The NCHHSTP 2010–2015 Strategic Plan and the Pursuit of Health Equity: A Catalyst for Change and A Step in the Right Direction

On October 19, 2010, the Centers for Disease Control and Prevention (CDC), National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP) held its Health Equity Symposium entitled “Establishing a Holistic Framework to Reduce Inequities in Human Immunodeficiency Virus (HIV), Viral Hepatitis, Sexually Transmitted Diseases (STDs), and Tuberculosis (TB) in the United States.” For those of us working on health equity issues at the state level, it was an honor to participate in such an important national event with distinguished colleagues Paula Braveman, MD, and Scott Burris, JD, who offered perspectives on some of the most pressing issues relating to health equity based on specific aspects of the NCHHSTP Strategic Plan.1

Overcoming health inequities in the United States is entirely possible by changing the way we define, think, and address the problem. The preceding statement is meant to challenge public health professionals to champion effective health equity strategies in public health systems. We hope the following thoughts will compel you to seize opportunities to address health inequities using a holistic framework, even when it may be unpopular or uncomfortable to do so.

NCHHSTP STRATEGIC PLAN

Strategic plans are often developed with the best intentions, only to suffer the fate of other planning initiatives (i.e., to exist on bookshelves of their creators and stakeholders without any real life or action beyond the planning process). With this in mind, one must ask the question, how is the NCHHSTP Strategic Plan different, and will it suffer the fate of other well-intentioned planning documents? The NCHHSTP Strategic Plan is different in that it speaks to the need of addressing viral hepatitis, HIV/acquired immunodeficiency syndrome (AIDS), STDs, and TB in a holistic fashion, with an emphasis on addressing the root causes of health disparities for these diseases. Addressing the root causes of disparities is not often reflected in national public health planning documents, especially as a central theme. The NCHHSTP is to be commended, for
this is indeed a step in the right direction. The ability of the NCHHSTP to make good on this plan, however, depends upon four key factors:

1. Defining health equity concepts in concrete terms to devise realistic solutions,
2. Moving beyond program silos and embracing the concept of syndemic orientation,
3. Using technology and data to identify social determinants of health (SDH) to make data-driven decisions for resource allocation, and
4. Overcoming discomfort in the public health community to effectively address racism as a social determinant.

Framing health equity in concrete terms
The NCHHSTP Strategic Plan’s rationale statement reads: “The concept of health equity is aspirational and focuses on the distribution of resources and other processes that drive a particular kind of health disparity. . . . It is important to examine the structural drivers of health disparities in addition to individual behaviors.” While this statement is critically important, it reflects a major challenge in how health equity is often framed—the absence of describing, in concrete terms, what structural drivers (i.e., SDH) and disease burdens would look like when we actually achieve health equity. For the purposes of this discussion, health inequity is defined as “a difference or disparity in health outcomes that is systematic, avoidable, and unjust.” SDH are defined as “the complex, integrated, and overlapping social structures and economic systems that are responsible for most health inequities.” Health equity is defined as “when all people have the opportunity to ‘attain their full health potential’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance.’”

Framing health equity, health disparities, or SDH in concrete terms could start by changing the way we communicate health disparity data. For instance, it is well-known that HIV/AIDS disproportionately impacts African American and Latino women aged 15–44 years and African American and Latino males aged 15–35 years. A way to frame this issue in concrete terms would be to supplement existing disparity data with projected/estimated data on what these disease rates would be to supplement existing disparity data with projected/estimated data on what these disease rates would be to supplement existing disparity data with projected/estimated data on what these disease rates would be distinct from that of other groups. However, the complexities of health inequities. Understanding syndemic orientation and overcoming obstacles to its implementation will take some effort, but is necessary to move forward. Otherwise, the beautiful dream of health equity will never come to fruition, and the nightmare of health inequities will continue.

Adopting the syndemic orientation mindset
The NCHHSTP Strategic Plan defines syndemic orientation as “a way of thinking about public health work that focuses on connections among health-related problems, considers those connections when developing health policies, and aligns with other avenues of social change to ensure the conditions in which all people can be healthy.” Syndemic orientation is critical to achieving health equity. However, the following stark realities must be addressed to effectively apply this concept in local, state, and territorial health agencies:

1. Funding for public health is often categorical without expectations to integrate beyond programmatic silos. In other words, what gets funded gets done. While this generally plagues many public health interventions, it is even more daunting for health equity. Without dedicated and sustainable funding, health inequities are unlikely to be addressed in a coordinated, meaningful fashion.

2. Health equity is defined differently by national funding agencies. This requires health equity champions in states to find common ground among differing expectations from funders while simultaneously trying to reflect a unified response to health inequities within state and territorial agencies. This balancing act makes it difficult to build consensus, especially among categorical programs that continue to grapple with applying health equity concepts.

3. There is no widespread support to build infrastructure for health equity in local, state, and territorial health agencies. The few health equity offices that do exist are most likely to be placed...
low in the organizational hierarchy and to have few staff, small budgets, and high expectations to achieve policy, systems, and environmental changes. These offices are also the most vulnerable for elimination or downsizing during tough economic times.

