performance. We simulated the effect of cross-county migration on each county's life expectancy using a time-based simulation model. Between 1961 and 1999, the standard deviation (SD) of life expectancy across US counties was at its lowest in 1983, at 1.9 and 1.4 y for men and women, respectively. Cross-county life expectancy SD increased to 2.3 and 1.7 y in 1999. Between 1961 and 1983 no counties had a statistically significant increase in mortality; the major cause of mortality decline for both sexes was reduction in cardiovascular mortality. From 1983 to 1999, life expectancy declined significantly in 11 counties for men (by 1.3 y) and in 180 counties for women (by 1.3 y); another 48 (men) and 783 (women) counties had nonsignificant life expectancy decline. Life expectancy decline in both sexes was caused by increased mortality from lung cancer, chronic obstructive pulmonary disease (COPD), diabetes, and a range of other noncommunicable diseases, which were no longer compensated for by the decline in cardiovascular mortality. Higher HIV/AIDS and homicide deaths also contributed substantially to life expectancy decline for men, but not for women. Alternative specifications of the effects of migration showed that the rise in cross-county life expectancy SD was unlikely to be caused by migration.

### Conclusions

There was a steady increase in mortality inequality across the US counties between 1983 and 1999, resulting from stagnation or increase in mortality among the worst-off segment of the population. Female mortality increased in a large number of counties, primarily because of chronic diseases related to smoking, overweight and obesity, and high blood pressure.

*The Editors' Summary of this article follows the references.*



# Health Inequities

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“Health inequities are differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust.”

-Margaret Whitehead



# Healthy People 2010

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Healthy People 2010 recognizes that communities, States, and national organizations will need to take a multidisciplinary approach to achieving health equity—an approach that involves improving health, education, housing, labor, justice, transportation, agriculture, and the environment.

# What do you need to conduct a health equity campaign?

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## *Critical Components*

- Assessing local health department capacity
- Setting realistic goals
- Moving forward to achieve goals



# Assessing Local Health Department Capacity

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- Leadership
- Staff
- Organization
- Social and Political Climate





# Leadership

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- Is there a shared understanding about the root causes of health inequity?
- Is there a shared commitment to addressing the root causes of health inequity?
- Is leadership willing to devote resources (staff, time, funding) to address the root causes of health inequity?



# Staff

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- Have staff had opportunities to discuss the root causes of health inequities?
- Are staff comfortable with discussing racism, classism, and sexism?
- Are there facilitators with a strong understanding of the root causes of health inequity?
- Are there staff with the knowledge, skills, and time to follow up on recommendations from the forums?



