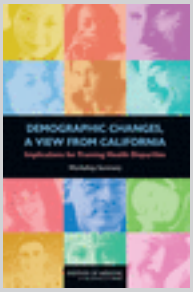

Demographic Changes, a View from California: Implications for Framing Health Disparities: Workshop Summary

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DEMOGRAPHIC CHANGES, A VIEW FROM CALIFORNIA

Implications for Framing Health Disparities

Workshop Summary

Karen M. Anderson, *Rapporteur*

Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

Board on Population Health and Public Health Practice

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Willing is not enough; we must do."
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Although the reviewers listed above have provided many constructive comments and suggestions, they were not asked to endorse the conclusions or recommendations nor did they see the final draft of the report before its release. The review of this report was overseen by **Bobbie Berkowitz.** Appointed by the National Research Council, she was responsible for making certain that an independent examination of this report was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this report rests entirely with the authoring committee and the institution.

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Preface

Since early 2007, the Roundtable has met with the objectives of increasing the visibility of racial and ethnic health disparities as a national problem, furthering the development of programs and strategies to reduce disparities, fostering the emergence of leadership on this issue, and tracking promising activities and developments in minority care that could lead to the reduction or elimination of disparities. The Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities includes representatives from the health professions, federal, state, and local government, foundations, academia, managed care organizations, advocacy groups, and community-based organizations. Its mission is to facilitate communication across sectors and—above all—to generate action.

Through its convening capacity and by holding public workshops across the nation, the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities aspires to advance understanding of health disparities and explore solutions for ending them. In doing so, it endeavors to make a lasting contribution to the quality of life for some of this country's most vulnerable groups.

With this goal in mind, on July 28, 2008, the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities convened a workshop in Los Angeles, California, America in Transition, a View from California: Implications for Addressing Health Disparities. By focusing on the complexities of immigration in the country's most populous state, California, the Roundtable looked at how the discussion of "framing" health disparities can influence the actions that are taken in response.

ACKNOWLEDGMENTS

The Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities thanks all workshop participants for their individual contributions to this workshop. Their willingness to share their time and expertise led to frank discussions about immigration, demographic changes, and the role of "framing" in highlighting health disparities for the public.

We especially want to give thanks to Alicia Dixon, our project officer for The California Endowment. The workshop took place at The California Endowment's Center for Healthy Communities. Thanks to Alicia and the other California Endowment staff, especially George Kim and Jessica Lieder, for ensuring that the workshop ran smoothly.

Thanks also to all of our speakers and panelists. Biosketches for all presenters can be found in Appendix B.

The Roundtable members also thank the Institute of Medicine staff for their ongoing efforts to support the work of the Roundtable. Sincere gratitude is extended to Dr. Rose Marie Martinez, Director, Board on Population Health and Public Health Practice; Karen Anderson, for planning, organizing, and implementing this workshop; and Thelma Cox, for managing all of the administrative components of the meeting. We also want to thank Patrick Burke and Hope Hare for their ongoing assistance and support.

Thanks to the planning committee that worked so diligently on arranging the workshop: Rajni Banthia, America Bracho, Will Crimi, Jamila Davison, Cara James, Jim Krieger, Rose Marie Martinez, Sam So, Mildred Thompson, Bill Vega, and Winston Wong.

Several Robert Wood Johnson Clinical Scholars volunteered as scribes during the breakout sessions in the afternoon (Rhondee Benjamin-Johnson, Nazleen Bharmal, Anisha Patel, Rashmi Shetgiri, and Kara Odom Walker). Thanks to all for your assistance during the workshop.

Finally, special thanks go to all of the sponsors who make the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities a reality. Financial support for the Roundtable and its activities was provided by the Agency for Healthcare Research and Quality in the Department of Health and Human Services; The California Endowment; the California Health Care Foundation; the Centers for Disease Control and Prevention in the Department of Health and Human Services; The Commonwealth Fund; the Connecticut Health Foundation; the Healthcare

Georgia Foundation; the Henry J. Kaiser Family Foundation; Kaiser Permanente; Merck & Co., Inc.; the Missouri Foundation for Health; the Robert Wood Johnson Foundation; and the W.K. Kellogg Foundation.

Nicole Lurie, *Chair*
Roundtable on the Promotion of Health Equity
and the Elimination of Health Disparities

1

Introduction

When researchers and policy makers discuss the differential health outcomes for racial and ethnic minorities, what language is appropriate to describe these differences? Are they "disparities"? "Inequalities"? "Inequities"? The definition used depends on how the differences are framed. How people talk about these issues has everything to do with public interest in the topic, what is understandable to people, and what energizes and engages them. The present workshop, then, focused on how these disparities should be framed and how this framework relates to the ways in which disparities are discussed at the community level and across the country.

This workshop follows two earlier workshops convened by the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities. The first, held in St. Louis, Missouri, focused on the interface between the health care system and the community in which it is based. The second, held in Atlanta, Georgia, looked at disparities in health outcomes across the life span, with a particular emphasis on young children.

SCOPE OF THE WORKSHOP

On July 28, 2008, the Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities sponsored a public workshop to discuss the role of framing health disparities in diverse communities in reducing health disparities. Because California is a state that has experienced—and that continues to experience—dramatic demographic shifts, the Roundtable thought that it was an important locale to look at the importance of framing health disparities for a range of dif-

ferent racial and ethnic groups. Framing, Roundtable Chair Nicole Lurie noted, is critical in determining how disparities are discussed.

The workshop, titled America in Transition, a View from California: Implications for Addressing Health Disparities, was organized to advance the dialogue about health disparities by facilitating a discussion of the topic among stakeholders in the community, including residents, academia, health care, business, policy makers, and philanthropy. The goal of the meeting was to discuss how the framing of health disparities in diverse communities influences the public debate about improving health outcomes. The workshop was also organized to help identify commonalities in community strategies, best practices, and lessons learned from community successes and failures in their attempts to address health disparities.

As populations shift across a geographic area, there is often a redistribution of health risk factors and health problems that leads to a need to reassess the solutions that will best address these redistributions. By understanding how demographic shifts in communities are affecting health disparities, the strategies that communities develop may differ depending on the racial and ethnic composition of that community. How issues of health disparities are framed may also differ across different racial and ethnic groups.

WORKSHOP AGENDA

After two keynote speakers talked about the changing face of American communities and the implications of these demographic transitions for California in particular, Lori Dorfman described the science of framing health disparities and its use in policy discussions.

These three morning presentations were followed by panels from three California communities: East Palo Alto, Fresno, and South Central Los Angeles. Each of these communities is grappling with major demographic transitions. By bringing together a panel of individuals from each community, the purpose was to learn how different racial and ethnic groups work together to solve health disparities and how they frame health disparities within the community.

The afternoon was spent in small breakout sessions facilitated by Roundtable members in which the community representatives talked with workshop attendees and Roundtable members about these issues in more detail and in a smaller setting and reported back on their discussions of the following topics and questions:

- Briefly talk about the demographic transitions that have occurred over the past 10 to 15 years in your community. Are there "old"

versus "new" ethnic groups in your community? What, if any, has been the impact of immigration on your community?
- What assets have your community's newer ethnic groups brought to the community?
- Have attitudes about race and expressions of racism changed with the arrival of new community members?
- Describe the major health and health disparity concerns in your community.
- How has the community worked to address these health and health disparity concerns? Specifically, how has your framing of these issues affected your progress?
- Have the different racial and ethnic groups worked together? What have been your successes in addressing these concerns? What have been your challenges in addressing these concerns?
- What suggestions on how to frame health disparity issues do you have for other communities?

KEY THEMES

Throughout the workshop, the speakers and the workshop attendees highlighted several recurring themes:

- Framing. An understanding of framing is critical to understanding how health disparities should be addressed. In particular, it needs to be recognized that the default frame in a culture of personal responsibility colors conversations about health disparities.
- Residential segregation. The issues of gentrification, urban renewal, and the historical practice of redlining all affect where low-income people of color can live. This, in turn, affects the health of low-income people of color.
- Race and racism. Race interacts with the process of residential segregation and thus cannot be ignored when health outcomes are being evaluated.
- Lack of access to health care. A lack of access to health care, especially to specialty care, is a major problem for low-income individuals of color and their communities.
- Lack of community infrastructure. A lack of safe places to walk and exercise and a lack of access to large grocery stores will have an impact on the health of the residents in that community. The skyrocketing obesity rates in some racial and ethnic minority groups are contributing to rising rates of chronic diseases, such as diabetes.

- Other community factors. Poverty and violence are major contributors to health disparities for some racial and ethnic groups.
- Shorter life spans for future generations. As several speakers noted, if current trends continue, children today will not live as long as their parents do. Studies of foreign-born immigrants and their children who are born in the United States also indicate that the American-born children of immigrants have shorter life spans than their immigrant parents.

ORGANIZATION OF THE REPORT

The report that follows summarizes the presentations and discussions that occurred during the workshop. Therefore, its scope is limited to the views presented and discussed during the workshop.

Chapter 2 reviews the changing demographics in the United States and in California in particular. E. Richard Brown, using data from the California Health Interview Survey, describes a number of health disparities among individuals in different racial and ethnic groups and notes the importance of having good data to document these disparities. Mindy Fullilove focuses on residential segregation and its history in the United States. She concludes that the ongoing problem of residential segregation is a major contributor to health disparities between people of color and other groups in society.

The concept of framing is covered in Chapter 3. Lori Dorfman defines the term "framing," describes its origins, and offers examples of how framing works in news stories. Because the ways in which health disparities are framed have consequences for how people address these disparities, it is important to understand framing.

