

MESSAGING TO ADVANCE HEALTH EQUITY IN PUBLIC POLICY
NAM Culture of Health Program Webinar Series

June 12, 2019
3:00-4:30 PM ET

QUESTIONS ANSWERED BY THE NAM CULTURE OF HEALTH PROGRAM STAFF

1. I wonder why and how the nine social determinants of health (SDoH) were selected for the Culture of Health Program.

A: The nine SDoH identified by the Culture of Health Program are grounded in the research and evidence base from the *Communities in Action: Pathways to Health Equity* report. The report committee identified these nine SDoH based on a thorough analysis of the scientific literature. The conceptual model in the report adapted elements of the *Culture of Health Action Framework* from the Robert Wood Johnson Foundation and the Prevention Institute's *Systems Framework to Achieve an Equitable Culture of Health*. More details on the committee's determination to select these nine determinants can be found in the [Communities in Action: Pathways to Health Equity Report](#) (pages 47-49).

QUESTIONS ANSWERED BY JENNIFER MESSENGER

1. How do you all determine WHERE the need is greatest? I am a health professional in the geographic information systems (GIS) space, and I wonder if other providers are aware of the power of understanding location and environment, especially in terms of targeting.

A: In the Voices for Healthy Kids work we intentionally leave this up to the community; our point is only that the community, together with policymakers, should define criteria for determining where the need is greatest, and build that into the policy so it's followed when policy benefits/resources are allocated. In some cases policies have defined greatest need by socioeconomic status, history of investment or disinvestment, accident/incident rates (in the case of safe routes to school or complete streets policies, for example), health outcome rates, etc.

2. How important is it to enlist the help of "trusted elders" in communities we seek to help?

A: If the community defines those voices to be important in exploring challenges and designing solutions, they should be included. The point is that you need to work with the community to define the issue, the power structure, the process, the research questions, the analysis, and the solution.

3. Does anyone on the panel care to comment on how this discussion fits with Moral Foundation Theory: how liberals and conservatives resonate differently to intuitive moral values?

A: We looked at a variety of research, including the Moral Foundation work of Jonathan Haidt, framework research, policy research, research around commonly held values at the macro and cultural levels, etc. We know that American culture is not a single thing; there are a whole bunch of different cultures and values that exist in various communities. But we were looking for values that resonate broadly at the aggregate level, across decision-makers and likely voters. Human potential and community emerged as being among a set of values that resonate with the broadest number of people across the spectrum. Opening that pathway to policy language is a starting point for focusing the policy where the need is greatest.

4. So far, many of these interventions have been about improving communities for everyone, which is easily supported by "start with those most in need, expand everywhere." I wonder if a different track would be needed for policies that actually protect low-income communities at the expense of the more advantaged (higher density zoning laws coupled with mandatory affordability, for example).

A: The Voices for Healthy Kids research explored how to convince a policymaker to build equity provisions into policy language after they've already agreed on the policy, not how to sell the policy itself. But I suspect you might be successful using the same values-based argument to introduce a policy solution that in itself would take effect where the need is greatest. The research does show, through the national likely voter survey, that people support making changes in places where the need is greatest, even if it means they get improvements later, or even if it raises their taxes.

5. What are the best ways/language/tools to use when promoting ally-ship to promote health equity?

A: Please find suggestions available in the Voices for Healthy Kids Messaging Guide, available here: <https://voicesforhealthykids.org>.

6. The social determinants included in the Culture of Health [Program] are great. Where and how should corporate behavior, including targeted/predatory marketing, influencing and contributing to elected officials, and lobbying regulatory mechanisms, fit into these social determinants? Should these forces - think tobacco, alcohol, firearms industries - be included as an explicit social determinant?

A: This is not the focus of the research I presented, but I would say a definite yes! I work on tobacco prevention in Oregon, and we are laser focused on industry/predatory marketing and the impact it has on rates of tobacco use and tobacco-related chronic disease. I'd say this is absolutely a SDoH. In addition, I view it as outright racism, which is also a SDoH.

7. Example of Values over Facts: Our state health department came up with “One Minnesota,” essentially meaning we are all one and should reach the same outcomes. However, some have perceived the “One” to mean we all have to become like each other - and exist as one. That’s a huge difference. Owners of the phrase have held to their value that “One Minnesota” is good because the intention behind it was good, but the fact is those receiving the message see it/value it differently and can be offended by it.