# Organization

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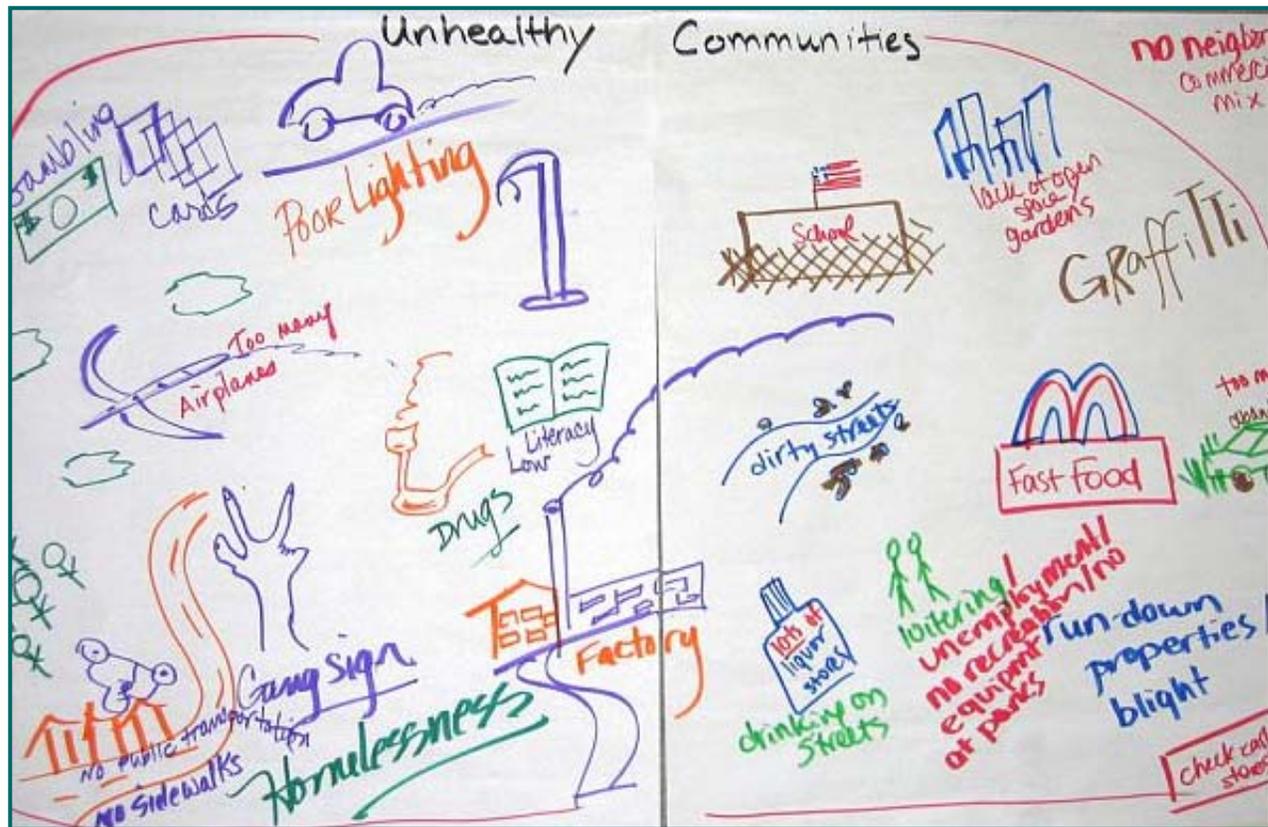
- Are there practices and programs already addressing the root causes of health inequity?
- Is the department building alliances with relevant organizations such as planning, housing, education, and transportation?
- Does the department provide the space and time for staff to increase their knowledge and awareness of social justice?
- Does the department provide opportunities for cross-divisional social justice work?



# Social and Political Climate

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- What's happening outside the health department that could be an opportunity for moving forward?
- What's happening outside the health department that could be an obstacle for moving forward?
- What's happening in other sectors that might be affecting health equity and are there ways to get involved?



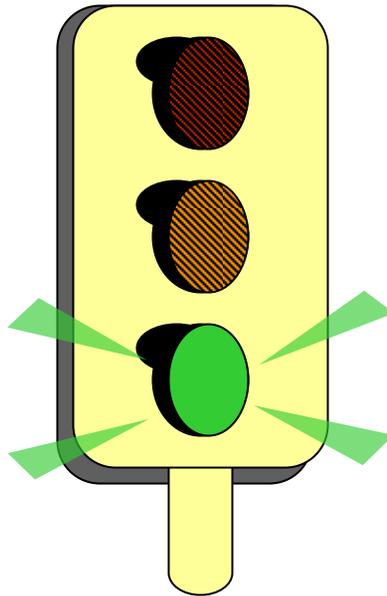
*"We need to be brutally honest and not have the typical bureaucratic response to this because no one wants another diversity training that dissipates after it is done."*