Chapter 4 presents the stories of three different communities in California that have experienced major demographic shifts. Three panels, one for each community, describe how these demographic changes have influenced health outcomes and how framing can lead racial and ethnic subgroups to work together to reduce health disparities. After the presentation of the comments of the three panels, Tony Iton offers his reactions and observations.

Finally, Chapter 5 describes the reports from the group breakout sessions in which the community representatives talked with workshop attendees and Roundtable members about these issues in more detail and concludes with comments from Roundtable Chair, Nicole Lurie.

Several appendixes contain additional information about the workshop. In addition to the meeting agenda (Appendix A) and biographical information about the speakers (Appendix B), Appendix C provides a list of relevant websites that the speakers mentioned in their presentations.

2

The Changing Face of American Communities: Implications for Framing Discussions About Health Disparities

"NO DATA, NO PROBLEM"

E. Richard Brown, Ph.D.
Director, Center for Health Policy Research,
University of California, Los Angeles

According to E. Richard Brown, academic researchers tend to focus on statistical outcomes and their implications, without calling attention to potential inadequacy of data needed to understand and assess policy issues. However, when looking at the changing face of America and the underlying trends and patterns, it is essential to ensure that good data exist in order to examine disparities and their causes.

Change in American Communities

Widespread demographic changes have been sweeping the United States, particularly in the last generation. This is leading to new populations and new immigrant communities across the country, instead of only those states typically known to receive immigrants (i.e., California, Florida, Illinois, New Jersey, New York, and Texas). Rather, immigrant populations are dispersing across the country and forming new communities in many different states.

Without good data, however, information about adverse health outcomes for these populations could not be tracked, leading to health disparities not being recognized, acknowledged, or addressed. Table 2-1 contains

TABLE 2-1 New Populations and Communities Established Throughout the Country by Deep Demographic Changes

	Asian and Pacific Islander		Hispanic/Latino	
	1970	2007	1970	2007
California	2.8%	13.7%	13.7%	36.7%
Georgia	0.1%	3.2%	0.6%	7.9%
Idaho	0.5%	1.7%	2.6%	10.0%
Kansas	0.2%	2.6%	2.1%	9.0%
Minnesota	0.2%	3.9%	0.6%	4.1%
North Carolina	0.1%	2.2%	0.4%	7.2%
Utah	0.6%	2.6%	4.1%	11.8%

SOURCE: Bureau of the Census (1970) and data provided by E. Richard Brown, based on his analyses of Census and other data. Table created by E. Richard Brown.

data from six states not typically known to receive immigrants as well as California and shows the demographic changes that have occurred. In 2007, for example, Utah's Latino population was nearly 12 percent of the state's population, whereas its Latino population was only 4 percent of the state's population in 1970. The changes have also been dramatic in California, where, due to a long history of immigration, no population, ethnic, or racial group makes up a majority in the state today. Therefore, the ability to track these patterns is critical.

The California Health Interview Survey (CHIS) is a comprehensive statewide survey of the health status of California residents. Sufficiently large samples of key demographic subgroups are surveyed, providing good information about immigration status, citizenship status, and so on. There is also a strong emphasis on the dissemination of the data from CHIS, with the goal being to be a source of evidence for policy discussions and policy development. The survey is conducted every 2 years, and $1 out of every $5 allocated for the survey goes toward dissemination. The CHIS also contains a data query system that allows free online access to the data. This helps get the data into the hands of the people who can use it to reduce and eliminate health disparities.

In both established communities and new communities, social stratification leads to health disparities between groups. There are disparities in health and health care by race and ethnicity, income, rural versus urban residential location, gender, and other social characteristics. For example, a disparity is said to occur if the data show that there are differences in the utilization of preventive services that all members of a population group should be receiving and differences in social factors unrelated to the incidence or the prevalence of disease. In other words, if there are differences

in health care utilization because of the social characteristics of the community, a disparity rather than a health care need exists.

Disparities are related to a number of different factors, including person-environment interactions (diet, physical activity) and social and environmental exposures (environmental justice issues). One example of research that used CHIS data assessed the effects of air pollution on asthma. As determined by the use of geographically coded data, air pollution rates were found to be associated with higher rates of emergency room visits because of asthma and with a higher frequency of asthma symptoms. These environmental effects on health status would not have been detected without access to the CHIS data.

A historical example can also be presented. In this case, the issue was not having the necessary data to make an informed policy decision. In the early 1980s in California, then-Governor George Deukmejian reached an agreement with legislative leaders to drop some recipients of the state Medi-Cal program. Those dropped were a population that was served by Medi-Cal but that did not qualify for federal matching funds. This group of medically indigent adults totaled approximately 250,000 people and the counties where they resided became responsible for providing care to that population. Not surprisingly, Lurie found that the affected population of patients encountered serious adverse health affects because of the lack of funding for their health care (Lurie et al., 1984, 1986). Brown approached the key legislative staff members in Sacramento to request funding to study the effects of this policy change. The request was denied. Without good data, then, access to strong evidence about trends or the effects of those trends was not available.

Five examples of good evidence about trends and their effects, all from the CHIS data, follow.

Example 1: Children's Access to Dental Care

Data indicate that oral health problems are the primary reason that children are absent from school. Additionally, dental care is critical for healthy eating as well as for social integration for adults because an obvious lack of access to dental care is an indicator of social class and social status. For example, low-income adults face a major barrier to success in their job searches because of the poor condition of their teeth.

Not surprisingly, the major reason that people do not seek dental care is a lack of dental insurance. This is the case even when other sociodemographic variables are controlled for statistically. The end result is racial and ethnic disparities in children's dental visits and in children's overall dental health.

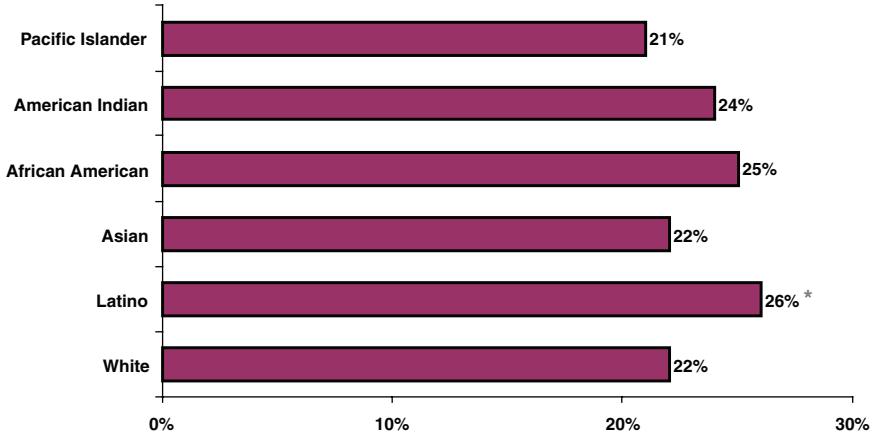

FIGURE 2-1 Percent of children who have not seen a dentist by age 11.
SOURCES: CHIS (2005); Pourat (2008). Created by E. Richard Brown.

In looking more closely at these data (Figure 2-1), Latino children are the most likely to have never visited a dentist. In fact, more than a quarter of Latino children have never visited the dentist by the age of 11 years. There are also subgroup differences, with Puerto Rican and South American children being the least likely to have visited the dentist.

Similar subgroup differences exist for Asian ethnic subgroups. South Asian and South Korean children are the least likely to have visited the dentist, whereas Vietnamese children are the most likely to have been to the dentist. What is critical here to note is that without good data, these subgroup differences for Latinos and Asians are invisible.

Example 2: Mammogram and Pap Test Access

Asian American women have the lowest cervical cancer and breast cancer screening rates among all racial and ethnic groups. Within Asian ethnic subgroups, however, there are significant differences in access to mammograms and Pap tests (Figure 2-2). South Korean women are the least likely to have had these tests, whereas Filipino women are the most likely to have been screened. The reasons for low rates of screening among these subgroups vary; but they include issues such as limited English proficiency, a lack of health insurance coverage, and the number of years that the individual has lived in the United States. However, by disaggregating the data, it is possible to target interventions to different vulnerable groups, guided

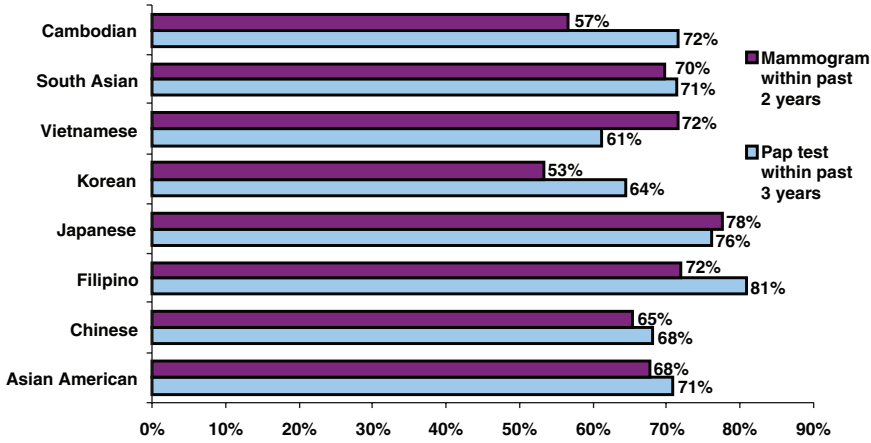

FIGURE 2-2 Mammogram screening and Pap test rates differ among women by Asian ethnic subgroup.
SOURCES: CHIS (2001); Kagawa-Singer et al. (2007). Created by E. Richard Brown.

by an understanding of the subgroup differences. Without good data, this is not possible.