A: This is understandable. The root of the problem is the idea that “we should reach the same outcomes.” This is equality, not equity. It ignores the fact that we all start from different places, we all need unique resources to create the lives we want, and we all may desire to end up in different places defined by culture, worldview, need, etc. I can imagine “One Minnesota” is also very alienating to the many tribes in the state who are sovereign nations and likely don’t identify with “One Minnesota.” Perhaps there’s a way to honor the intention of the phrase (we need to look out for each other and create “one” state where everyone can thrive) while acknowledging the (positive, beneficial, asset-laden) differences of the population.

8. Do you recommend that we launch a national Health Equity Bus Tour ... focused on community forums designed to give the community the “mic” ... and to use social media to give voice to what we learn?

A: Yes!

9. No one knows the greatest needs better than people who are the recipients of health disparities. There is a need to include community representation on committees addressing these concerns, otherwise you have a tendency to get more of the same.

A: Yes!

10. What sort of unintended consequences could arise from developing health equity focused policies?

A: This is a great question to be further explored with Voices for Healthy Kids. This would be a good conversation to have with multiple entities working in this space.

11. In lay terms, how do you describe and apply targeted universalism? Can you also describe the research to support this approach to message framing?

A: Policies that aim to help everyone, starting where the need is greatest to ensure effectiveness, then expanding to help everyone else.

12. Do you have any advice for talking about structural racism with policy decision-makers?

A: There are great resources available from Opportunity Agenda, Center for Social Inclusion, Frameworks, and others. [Voices for Healthy Kids] research didn’t pursue that line of communication because it didn’t prove to be a productive start to the conversation about policy

language. Rather, we found that starting with the idea of “start where the need is greatest” is a pathway to discussing how to determine that need, which can open a conversation about structural racism and the impact that continues to have on health outcomes.

13. Systemic racism and oppression is based on white supremacy and that language remains invisible. Racism is perpetrated by white people to the benefit of white people. The overall conversation regarding SDoH makes the white privilege aspect invisible. How is the claim to equity possible without addressing intentional inequity that continues through the silence?

A: We know systemic racism and oppression feeds into the SDoH that we have to address, but the focus of this research was not how to talk about white supremacy and overtly dismantle a system. We were looking at how to be the most effective in creating the most equitable policies now, intentionally trying to navigate the limitations of the current system to pass policies that advance health equity for communities still facing those systemic barriers. With some decision-makers, using health equity language from the beginning can shut down a conversation, and the research has found that equity itself is not always a shared value, especially in the way we may be defining it. So we looked for the best and most effective approaches for policy advocates to keep decision-makers at the table and lay groundwork before moving into more overt equity language. The goal is not to avoid talking directly about equity, but rather to start conversations in a way that will open the door for a direct conversation. This work is focused on incremental change that can happen now, which is just a part of the bigger, much-needed, and vital conversation about systemic inequity.

14. Speaking of incremental change, could a presenter please succinctly differentiate between long-term goals and short-term objectives, i.e., keeping our eyes on the proverbial “prize” while trudging steadily and courageously along, day by day?

A: There are a few ways to distinguish this. Some advocates focus on the “short-term” of just passing the policy, and miss the opportunity to create longer-term change by ensuring that the policy is designed to advance health equity. The message guide I shared encourages this longer-term approach, by securing language in the policy to advance equity. Bigger picture, I would say that the work we’re talking about here is in the category of trudging steadily and courageously along, trying to create changes within the current system of inequity.

15. I’m a little confused about the criteria behind eligibility. Is the idea that policies should emphasize vulnerable constituencies rather than vulnerable places?

A: Eligibility refers to the idea of need not being limited to a certain group or type of community, and it was a key concept in our testing with decision-makers and likely voters. Greatest need is determined based on the criteria that we set up together, and any community can be eligible and considered as being the most in need for a policy’s efforts. Decision-makers are more comfortable hearing that, as conditions change, those with the greatest need can benefit rather than having policies locked into a specific place.

16. How do we approach policies on social determinants that are really difficult to get likely voters and politicians to accept? Mass incarceration is probably the most difficult—are there additional strategies we can employ to convince the public that there is a better way to be doing this?

A: The Voices for Healthy Kids research explored how to convince a policymaker to build equity provisions into policy language after they've already agreed on the policy, not how to sell the policy itself. That said, I would say the place to start is values. What do your decision makers and voters value in the community, and how do those values connect to the changes you seek to create? California Women's Foundation did some really good work on messages about sentencing reform based on the impact on women/mothers and the generational [SDoH] impact of incarceration—that might be a place to look.