*-screening participant*

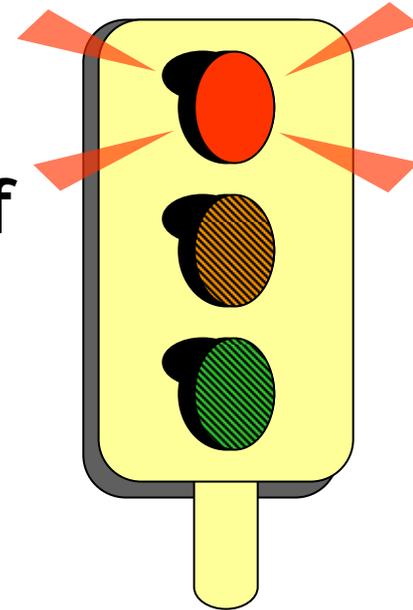
# Scenario 1: Assessing Capacity

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**Leadership**



**Staff**



# Scenario 1: Setting Goals

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Increase knowledge and awareness of health equity among staff and build critical mass.



# Scenario 1: Moving Forward

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- Internal screenings and discussions of the films

- Dialogues on racism, classism, & sexism

- PH 101



- Encourage staff to increase their knowledge

- Making the time and space for social justice

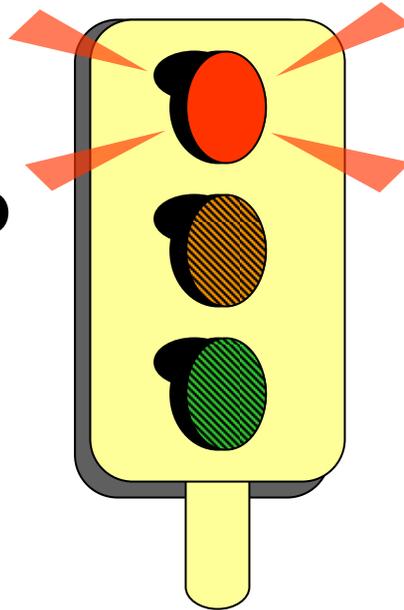
*“Local health departments can be a vehicle for educating the public about health, diversity, and racism.”  
-screening participant*



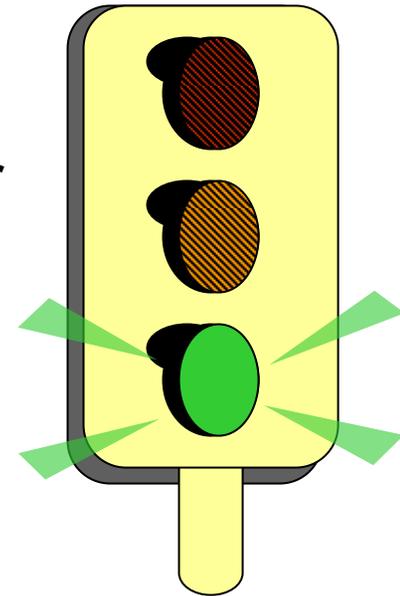
# Scenario 2: Assessing Capacity

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**Leadership**



**Staff**



# Scenario 2: Setting Goals

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Increase knowledge and awareness among leadership and create buy-in.



# Scenario 2: Moving Forward

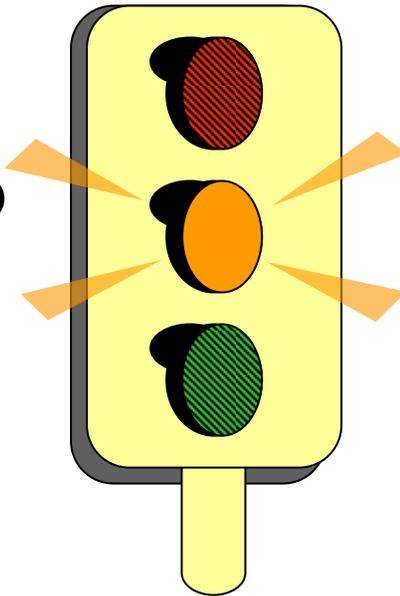
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- Create small discussion groups to view the films
- Find opportunities to show the films like all-staff meetings
- Find an ally on the Leadership Team