Example 3: Diabetes Rates

It is well known that the rates of diabetes differ among racial and ethnic groups. Diabetes is a major cause of death in the United States, and diabetes is a major cause of disability and functional limitations. Diabetes can result in blindness, permanent kidney damage, cardiovascular disease, and lower limb amputations. It is a consequence of obesity, family history, a lack of exercise, and other factors.

By comparing subgroups and adjusting for age, the rates of diabetes are seen to be far lower for some Asian subgroups than for others (Figure 2-3). Rates are far lower for Chinese Americans, for example, and far higher for Filipinos and South Koreans. The diabetes rates for all Asian subgroups, however, are far lower than the diabetes rates for Native Americans, which is the group with the highest rate of diabetes in the entire population.

There are also differences in the rates of diabetes among Latino subgroups. Mexicans and foreign-born Latinos have the highest rates, and these rates are considerably higher than those for all Asian American subgroups. These differences can be used to more finely target public health and clinical interventions to groups with concentrated needs for services.

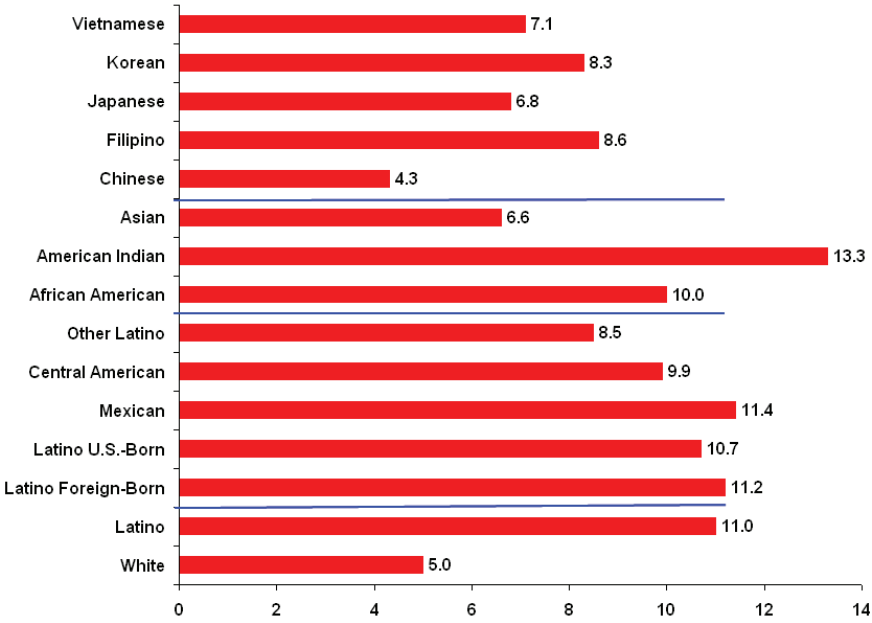

FIGURE 2-3 Age-adjusted diabetes prevalence by race and ethnicity, adults ages 18 years and over, 2005.
SOURCE: CHIS (2005). Created by E. Richard Brown.

Example 4: Variation in Diabetes Rates by Geography

What accounts for the subgroup differences in the rates of diabetes among subgroups of the population described in the previous section? Both demographics and community factors play a role. In considering county-level data from the Bay Area in Northern California, the rate of diabetes in Santa Clara County is nearly 8 percent, and the rate in Solano County is 8 percent. In contrast, the rate in the nearby county of Marin was only 3 percent. These differences in the rates of diabetes are due to the demographic factors described earlier, as well as to local conditions in the community. All of these differences would be missed if the data were not disaggregated across geographic locations. For example, the food environment is very different in Marin County than it is in the other counties in that the population of Marin County has greater access to produce, locally grown food, and supermarkets as well as lower numbers of fast-food restaurants.

Example 5: The Retail Food Environment Index

Expanding on the role of fast-food restaurants in obesity and diabetes, researchers studying this link have developed an indicator of the role that the food environment plays in a local geographic area. This indicator, called the retail food environment index (RFEI), is the number of fast-food restaurants added to the number of convenience stores divided by the total numbers of grocery stores, produce markets, and farmer's markets:

$$\text{RFEI} = \frac{\text{no. of fast-food stores} + \text{no. of convenience stores}}{\text{no. of grocery stores} + \text{no. of produce markets} + \text{no. of farmer's markets}}$$

In this way, the RFEI scores for different counties, which are computed at the census track level, can be compared to explain the differences in county-level diabetes rates. The statewide average RFEI for California is 4.2. This means that for every grocery store, produce market, or farmer's market in a geographic area, there are 4.2 fast-food outlets or convenience stores. Higher scores, then, mean fewer healthy food alternatives, and those geographic areas with higher RFEI scores also have higher diabetes rates. Higher scores are also significantly related to obesity rates, as seen in Figure 2-4.

This is an environmental justice issue, and these data can be used to provide evidence of the need for policy changes at the local level. For example, in Los Angeles city council enacted an ordinance to limit the development of new fast food outlets in South Los Angeles. This is an important example of how experts working in advocacy and policy at the local level can use data to champion an issue, even in the face of political opposition.

Reaction and Discussion

Roundtable member Jim Krieger asked about the diabetes rates in California for Native Americans and Pacific Islanders. In Seattle, Washington, which also has large Asian and Pacific Islander communities, the highest diabetes rates are found among Pacific Islanders, Native Americans, and Alaska natives. Brown responded that the CHIS does not currently have a good sample of data for Pacific Islanders, so any information about the diabetes rates in that community comes from hospitalization rates and mortality data. However, Brown indicated that he is working with Pacific Islander advocate groups to oversample that population to collect better data for that population.

Workshop participant Christina Jose asked whether the CHIS includes

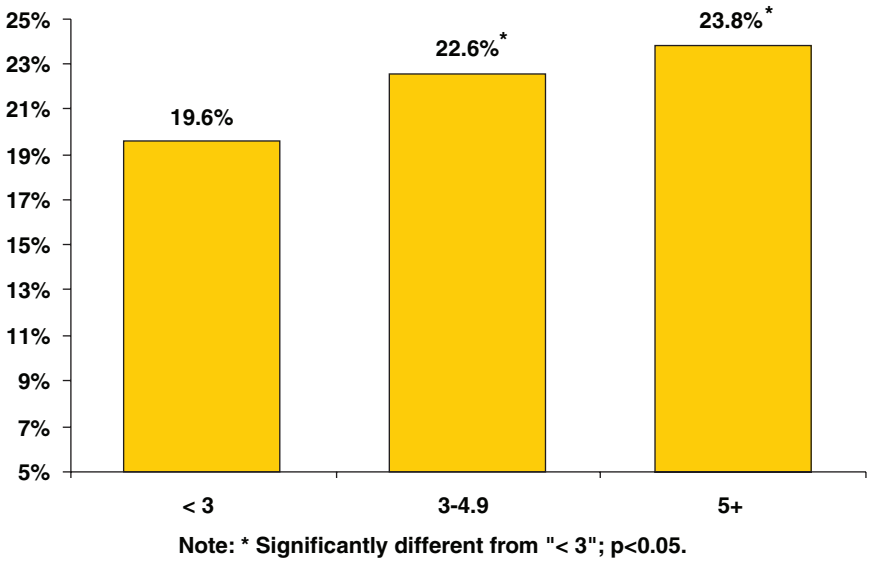

FIGURE 2-4 Percent obese as a function of RFEI using urbanicity—specific buffers, adults age 18 and over, California, 2005.
Source: Babey et al. (2008). Created by E. Richard Brown.

information about the rates of mental health problems. Brown said that it does have a mental health module, which includes mental health status, mental health service utilization, and access to mental health services.

Workshop participant Charles Vega asked about the new regulations in the city of Los Angeles that limit the number of fast-food establishments and convenience stores. In addition to these limits, he asked whether there are better ways to get healthier foods into the community. Brown responded that community groups and advocacy groups work to expand access to good food such as good-quality produce and inexpensive foods. Efforts to bring supermarkets into low-income communities are also being organized.

UNITY OR APARTHEID?

Mindy Thompson Fullilove, M.D.
Professor of Clinical Psychiatry and Public Health, Columbia University

Mindy Fullilove framed her comments as a series of philosophical issues about the changing face of American society rather than a focus on

data. Her presentation began with a discussion about racism in American society and how this is "the elephant in the room" in any discussion of health disparities. Fullilove explained that the existence of racism in society "grabs everybody in the gut" and is anchored on one end by blacks saying, "Yes, there is racism in our society" and on the other end by whites saying, "But I am not racist." All people fall somewhere along this continuum, she said, and all of us have different kinds of feelings about whether America is a racist society.

The Myth System of Apartheid

In considering health disparities, Fullilove argued that it is essential to acknowledge "the myth system of apartheid." For example, while she was recently working in Paris, Fullilove read an article about what's new in New York. One of the quotes in the article was a statement from a West African organization that described the old-line black organizations as "whiny" and that they just need to die off so that new energy can take over in Harlem.

Unspoken but implicit in this statement is this: "Black people are in trouble because they don't work hard enough, because they just didn't get along, they didn't want to fit in, they didn't want to go to school." This negation of the reality of apartheid can set back the efforts and destroy the unity that is needed to end health disparities and other inequalities, Fullilove stated.

Apartheid is very real and it is all around us, Fullilove argued. One can think about the history of the United States in terms of the system of apartheid. For example, the European settlers who first came to the Americas asked the Native Americans to "just move over a little bit." Then, there was the Constitutional Convention, where inequality was written into the United States Constitution. Both serve as historical examples of apartheid.