4. Organizations are complex and designed to maintain themselves, whether they are engaged in noble pursuits or supportive of unproductive activities. Public health organizations are not exempt from this reality nor will they change without the demand of their internal members and external stakeholders.

The key to maximizing the benefits of a syndemic orientation lies in bold and courageous leadership. Leaders must clearly articulate the importance of health equity and set expectations to address the issues that permeate throughout all levels of their organizations. Leaders must also require that syndemics be reflected throughout the entire life cycle of all public health interventions—from program planning to allocating funds to evaluating program impact. Leaders must be steadfast in their resolve to support syndemics and manage conflict, as there will obviously be pushback from colleagues who believe that addressing SDH is not their responsibility and is beyond the scope of their public health practice.

Leaders will hear comments such as, “My public health program cannot possibly solve the problem of poverty,” “High dropout rates have little to do with HIV infection trends,” or “My public health program cannot address the effects of racism—it’s just too big of a problem.” These types of responses are indicative of colleagues who sincerely want to address health inequities, but who are in need of direction and courageous leadership. These colleagues need leaders to reinforce a new mindset, provide direction, and communicate new expectations. Leaders must also help their staff understand that it is not their job to completely solve social and environmental factors that result in health inequities, but it is within their power to incorporate a response to those factors within the scope of their interventions. This response also includes partnering with organizations whose primary responsibility is to respond to SDH.

So what does syndemic orientation look like in practice? Examples include, but are not limited to, the following:

- Providing briefings for federal legislators on the need to appropriate flexible funding within and beyond categorical programs
- Modifying the grant-making process to support joint grant opportunities from a cross-section of categorical programs that incorporate SDH
- Conducting program impact evaluation studies that hold funders and their subgrantees responsible for demonstrating the effect of program interventions
- Training the existing (and future) public health workforce to think beyond specific health conditions to address SDH
- Updating data and surveillance systems to collect and exchange information on health conditions, SDH, and race/ethnicity
- Retooling existing public health interventions using a health equity lens
- Reaching consensus among federal funding agencies regarding definitions of health equity and best practices for responding to SDH

Although these strategies may seem daunting, they are entirely possible, cost-effective, and within the scope of all public health agencies.

The syndemic orientation mindset must also go beyond the NCHHSTP to the entire CDC and other federal agencies, and their state and territorial counterparts. These U.S. agencies include, but are not limited to, all sectors of the Department of Health and Human Services, the Department of Commerce, the Department of Housing and Urban Development, the Department of Transportation, the Department of Education, the Department of Agriculture, and the Justice Department.

Using data and technology to identify SDH and make decisions

The NCHHSTP Strategic Plan calls for the identification of SDH. This goal is extremely important but often difficult to accomplish because of the widespread unavailability of datasets and/or technology that reflect the simultaneous interaction of different SDH. During the Health Equity Symposium, participants learned how to overcome this obstacle using market research data and software with geographic information system capability from Nielsen Claritas (San Diego, California). Tools such as this software contain robust datasets and are used by Fortune 500 companies to understand environments where they can conduct business and be successful. These tools can also be used to create detailed thematic maps or charts to display particular characteristics or elements of environments and populations, such as physical, social, or behavioral determinants of health for policy-making and targeted interventions.
Poverty and educational attainment are often used to detect areas with health inequities. Market research software was programmed to detect census tracts in Atlanta, Georgia, with the highest concentrations of poverty and the greatest number of people with less than a ninth-grade education. This research yielded a detailed map of metropolitan Atlanta that highlighted two census tracts (Figure 1). Census tracts generally contain a population of 1,200 to 8,000 people, with an optimal size of 4,000 people. This level of geography is appropriate to implement and analyze public health interventions.

Using the software, an additional variable was added to the map, which displayed the greatest concentration of African American males aged 15–34 years ($n=1,000–1,300$) (Figure 2). This group was chosen because it experiences high HIV-related disparities and is often targeted for HIV-prevention interventions.

Demographic data based on the thematic map revealed that the census tract with the largest concentration of African American males aged 15–34 years is in an area with a 2009 estimated population of 18,000 residents. The racial makeup of the area is 96% African American. Of those >16 years of age, 10% are unemployed, 57% are not in the labor force, and 47% live below the federal poverty level. The thematic map also revealed that the highest concentrations of African American males aged 15–34 years in metro Atlanta were found in a geography that encompasses the Fulton County jail. This finding is in stark comparison to the area around the Georgia Institute of Technology, where it was less likely for African American males to live in large numbers (Figure 3).