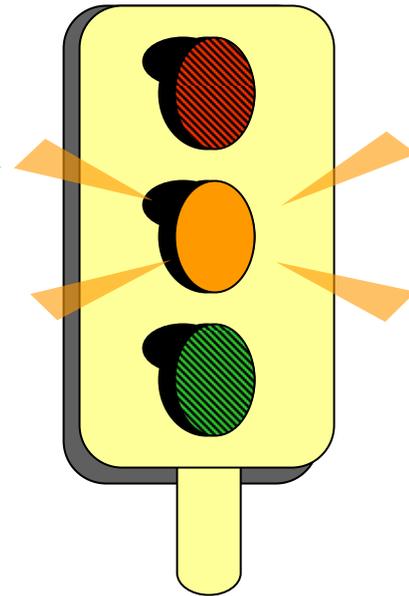
# Scenario 3: Assessing Capacity

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**Leadership**



**Staff**



# Scenario 3: Setting Goals

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Build and maintain momentum, critical mass, and staff capacity to go deeper into social justice work.

# Scenario 3: Moving Forward

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- Dialogues to address issues that arise from film screenings
- Forums with agencies
- Strategic planning
- Policy analysis and advocacy



*“Local health departments can convene decision-makers so that they really understand the importance of their decisions in impacting health. They can work across jurisdictions to look at systemic issues.”*

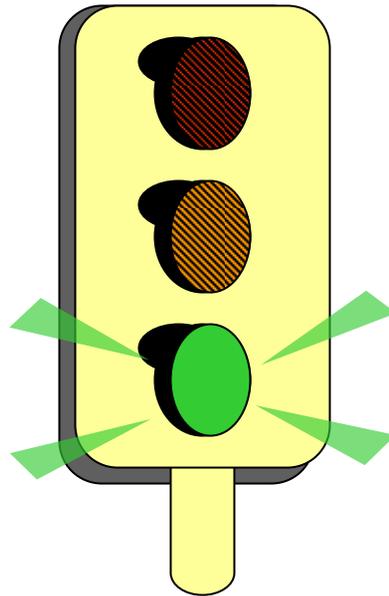
*-screening  
participant*



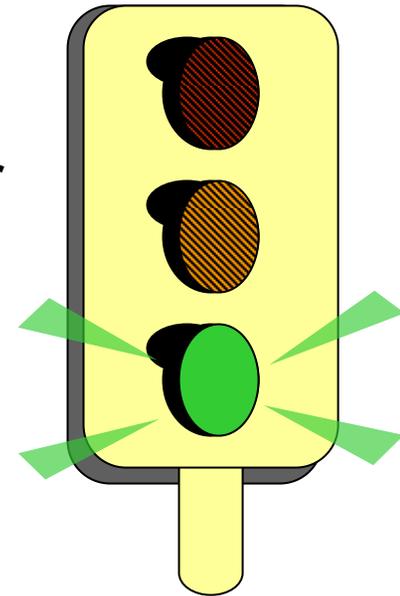
# Scenario 4: Assessing Capacity

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**Leadership**



**Staff**



# Scenario 4: Setting Goals

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Partner with communities to address the root causes of health inequity.



# Scenario 4: Moving Forward

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- Forums with community residents
- Organize, mobilize, and act with community residents to eliminate health inequity



# Before using the film externally...

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You must consider:

- Leadership support
- Staff readiness
- Organizational capacity for facilitation and follow-up
- Appropriate audience for capacity

*“We can do the internal and external work in tandem, but we have no right to ‘teach’ the community unless we have engaged in these discussions about health equity ourselves.”*

*-screening participant*



# Tools to Help You

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- Community tool-kit
- Discussion and action guides
- Event planning guide
- Reporting highlights/outcomes of the event
- Fact sheets



*"This film will have a major impact.  
The film was very powerful and very  
eye-opening for me. I appreciate  
the opportunity to screen it."*

*-screening participant*



*"This film is breaking ground. It will impact people forever. We can start small and document the outcomes."*

*-screening participant*