Another example of the existence of apartheid in the United States can be seen in Los Angeles. There are actually two cities, the first being what Fullilove called "monumental Los Angeles." This is the city with the giant bank towers and glass corporate buildings. Then there is the Los Angeles that Fullilove described as being "off the grid." This is, according to Fullilove, the embodiment of what apartheid looks like. Monumental Los Angeles did not exist from the time of the city's founding; it replaced the older city where residents actually lived. As an outcome of the development of monumental Los Angeles, there is no space left for low-income people, individuals with mental illness, and the other residents who will be pushed aside for the new, the glossy, and the buffed up. Marginalized people will be pushed aside in the dynamic of apartheid, because "apartheid needs to eat the space," said Fullilove.

Redlining

In the 1930s, the system of redlining was systematized and superimposed (Hillier, 2003) over the existing patterns of segregation. Redlining is a system of preferential investment, and it codified inequities in investments in different neighborhoods of a city. This codification took place along very specific lines that involved nonwhite status and living in a neighborhood with old buildings. This was how American cities were divided up. Only being a white Protestant was considered desirable.

Nonwhite status did not simply mean Negro, however. It also included Jews, Italians, immigrants, Poles, and other ethnic groups. In other words, according to Fullilove, the conception of "race" is a made-up system and a system that is always evolving in the definition of the excluded "other."

Figure 2-5 shows a map of the city of Philadelphia in the 1930s, in which the red areas are designated for those people who were common and skilled laborers. They were a mix of the foreign-born, Negroes, and families on relief. The red zone meant "don't invest money here." This was not an absolute imperative but rather a guide to investment. This was saying, "Don't invest your money where the poor people and the working people live." Segregation had previously already existed in American cities; redlining just came in and built upon that legacy of segregation.

In the United States today, different Western European ethnic groups, for example, Irish, Jewish, and Polish groups are all considered to be Caucasian. In contrast, in 1937, it was a diverse society with many different groups rather than one condensed category of Caucasian. This is what Fullilove referred to as "patterns of lumping and splitting." The outcome of this diversity in society is social stratification, and social stratification is the basis of health disparities, according to Fullilove.

Consider another, similar example of social stratification from the United States. A recent documentary called *Passing Poston* followed Japanese Americans who were imprisoned during World War II and who went back to visit the Poston internment camp many decades later. During World War II, Japanese American citizens were herded onto trains and interned in camps, causing them to lose their land, homes, businesses, and most importantly, their status as free people. In contrast, no effort was made to intern German or Italian citizens during World War II in the United States, even though the United States was also at war with Germany and Italy.

Another example of the effects of residential segregation can be seen in the evolution of Boston Harbor, as described by Herbert Gans in his famous book *Urban Villagers* (1962). The Boston Harbor geographic area was a largely Italian community that was destroyed over time through the process of urban renewal. Not only did this lead to "grieving for a lost home," but

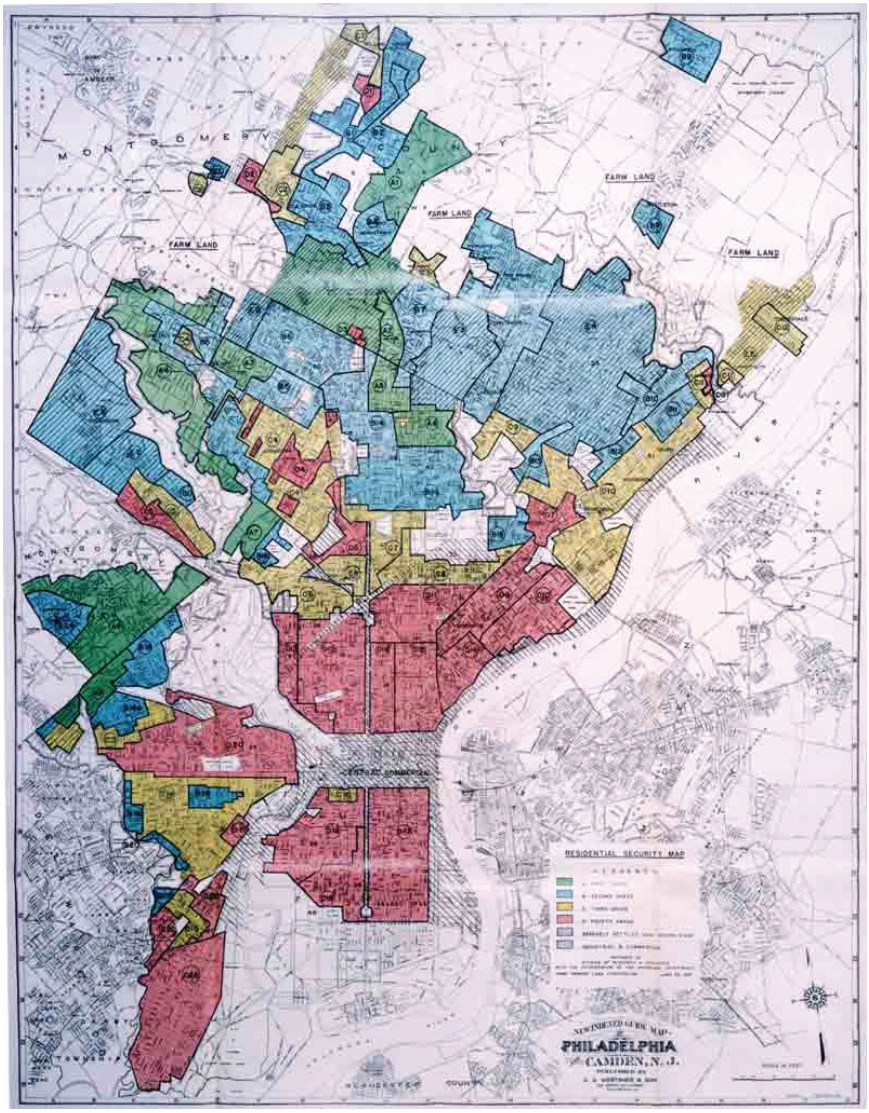

FIGURE 2-5 Redlining of Philadelphia.
SOURCE: Federal Home Loan Bank Board.

it also led to the scattering of people across the greater Boston area. Social networks were destroyed and the resources of the former residents were undermined.

However, in looking more specifically at how urban renewal affected African Americans, the story is different. African Americans could move only to other segregated neighborhoods. Urban renewal for African Americans, then, constituted a deepening of apartheid, according to Fullilove. Neighborhoods that had previously been made up of mixed populations of African Americans and immigrants from Europe became black-only neighborhoods.

Downtown Pittsburgh, Pennsylvania, is another example of how urban renewal efforts affected African Americans (Figure 2-6). Before urban renewal, the Hill District of Pittsburgh was composed of both African Americans and ethnic immigrant groups. African Americans, however, could only move to other parts of the Hill District or other African Ameri-

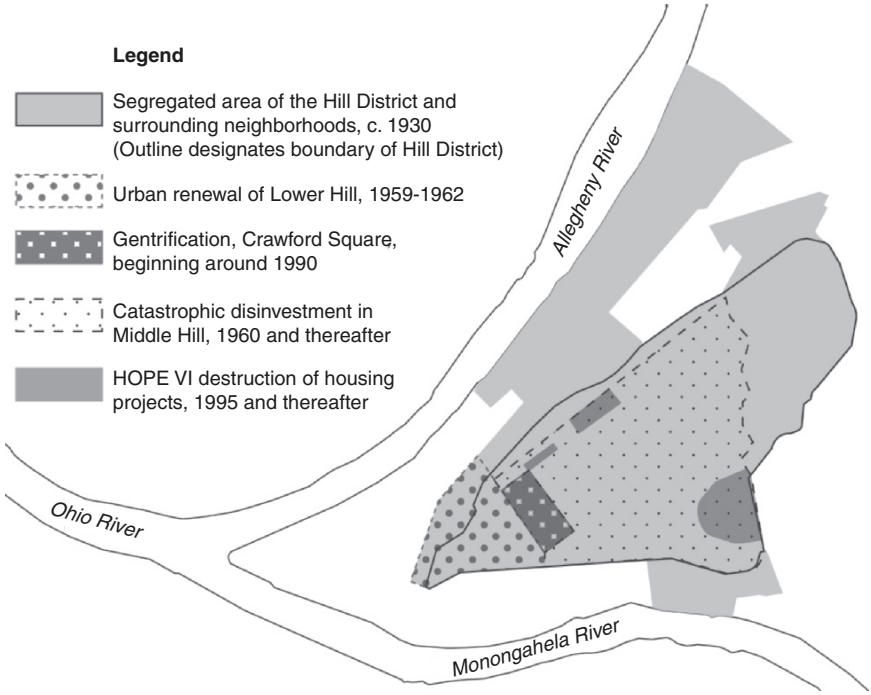

FIGURE 2-6 Movements of different ethnic groups in Pittsburgh, Pennsylvania, from 1930 to 1995.
SOURCE: Wallace and Fullilove (2008).

can neighborhoods, unlike the immigrants, who scattered elsewhere across the city.

In looking at big city neighborhoods before 1960 that were destroyed through urban renewal, Fullilove pointed out that several mechanisms were at play. First, the redlining followed the African Americans. If an area was populated by African Americans and they moved out, that area became a different zone (i.e., it was no longer a redlined zone). All of the investment thus went into improving the areas receiving new investment rather than the African American neighborhoods. In contrast, when African Americans move to other neighborhoods, the disinvestment follows them, according to Fullilove. The lack of supermarkets in African American neighborhoods is an example of this problem of the disinvestment process.