17. The abstract definitions of health equity that likely voters would agree with is encouraging, but I'm curious how voters might be able to get more on board with actual programs/policies rather than broad conceptual statements. The big national example is health care: many voters think that all people should have access to health care, but not as many believe in a program like Medicare-for-all or similar alternatives. What can help bridge the gap here?

A: This is not my area of expertise so I'd be speculating. Going back to the research, though, you might look at the values and the argument that we found effective in building equity into policies and test whether those elements could work here. I do know, from work back before the Affordable Care Act, that reassuring people that their care will still be reliable, quality, and effective is key, along with the personally relevant benefits of a healthier society overall.

18. Do you have any examples of how this messaging might be used to address or prevent gentrification? It seems like that could be a side effect of policies that are health equity focused.

A: I don't have direct examples of this but would love to see them! Maybe in persuasive arguments about economic development and neighborhood investment—start where the need is greatest (e.g. the most local businesses are being pushed out)?

19. You mentioned a lot of different kinds of justice (food, language, environmental), but do you integrate the social justice lens of the very different roles and solutions that agent and target groups have in reducing inequities?

A: We offer the research and message guide as a framework that local advocates can use to create their own messages and approach—so yes, they would absolutely bring in those lenses and roles as they form their strategy.

20. I work for a state health department. My policy-decision makers are admin. Do these strategies also apply to different venues and types of policy-makers?

A: We tested them with elected officials specifically.

21. Are you thinking about or asking how white people have through policy created segregated and inequitable conditions for populations of color and the lack of access to generating their own ability to address their own issues without white people coming in to “help” people of color?

A: There are excellent questions and critical issues being raised here and throughout the question chain. This particular research focused on how to be most effective in creating more equitable policies within the current system. We understand that this system is built on systemic racism and oppression (and yes, these are SDoH, to be certain) and must be dismantled and rebuilt. There are limitations in this research and the messages; we are trying to navigate the limitations of the current system.

22. I guess I am still trying to gain buy-in from admin and staff on health equity and am wondering if these same strategies apply across this spectrum.

A: We tested the messages specifically with elected officials, but anecdotal evidence from Voices grantees indicates that they will work with other decision makers too.

23. Why did you pick likely voters?

A: We wanted to see how the constituency of decision makers were in alignment with these ideas. Being able to tell decision makers that “likely voters” support these ideas felt more powerful than “general public.”

24. How was the likely voter sample selected?

A: Random sample, oversample among communities experiencing health disparities + counties that switched from Obama to Trump.

25. Regarding your results on likely voters, have you shared them with public officials? I wonder if they realize and accept these views of their own constituents.

A: We provided the polling results in the message guide, along with tips on how advocates can use them to make the case to decision makers. You’ll find details in the message guide at <https://voicesforhealthykids.org/healthequity>.

26. With certain audiences (conservative), equity can be a negatively charged word. What suggestions do you have to use alternative language that will tap into their and our mutual values and help us make progress toward health equity? Thank you for this webinar and focus on this and SDoH!

A: That’s exactly what the message guide focuses on! You can download the guide at <https://voicesforhealthykids.org/healthequity>.

QUESTIONS ANSWERED BY BEN SCHMAUSS

1. How do you define “fair” opportunity? Who determines “fair” opportunity? What is the criteria for “safe” and who determines “safe”? Are there definitions for these types of terms and who has the power to implement these terms? Thanks.

A: In policy terms “fair” is defined, or not, by the policy-making body. From my experience, best practice is a policy-making body, with significant input from the community, inserting policy language that clearly reflects fairness and outlines what that looks like when implemented. Relative to your question about “safe” and who determines “safe,” the key elements of a comprehensive policy include accountability measures that require implementation plans created in concert with community input and public reporting of clearly defined performance measures. We seek out evidence-based best practice and then work with elected officials to translate best practice into policies that fit the needs of their communities.

2. From a conservative point of view, do they ever have people say "how will building a bike path for people who need it the most [aka more equitable policies] be better for us all?" and what is your response?

A: We do get questions specific to bike paths, and biking in general, around the complete streets work we do from all areas of the political spectrum. There seems to be a common assumption that complete streets means sidewalks and bike lanes. Addressing and educating on what we are trying to do usually helps people get a vision of why it is important and how it can benefit the whole. What we have tried to do is bring this back to the shared values of community and human potential. So my response would be something like: “When people make decisions about their health—or the health of their children—the choices they make depend on the choices they have available. We know when safe options are available to walk or bike to a local park, work, library, or school, people use those options. Creating effective policies that address the areas of greatest need first and then expanding to all areas allows our limited resources to have the greatest impact.”