The data from the thematic map provided ample content for social commentary and the ability to predict health inequities that will result from those conditions. We know the negative impact of 10% unemployment on the national economy of the United States. Imagine for a moment the health of our citizens if 47% of U.S. households lived below the federal poverty level and 57% were not in the workforce. This statistic would not only be worse than the Great Depression, but also would signal the collapse of our country as we know it today. Yet, there are countless rural and urban
communities in our country where these statistics are an everyday reality and have existed over a protracted period of time. Based on these data, how can residents who live in areas with these harsh social conditions ever be expected to attain the best health possible without deliberate interventions?

The strategic use of market research technologies that are fortified with public health data provides public health practitioners with a three-dimensional perspective of SDH. In turn, this perspective provides the opportunity to develop three-dimensional interventions that function to address not only health conditions, but also the underlying causes of disparities. With this in mind, the thematic maps suggest that HIV-prevention initiatives in Atlanta for African American males be incorporated within a progressive and robust employment program. This type of HIV-prevention initiative could provide residents with a living wage, train them for careers (as opposed to jobs) to respond to widespread unemployment, and provide them with access to educational opportunities to break the cycle of poverty. This intervention would also depend upon a strong partnership with the local department of corrections to keep young African American men out of jail, thus diminishing the proliferation of what many refer to as the prison-industrial complex.

Overcoming discomfort with racism as a social determinant
SDH are complex, persistent, and sometimes controversial. No one person or organization can be expected to have all of the answers that underscore the importance for ongoing training, dialogue, and collaboration. The NCHHSTP Strategic Plan provides a catalyst for addressing SDH, including those that make us uncomfortable, in a different way. Many in the public health community are more comfortable dealing with SDH when they focus on poverty, education, housing, and transportation. We tend to speak with ease about these factors and their connections to health disparities. However, when the issue of racism is added to the discussion, the comfort level greatly diminishes, and conversations tend to take a different direction or stop altogether.

Figure 2. Metropolitan Atlanta census tracts with the highest concentrations of poverty and the greatest number of African American males aged 15–34 years, 2010
The reality is that a post-racial society does not exist in 21st century America. It seems we were more honest and willing to address issues of race from the 1950s through the 1990s, as reflected by the Civil Rights Movement, the Kerner Commission Report,7 school desegregation, the 1992 Los Angeles riots, and even the O.J. Simpson murder trial. In fact, we are so hypersensitive about race today that a tremendous amount of energy is spent convincing ourselves (and others) of its relative unimportance, especially when considering the desire for political correctness. The ongoing denial of the pervasive, negative impact of racism not only reveals the unconscious magnitude of the problem, but actually destines our society to repeat and relive many racial problems of the past.

There are three main ways the public health community tends to address the impact of racism on health and health disparities. We either deny its impact on population health altogether, minimize its effects in favor of another social determinant of health (e.g., poverty), or focus on the relative or absolute difference in disease burden (health disparities) without addressing underlying causes (which often include racism).

The denial continues despite the existence of empirical evidence to the contrary, such as the 1985 Report of the Secretary’s Task Force on Black and Minority Health,7 the Institute of Medicine’s Unequal Treatment,8 California Newsreel’s Unnatural Causes documentary,9 or “The Economic Burden of Health Inequalities in the United States,” by the Joint Center for Political and Economic Studies.10 However, there is hope, as this problem of denial can be overcome by helping the public health community transcend its understanding of racism at the individual level to instead focus on structural racialization. The Kirwan Institute at The Ohio State University defines structural racialization as “a system of social structures that produces cumulative, durable, race-based inequalities.” Structural racialization is also “a method of analysis that is used to examine how historical legacies, individuals, structures, and institutions work interactively to distribute material and symbolic advantages and disadvantages along racial lines.”11

Acquiring skills to apply the concepts of structural racialization can help public health practitioners manage and move beyond personal discomfort to address...
the manifestations of racism in a holistic manner. This concept not only aligns with major themes of the NCHHSTP Strategic Plan, but it also supports current evidence-based public health strategies that utilize systems, policy, and environmental change approaches. Structural racialization also supports the concept of syndemic orientation in a way that is actionable and measurable. We must clearly understand that this learning process is continuous, but necessary, if we wish to maintain skill sets relevant to solve current public health problems that involve race.

FUNCTIONING AS A CATALYST

The majority of public health practitioners may sincerely want to eliminate health inequities but may not have the skill set or comfort level to effectively intervene. By properly framing health inequities, adopting a syndemic orientation, and confronting sensitive issues, we can make a real difference. The NCHHSTP Strategic Plan provides a useful framework for public health practitioners to become true change agents and function as catalysts for the elimination of health inequities. A catalyst is defined as anything that can speed up a reaction but is not consumed in the process. Health inequities are difficult to address, and the potential for burnout is high. Moreover, the lack of essential skills to address the problem has the potential of “consuming” the public health practitioner in ways that are unhealthy and unproductive. However, the ideas presented in this article are within our own spheres to speed up activities to respond to health inequities without “burning out.”

The World Health Organization believes health disparities can be eliminated in a generation.4 We agree. The public health community remains our best hope to lead, coordinate, and sustain this fight. We must remain hopeful, keep the faith, and meet the challenge.

REFERENCES