Second, HOPE VI, the Housing and Urban Development program created in the early 1990s, demolished housing projects that were determined to be severely stressed and displaced the populations living in those projects. Gentrification then occurred in those areas and further displaced the population. It is, Fullilove asserted, the same pattern that urban renewal followed in the 1950s in the United States, and in the 1950s urban renewal followed the path of redlining in the 1930s that caused changes in patterns of investment, patterns of resource access, and patterns of space sharing.

Fullilove stated that there are two hypotheses about this population displacement process. The first is the idea that the United States is trying to do the same thing that happened in Europe: move the poor out of the cities and move the well-to-do back into the city centers from the suburbs. This is called "the vast white ring conspiracy hypothesis," as humorously depicted in Figure 2-7.

The second hypothesis, offered by David Harvey (1973), is that developers make money by building new buildings and not by maintaining or improving already existing buildings. In looking at American cities, according to Fullilove, the urban areas have already been built, so where do developers want to go next? They go back to the city center; to land that has been cleared by the processes of disinvestment and urban renewal. Developers can then start tearing down old buildings and building new buildings all over again.

If Harvey's hypothesis is correct, then, the city center is the place to build, and white people will follow because their dollars are needed to inhabit all of the new dwellings that are being built. However, according to Harvey, once the new development moves out to the first ring of the older suburbs, which by then will have suffered from disinvestment, the same cycle will take place: buildings will be torn down and then built up all over again, but this time in the first ring of the suburbs.

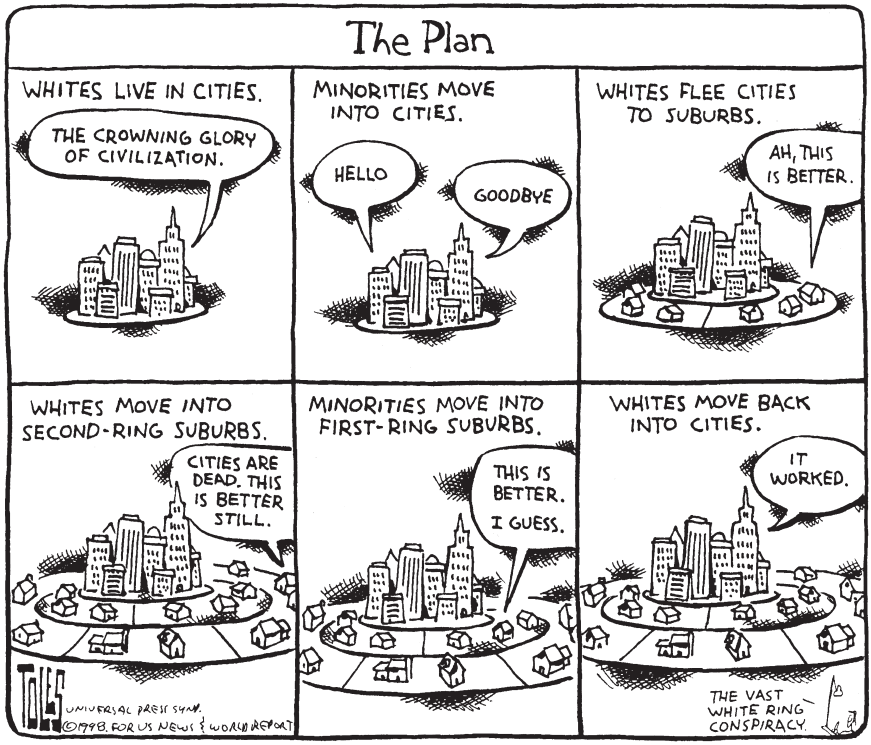

FIGURE 2-7 The Plan.
SOURCE: TOLES © The Washington Post. Reprinted with permission of UNIVERSAL UCLICK. All rights reserved.

Collective Consciousness

Fullilove described work on the topic of collective consciousness that she coauthored with Rodrick Wallace (2008). That work focused on how groups work together. Under conditions of apartheid, the dysfunctional assumptions that are a part of the apartheid system impede the ability to collaborate across groups. For example, she said, white people and black people hold different assumptions about how the world works. Black people, for example, believe that the government is out to get them. White people, stated Fullilove, in contrast, believe that black people whine too much (and some Africans apparently share this belief, as noted earlier in this section). These are very different worldviews, which make it difficult to communicate across groups to find common causes and solutions. In addition, the more groups that are involved, the more complicated the conversations will be. This, in turn, leads

to social disintegration, ideological barriers between groups, and the inequitable distribution of resources across groups. This is the context in which the urgent problems of health disparities exist.

Fullilove described data indicating that in considering the health of white men, even rich white men living in the United States had worse health outcomes than poor white men living in Great Britain (Banks et al., 2006). In other words, a system of apartheid benefits no one, not even those people in the most privileged group (rich white men). It is important to note that Americans believe that, in general, white people are doing okay and black people are not, she observed. However, the data of Banks and colleagues show that this is not true: everyone living in the United States, even those in the most privileged groups, is suffering because of health disparities.

This is what Fullilove calls a "classic double bind." A double bind is when a person receives conflicting messages that make it unclear how to respond. How, then, does one get out of a double-bind situation? The answer is through the process of reframing the issue. How, then, is the issue of health disparities to be framed? Fullilove stated that she believes that the frame that should be used is that "apartheid harms us all."

Once apartheid is understood, new strategies for action can begin to be put into place. Fullilove described her father, Ernest Thompson, who was the first full-time, paid African American organizer for his union, the United Electrical Radio and Machine Workers of America. It was his role within the union to help his colleagues understand that the oppression of minorities and women destroyed the unity of the union. Thompson's message was that overcoming racism and sexism were essential to the unity of the workers. All workers would benefit from getting past old divisions because of social segregation and racist stereotypes and realizing that everyone shares an investment in job security, job safety, and decent pay.

Reaction and Discussion

Roundtable member Allan Goldberg raised the issue of the situation in New Orleans, Louisiana, after Hurricane Katrina. He stated that the country turned its back on New Orleans and that this would not have happened if it had been, for example, Orlando, Florida that had been hit. He asked Fullilove what people can do to reenergize around these issues and make sure that this does not happen again.

Fullilove replied that, unfortunately, this is typical in the history of the United States: events like Hurricane Katrina happen in all of major U.S. cities, and the outcome is the replication of inequality and the marginalization of the vulnerable. She suggested that simple things, like learning another

language, can help to change things. Fullilove also suggested that this is a constant battle.

A second questioner, Gilda Haas, talked about legislation passed in the city of Los Angeles that protects residential hotels. She stated that this is a long-term fight but that it can result in people who live in buildings providing affordable housing being protected from the forces of development. Fullilove responded with a story about Miles Horton, who founded the Highlander School during the 1930s. The Highlander School was an institution for labor and civil rights organizing that had been founded in the South. Horton said that in life, one should have a goal. However, if that goal is attainable during one's lifetime, then that is not a good goal. Instead, a bigger goal, something that will not be attained during one's lifetime, is needed.

Today, Fullilove said, laudable goals include working to make the United States an equitable society, working for global sustainability, and working for climate change. These are the goals to be passed along because they will not be resolved during our current lifetime.

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3

Framing Health Disparities

Lori Dorfman, Dr.P.H.
Director, Berkeley Media Studies Group

Lori Dorfman is the director of the Berkeley Media Studies Group (BMSG), a project of the Public Health Institute. The Public Health Institute is an independent, nonprofit organization dedicated to promoting health, well-being, and quality of life for people throughout California, across the nation, and around the world. BMSG studies news coverage of public health issues, provides professional education for journalists, and conducts media advocacy training for community groups and public health advocates. It is from this perspective that Dorfman delivered her comments. She began her presentation by describing why BMSG focuses much of its research on the news. The goal of public health is to improve the health of populations and to do this by improving the conditions in which they live. The news is crucial to public health, according to Dorfman, because policy makers pay attention to the news and policy makers are making key decisions about whether the environments surrounding the public support health or foster disease. Therefore, if public health practitioners want to get the attention of policy makers, they need to understand how public health issues are portrayed in the news and be able to interest reporters in public health stories. By studying the news, BMSG can determine how public health issues are portrayed, including what part of the story is being told and what part is being missed.

FRAMING PUBLIC HEALTH ISSUES

According to Dorfman, framing public health issues is complicated and difficult in part because it involves the issue of race, one of the most difficult topics to discuss in the United States. Although there are no easy answers or magic words, understanding how these issues are framed is a good place to start.

To begin, a definition of the concept of "framing" itself is needed. "Framing" is an abstract idea, one studied by individuals from many disciplines, including social psychology, cognitive linguistics, sociology, economics, and political science. Scholars from these fields teach that frames are the conceptual bedrock for understanding anything. Frames help people extract meaning from all sorts of texts: words, pictures, events, or interactions.[1] That is, people are able to interpret words, images, actions, and text of any kind only because their brains fit those texts into a conceptual system that gives them order and meaning. Just a few cues—say, a word or an image—trigger whole frames that determine how people understand the matter at hand. Frames, Dorfman says, are structures that people's minds bring to text to make sense of it. Frames are mental structures that help people understand the world.

At the same time that people have frames operating from within, there are cues from the environment that also influence people's understanding of the world. Framing is therefore an interaction with the ideas in people's minds and the cues that they encounter. The external cues can activate people's internal assumptions and values. Recent research in the field of cognitive linguistics indicates that some assumptions, values, explanations, or stories are more easily triggered than others.

To illustrate, Dorfman used the example of looking up a new word in the dictionary. After one goes to the trouble to look up and really learn the new word, it suddenly seems as if one sees it everywhere. It is a paradox of sorts: the word was there all along, but the person's brain did not recognize it until after he or she learned it. As Walter Lippmann put it, "For the most part we do not first see, then define, we define first and then see" (Lippmann, 1965).

Dorfman used a second example to illustrate how people's brains react to cues in the environment (Figure 3-1). With a few external cues, people think that they know what is said in the first box. In other words, a person's brain fills in the blanks. The second box, however, which shows the actual text, indicates that the person's interpretation would have been wrong. This

[1] There is a broad literature on framing. See, for example, the work of Lakoff (1996) and Hall (1997). For studies of how public health issues are framed in news coverage, see http://www.bmsg.org/; for studies of how people interpret frames, see http://www.culturallogic.com/ and http://frameworksinstitute.org/.

FIGURE 3-1 Example of the importance of external or environmental cues.
SOURCE: Adapted from BMSG (2005).

is how framing works: frames fill in the blanks, giving meaning to what people see. Human minds are so efficient at filling in the blanks that the process is unconscious and unquestioned, which can be a problem when the answer is wrong, as it was in this case.

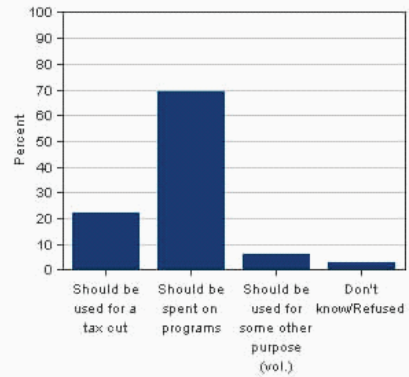
Another example, from the Pew Research Center for the People and the Press in 1999 (Figure 3-2), shows how two variations of a question from the same public opinion poll garner different responses depending on how the question is asked. Essentially, the poll asked the same thing, but because the questions are expressed slightly differently, the percentages of people choosing the different answers were dramatically different.

One explanation for the discrepancy in the poll results could be that the word "government" has been demonized in the United States and is therefore dismissed out of hand by most people. If this is true, this is a major problem for the field of public health because public health must rely on the government as the solution in many instances. A second explanation is that the second question is more descriptive and concrete than the first question. Either way, the words used matter, as they made a difference in how people responded.

A key concept here is that the brain interprets external stimuli—words, images, interactions—on the basis of what it already knows. It means that the more that an idea is repeated, the easier it is for people to "see." In addition, information that contradicts well-formed and strongly held ideas and beliefs is hard for people to integrate. Therefore, reframing needs to take place, by which people learn to tell new stories and adopt new ideas.

President (Bill) Clinton has proposed setting aside approximately two-thirds of an expected budget surplus to fix the Social Security system. What do you think the leaders in Washington should do with the remainder of the surplus? Should the money be used for a tax cut, or should it be spent on programs for education, the environment, health care, crime-fighting and military defense? [Q.31F2]

22%	Should be used for a tax cut
69%	Should be spent on programs
6%	Should be used for some other purpose (vol.)
3%	Don't know/Refused

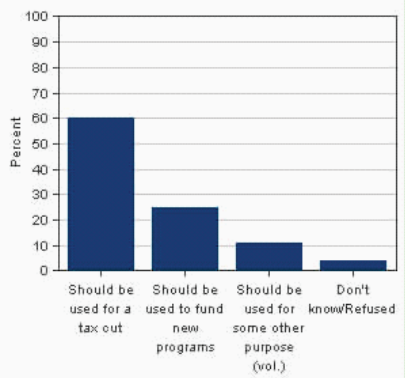


Subpopulation/Note: Asked of Form 2 half sample.

Survey by Pew Research Center for the People & the Press. Methodology: Interviewing conducted by Princeton Survey Research Associates, July 13 - July 18, 1999 and based on 1,200 telephone interviews. Sample: National adult.

President (Bill) Clinton has proposed setting aside approximately two-thirds of an expected budget surplus to fix the Social Security system. What do you think the leaders in Washington should do with the remainder of the surplus? Should the money be used for a tax cut, or should it be used to fund new government programs? [Q.30F1]

60%	Should be used for a tax cut
25%	Should be used to fund new programs
11%	Should be used for some other purpose (vol.)
4%	Don't know/Refused



Subpopulation/Note: Asked of Form 1 half sample.

Survey by Pew Research Center for the People & the Press. Methodology: Interviewing conducted by Princeton Survey Research Associates, July 13 - July 18, 1999 and based on 1,200 telephone interviews. Sample: National adult.

FIGURE 3-2 Different responses to two variations of the same question. SOURCE: Pew Research Center for the People and the Press (1999).

THE DEFAULT FRAME: RUGGED INDIVIDUALISM AND PERSONAL RESPONSIBILITY

The framing process happens whenever people interpret cues of any kind. It is critical, then, to talk about cultural cues in the United States and how those cues influence society. Small cues from words or pictures can trigger whole sets of ideas in the minds of audiences, who fill in the rest of the story. Thus, from a public health perspective, the question is: are we triggering the right frame, one that will help people understand that environments affect the population's health? If not, it will be hard to help people see the importance of the policies that can help rectify health disparities.

It is also critical to understand what is wrong with the typical, frequent cues that people receive and how they perpetuate ideas about what is possible and how things change. In American society, people operate with a default frame that elevates the notion of personal responsibility above institutional accountability. This is in large part because in American culture the stories that people tell themselves about themselves in various forms of media and other venues are typically hero stories, such as the Horatio Alger myth emphasizing the idea that if people try hard enough or work hard enough, anything can be accomplished. A commonly applied metaphor for this idea is "pulling yourself up by your bootstraps." Even computers "boot themselves up"—that is, they start from nothing to become something—indicating how deeply this metaphor runs in society.

Dorfman pointed out that the flip side of this metaphor is that if a person fails, it is his or her own fault. These two ideas are parts of the same whole; one cannot exist without the other. The challenge facing public health advocates in the United States today is that this is the unspoken starting point for any conversation about health disparities or any other health problem. Any cues about health will be interpreted against this backdrop, unless an alternative is provided. This means that, for example, delivering simple statistics about health disparities is likely to engender a response such as, "Well, that's too bad. Those people should try harder," rather than a response that points to the conditions surrounding individuals. Although this might seem inconsistent with Dr. Brown's earlier statement about the importance of data, the point is that having good data is necessary but not sufficient in altering frames.

Americans do have alternative stories that illustrate the "collective good," but those stories are harder to trigger. For example, for most people, the story of civil rights in the 1950s and 1960s is understood almost exclusively as a hero story. Of course, there were important heroes in the civil rights movement. People need to hear more about heroes like Rosa Parks and the Reverend Martin Luther King, Jr. However, Dorfman suggests,

should we not also hear just as often about the institutions and organizations that nurtured and supported those heroes? Why is the role of the Highlander Center, as described by Mindy Fullilove, not as well known as the name of Rosa Parks?

An example of a story about the collective good is the popular culture idea of a barn raising, in which the entire community comes together for the day and works together to literally frame and build a barn. Together, people build what none of them could do alone. However, this is an image that is based in the 19th century. People have few readily available images of what it means to work together for the collective good today.

The fundamental problem, according to Dorfman, is that the stories that reinforce individualism are the ones that are heard the most, and they are the ones that are the most easily evoked and the most frequently cued. Therefore, to address health disparities, new stories, a new language or a "second language" for public health, are needed (Wallack and Lawrence, 2005). These new stories can help people see that along with personal responsibility, environments shape health.

THE ROLE OF THE MEDIA

The media plays an important role in setting the agenda around public health issues for policy makers. They help frame the debate, which can influence the choices that are made about how health disparities may be rectified.

Media researchers have identified two types of news stories, the episodic story and the thematic story (Iyengar, 1991). Dorfman compared the difference between episodic and thematic stories to the difference between a portrait and a landscape. Most news stories are portraits, or episodic stories, that focus narrowly on people or events rather than on the context surrounding those people or events. About 80 percent of television news stories and most newspaper stories are episodic. In the news, people see, over and over again, stories that emphasize individuals or specific events without much attention to the broader context of the story.

In experiments, when researchers ask viewers who have seen episodic news to identify who has responsibility for causing or fixing a problem, no matter what the topic is, viewers who have seen stories framed as portraits will respond in ways that tend to blame the victim. This is consistent with the default frame and consistent with what social psychologists call the "fundamental attribution error." This tendency to attribute responsibility for solving a problem to the individual rather than institutions or other aspects of the environment surrounding individuals is a problem for public health, in that the types of policies designed to improve public health usually address changing the conditions surrounding people.

The good news is that the other 20 percent of news stories are framed thematically, more like landscapes. In this case, the news story still generally depicts a central person or event, but there is some context around that person or event. Viewers respond differently to this type of story. When viewers see stories framed as landscapes or thematic stories and are then asked in experiments about who has the responsibility for causing or fixing the problem depicted, they tend to answer in ways that include institutions or government as part of the solution. The inclusion of even a little more context in a 2-minute television news story can trigger a different understanding by viewers. This is a hopeful finding for public health professionals who must rely on governmental strategies to solve health problems.

Unfortunately, however, when the protagonist in these thematic or landscape stories is African American, this effect no longer holds. Rather, viewers go back to "blaming the victim." This finding is extremely disheartening and evidence of the extraordinary difficulty that this country has when it comes to race. This is an enormous problem that simple prescriptions about storytelling cannot easily overcome. Other research on how the public understands—or does not understand—health disparities reinforces the challenges that researchers and the public health community face in reframing health disparities. Researchers studying how inequality is understood found the following, for example (Grady and Aubrun, 2008):

- Operating from the default frame, the average person sees disparate health outcomes as evidence of the natural order of things rather than as evidence of a problem that needs to be rectified.
- The American culture's emphasis on individual responsibility blinds people to the systemic factors that affect population health.
- Such thinking reinforces us-versus-them divisions that distance groups from one another (and, if the default frame is not challenged, can be reinforced whenever public health statistics are disaggregated by race or socioeconomic status).
- Guilt, denial, and "compassion fatigue" can undermine support for taking action on health disparities.

STEPS TOWARD REFRAMING HEALTH DISPARITIES

Dorfman suggested that to alter frames, public health advocates should consider the following questions:

- What cues are we giving?
- What stories are we telling?
- What values do these stories activate or trigger?
- What actions are we taking?

In other words, according to Dorfman, reframing is more about what public health advocates do than what they say.

In the earlier example from the civil rights movement, the community organizing that was ignited by Rosa Parks' refusal to give up her seat on a Birmingham bus one Thursday afternoon was about actions as much as words.

In a current example from public health, advocates and funders concerned about obesity and related health problems are acting to change the built environment so it encourages daily activity, such as walking to work. Major structural changes, however, require significant resources. In the case of changes to roads and sidewalks, these resources can be found in the federal transportation legislation to be authorized by the U.S. Congress in 2010. These funders are therefore providing public health groups with the resources needed to work on the transportation sector as a solution to the problem of obesity. They are also providing resources to reformers in the transportation sector to work with public health. Their collective actions will help reframe transportation so it is understood and acted upon as a public health issue (Bell and Cohen, 2009).

In conclusion, Dorfman reiterated that actions influence reframing as much as how things are talked about. That is, the message is never first; rather, the reframers must know what needs to be changed. Public health professionals need to be clear about how they are going to make the changes and why change needs to occur. Beyond words, Dorfman says, actions are needed. What organizational practices within public health itself can be instituted to establish mechanisms for rectifying health inequities? Health disparities are about inequities, as well as about race and class, and both of these are very difficult to talk about in the context of the default frame. It is therefore important to be clear about what the goal is, what people are trying to do, and how this will be accomplished.

Dorfman summarized by reminding the workshop participants about the quotation in the front of every Institute of Medicine publication, by Goethe: "Knowing is not enough. We must apply. Willing is not enough. We must do."

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4

How Have California Communities in Transition Framed Health Disparities for Action?

Mildred Thompson introduced the session described in this chapter by talking about why this Institute of Medicine workshop was held in California. In considering the issue of changing demographics, there was no better place to begin than California. In California, the conversations go far beyond white and black and include immigrants, Native Americans, Latin Americans, and Asian Americans. It is an opportunity to be inclusive and to bring everyone to the table.

Three California communities were profiled: East Palo Alto, Fresno, and South Central Los Angeles. Individuals from each community discussed the issues surrounding the demographics, health, and new populations coming into the community. They presented information about how the different groups worked together and how the different groups framed the issues. Finally, individuals from each community discussed what has been effective in bringing attention to health disparities issues. After the presentations by the individuals from the three communities, Tony Iton shared his thoughts about and reactions to the presentations.

EAST PALO ALTO

Luisa Buada, R.N., M.P.H.
Chief Executive Officer, Ravenswood Family Health Center
South County Community Health Center, Inc.

Luisa Buada described her background working in community health centers for the past 35 years. She is currently the chief executive officer

of the Ravenswood Family Health Center, a federally funded community health center.

History of East Palo Alto

East Palo Alto is a city of 2.5 square miles and was incorporated 25 years ago. It sits physically between the 101 freeway and the southwest end of the San Francisco Bay. East Palo Alto is in San Mateo County, which is also home to several of the wealthiest communities in the United States (Atherton, Palo Alto, Menlo Park).

Historically, East Palo Alto began as an unincorporated agricultural area of nurseries, orchards, and family farms. Even today, although the nurseries have disappeared and there are few family farms left, sidewalks remain unpaved. Buada described the houses with picket fences and flower gardens in East Palo Alto as being "reminiscent of a sleepy Central Valley town."

The majority of the residents in East Palo Alto (80 percent of the population) were African American families up until the 1980s. These families were driven out of the nearby predominately Caucasian areas by de facto segregation and redlining. These protective ordinances (as described earlier by Mindy Fullilove) prohibited the sale of homes to nonwhites until 1947, thereby pushing these families into cities that ring the margin of the San Francisco Bay, adjacent to heavily polluted industrial areas. Other examples of these Bay Area cities (besides East Palo Alto) are Marin City, Vallejo, and Hunter's Point.

In the 1980s, an influx of Latino and Polynesian immigrants seeking low-income housing moved into East Palo Alto. Today, more than 56 percent of the population is Latino, 7 percent is Pacific Islander (primarily Tongans, with some Fijians and Samoans), and only 22 percent of the population is African American.

However, in contrast to East Palo Alto's wealthier neighbors in the county, most residents live in poverty or do not earn a living wage. In San Mateo County, a "living wage" is calculated to be 400 percent of the poverty level; this is due to the high cost of housing in the county. In East Palo Alto, 77 percent of school-age children qualify for free or reduced-cost lunches. The unemployment rate is nearly 10 percent, whereas the average for the county is 4 percent. In the patient population served by the Ravenswood Family Health Center, 63 percent are uninsured and one-third prefer to communicate in a language other than English.

Other challenges that East Palo Alto residents face include drug and alcohol addiction and the associated violence, involvement with the criminal justice system, and destabilized families. The community has no major supermarkets. The prevalence of diabetes and the rate of mortality from

diabetes are four times as high as they are in other places in the county. The high school dropout rate is at 65 percent. Nearly half of all fifth graders are overweight or obese.

Responding to These Challenges

Despite these challenges, Buada stated, East Palo Alto residents have found ways to collaborate and work together. In the Ravenswood Family Health Center, the clinic operates in response to the needs of a diverse community. For example, all services are aligned to the mission statement of the clinic. All clinic hiring decisions consider not only job qualifications but also cultural heritage, language skills, and an interest in prevention; 85 percent of the clinic's staff members speak either Spanish or Tongan. Clinic staff members are trained in mediation, conflict resolution, and group problem solving.

Because of the community's growing interest in prevention, the Ravenswood Family Health Center established a 4-year collaborative called "Get Fit East Palo Alto." This collaborative helped to support a local farmer's market that opened in the spring of 2008. More recently, the clinic received a grant from the federal Office of Minority Health to create a project called "Multicultural Community Health Connections." African American, Latino, and Pacific Islander health navigators are working with the community on diabetes education and screening, with a particular focus on health education, nutrition, and avoiding chronic disease.

Finally, despite the socioeconomic challenges, the residents of East Palo Alto are resourceful, creative, and resilient. Nonprofit organizations are working together with faith-based groups to improve the health and well-being of the community, often with few material resources at their disposal.

Melieni Talakai, R.N.
Vice-Chair, Board of Directors,
Ravenswood Family Health Center

Melieni Talakai trained as a nurse in New Zealand and has lived in East Palo Alto since 1982. She is a nurse at the San Mateo County Mobile Clinic and is on the board of directors of the Ravenswood Family Health Center.

As a native Tongan, she still thinks about the challenges that Tongan patients face in the U.S. health care system, how the U.S. system is linked to health care back home, and how she can help. In Tonga, residents are provided with free health care. In the United States, Talakai stated that with the majority of Tongans, health is not the top priority, especially in

this country, where new immigrants have so many more issues competing for attention (for example, employment and housing). This makes disease prevention even more of a challenge.

The Tongan Community in East Palo Alto

Talakai estimated that between 10,000 and 15,000 Tongans live in the Bay Area. However, there is not a Tongan physician in the community, and there are only a few Tongan nurses. This makes it difficult to find solutions for health problems affecting the Tongan community. She also added that this creates a sense of urgency for the community because of the pipeline problem: it will take another 15 years or so for Tongan children to grow up and be trained as physicians and nurses.

Even within the community, Talakai stated, framing must be used. For example, to reach the Tongan community, one must work through the faith community. East Palo Alto has, she estimated, eight Tongan churches, with the membership in each church ranging from 20 to 100 people. Collaborations with the Tongan churches focus on providing access to care, including, for example, invitations to the local health fair, which was a major success. About 600 Tongans, Samoans, and Fijians attended. This was important, because it provided evidence to San Mateo County that the Tongan community has health needs that are not being addressed.

Ruben Abrica
City Council Member, East Palo Alto City Council

Ruben Abrica is a former mayor of East Palo Alto and is currently a member of the city council. His professional background is in teaching and educational research.

East Palo Alto recently celebrated its 25th anniversary as an incorporated city. Abrica stated that he believes that without this effort to become incorporated as a city, the displacement forces that East Palo Alto residents face would have been too strong for them to deal with. One of his specific goals as a member of the city council is to provide health insurance to every child in East Palo Alto. As a former mayor of East Palo Alto, Abrica convened a community health roundtable to focus on issues of environmental justice.

In discussing the importance of framing, Abrica used an example from his own political career that involved, as he described it, "this whole black-brown issue." When he was first elected to the city council, Abrica was the only Latino elected in a predominantly African American community. Despite this, he stated, no one in the media ever asked him the question "How is it that a Latino managed to get elected in a mostly African Ameri-

can community?" However, when he lost an election in the late 1980s, Abrica stated, the first question that the reporters asked was whether he had lost because he is Latino.

Abrica described East Palo Alto as having been a majority minority community for over 40 years. Today, however, although it is still a majority minority community, East Palo Alto is now predominantly Latino rather than African American. This has led to a number of inherent tensions. For example, Abrica stated, sometimes "I had to speak bilingual to power," meaning that he had to present the Latino perspective in the political context. Another of Abrica's sayings is that "We are one city." At the same time, there are many different communities, and he noted that there are many ways to conceive of community: ethnic, racial, cultural, religious, and linguistic.

Abrica emphasized the importance of reframing East Palo Alto as a new city. To have self-determination and responsibility for governing, it was important to incorporate as a city. However, unlike other cities, the mayor and city council members in East Palo Alto have no office, no staff, and no budget.

In short, Abrica emphasized the importance of always working together and confronting inequality. If leadership does not adapt to change, this can lead to a loss of resources and activity.

Douglas Fort
For Youth, By Youth
Founder and Director, Intervention/ReEntry/Street Team Services

Douglas Fort discussed health disparities in "the hood." More specifically, his focus was on the clientele that most people do not talk about: prostitutes, hustlers, and gang members (Crips and Bloods, Sureños, and MS-13s). This clientele does not have access to the services that are provided to other groups.

Fort described these people as having "the disease of violence." More specifically, he explained that murders and shootings are health problems, and correlates with redevelopment and gentrification efforts as well as disinvestment.

Redevelopment and gentrification led to the availability and use of crack cocaine, the easy availability of weapons, a lack of social capital, and poor educational opportunities, said Fort. This was all a part of the community in which Fort grew up, and according to him, the same things that happened to the African Americans in the community are now happening to the Latinos in the community. African Americans have moved out of East Palo Alto to other communities in the Bay Area, such as Antioch

and Pittsburg. Latinos have now moved in to East Palo Alto, and the same things are going to happen, according to Fort.

Fort also described the state of mind of a gang member. In the East Palo Alto area, it is the Crips and the Bloods; in Los Angeles, it is the Norteños and the Sureños. This problem exists regardless of skin color. This is a problem of not valuing one's self and therefore not valuing education or property. According to Fort, youth join gangs because they have no sense of identity.

Discussion, East Palo Alto

Following the presentations, John Andrews, from the American Indian Healing Center in Whittier, California, and a previous resident of the area asked the East Palo Alto panelists about the relationship between Stanford University (located in Palo Alto, California) and the Ravenswood Family Health Center. In particular, given the 63 percent uninsurance rate in East Palo Alto, he wondered about the difficulty of accessing specialty care at Stanford Medical Center.

Luisa Buada responded that the Ravenswood Family Health Center does lease pediatricians and obstetrician-gynecologist providers from the Lucille Packard Children's Hospital (part of the Stanford Medical Center). In this way, women and their children have access to services. However, uninsured adult patients must go to the San Mateo County facility, where there is a 3- to 5-month delay for specialty care.

Buada also noted that the center does train Stanford medical students, but she emphasized that when students come to work in the clinic, they are working to meet the community's needs first. There has to be, she stated, "mutual benefit" for furthering student education while meeting the needs of community residents.

FRESNO

Keith Kelley
President and Chief Executive Officer, Fresno West Coalition for Economic Development

Keith Kelley is the founding executive of the Fresno West Coalition for Economic Development, which is a community development corporation. West Fresno has the highest concentration of poverty in the city of Fresno, which is the largest city in the San Joaquin Valley.

The City of Fresno

Fresno is the agricultural capital of the world. The top five counties in the San Joaquin Valley gross more money from fruits and vegetables than anyplace else in the world; Fresno is number one in the world.

At the same time, said Kelley, there is disheartening news about the San Joaquin Valley. A newspaper article in the Fresno Bee stated that, according to *The Measure of America: American Human Development Report 2008-2009*, of the 436 congressional districts in the United States, the district that includes Fresno ranks last in income, health, and educational attainment.

Similarly, in 2005, Brookings Institution researchers studied poor neighborhoods in the United States. Because the study was performed after Hurricane Katrina, the researchers expected that New Orleans would be the poorest neighborhood in the country. In actuality, however, New Orleans was number 2 and Fresno was number 1.

According to Kelley, if the San Joaquin Valley were a state, it would be the most impoverished state in the United States. At the same time, the state of California has the fifth-largest economy in the world. The economic disparity is thus obvious. Despite the wealth in the state as a whole, the San Joaquin Valley has been passed by.

Kelley related a story about Alan Autry, the outgoing mayor of Fresno. He had criticized California governor Arnold Schwarzenegger for "balancing the budget on the backs of the cities in California." The governor decided to put some money into the San Joaquin Valley, which led to the formation of the Central California Partnership.

This partnership, in turn, led to interest from foundations focusing on health disparities in the area. For example, The California Endowment is partnering with the Fresno West Coalition for Economic Development on an initiative called California Works for Better Health.

The Fresno West Coalition for Economic Development focuses on business development in the Fresno West community. The organization is currently partnering with another nonprofit organization called Social Compact. Social Compact uses a drill-down methodology to determine the assets in a neighborhood that is seeking economic development. This process involves looking at nontraditional data sources such as building permits, utility usage, and banking patterns to create a picture of a community's economic health. Knowledge of the assets of a neighborhood is a critical tool in encouraging economic investment in the community.

Another success story involved the founder of the Fresno West Coalition for Economic Development, Myser Keels. He mobilized the community to lobby for a supermarket in West Fresno, and he succeeded. Residents now have access to fresh fruits and vegetables. This was the start of the Fresno West Coalition for Economic Development.

In summary, it is important to identify the assets in a community to build an argument for business development and job creation. This is the approach that the Fresno West Coalition for Economic Development has taken.

Lue N. Yang
Fresno Center for New Americans

Lue Yang is the executive director of the Fresno Center for New Americans, a nonprofit organization that provides services to immigrants and refugees from Southeast Asia. He is a member of the Hmong immigrant community in Fresno.

Southeast Asians in the Fresno Area

Yang began his presentation by describing several of the health disparities affecting the Southeast Asian community in the Central Valley (San Joaquin Valley). The first factor affecting health disparities is the fact that the Asians in that region have the highest rate (40 percent) of limited English proficiency (LEP). In contrast, only 30 percent of the Latino community has LEP. Overall, within the state of California, more than one-third of all Asian residents have LEP. In the Central Valley, the majority of Southeast Asians live in the cities of Fresno and Merced. The lack of language-appropriate interpreters thus affects access to both physical and mental health care services.

A second major health disparity involves access to health care. Because many Southeast Asians came to the United States from communist countries, trust is a major concern. Cultural issues are also central to treatment regimens; for example, a patient who does not trust his or her physician's prescriptions may decide to take an herbal medication instead.

Health care workers are often not sensitive to the cultural beliefs of the Hmong, stated Yang. He gave an example of a tuberculosis patient who refused to take her medication because it tasted bad. She was not told, however, to eat food before swallowing the medication. Similarly, a patient who is told that he or she needs surgery might want to check with the clan leader to perform a spiritual ritual first.

A third example of health disparities can be described by a situation in which a couple was meeting with a mental health care provider. In the Hmong culture, women do not shake hands; only the men do. Consequently, when the clinician shook the woman's hand, her husband became extremely uncomfortable.

Each of these examples highlights the importance of cultural competence in the health care system.

Interpretation is also a major problem. It is common for parents who are going to see a health care provider to bring their children who do speak English so that they can serve as translators. However, not surprisingly, the translations from the children are not always accurate or appropriate. This led to a lawsuit against San Joaquin County for failing to provide culturally competent interpreters.

In Fresno, only one physician speaks the language of the Hmong, but 30,000 Hmong live in Fresno. This situation makes the lack of workforce diversity in the health care arena a major barrier to reducing health disparities. It also makes it difficult for patients to trust their health care providers. Because that one physician cannot meet the needs of all these people, much of the Southeast Asian community has difficulty accessing linguistic and culturally appropriate medical care.

Finally, transportation and lack of child care are major barriers to reducing health disparities for this population. Because of the limited English proficiency issue, many Southeast Asians do not apply for a California driver's license. Similarly, accessing quality child care is a major barrier for the same reason.

Genoveva Islas-Hooker, M.P.H.
Regional Program Coordinator,
Central California Regional Obesity Prevention Program

Genoveva Islas-Hooker is the regional program coordinator for the Central California Obesity Prevention Program. She began her comments by pointing out that the three speakers on the Fresno panel represent the three largest ethnic and racial groups in the Central Valley: African Americans, Latinos, and Southeast Asians. Representing the Latino community, she commented that although Latinos have been the majority group for some time, this is not reflected in their levels of educational attainment, participation in the political process, or access to health care. These discrepancies in achievement are areas that contribute to the exacerbation of existing disparities being experienced by the Latino community.

Genoveva's family experiences in the Central Valley are, she stated, a classic example of the Latino experience in the San Joaquin Valley. Many people, when they think of farming, have a romanticized vision of green landscapes and easy living. The truth is very different from this vision, Islas-Hooker commented. Framing this vision of what it really means to work in farm labor is very important in terms of determining the truth for the Latino population in Central California.

In his earlier comments, Kelley described the Central Valley as being the agricultural center not only of the state of California but also of the nation. Despite this agricultural bounty, the Latino community experiences major

health disparities compared to health outcomes for the white population, and Islas-Hooker believes that this is due to the exploitation of the farm worker population in the region.

Although the Central Valley has a great deal of wealth, it is maldistributed within the population. Farm workers, for example, do not make a living wage, according to Islas-Hooker. Not surprisingly, this limits access to health care services. The communities where farm workers live lack infrastructure, which means there are no sidewalks, no streetlights, no animal control, limited access to healthy foods, and no law enforcement officers. All of these environmental factors limit the possibilities for physical activity and healthy eating, which in turn contributes to the obesity epidemic occurring in the Central Valley, particularly in the Latino population.

Islas-Hooker described her family's experience in the Central Valley. Both of her parents immigrated to California from Mexico. Although her father's family was originally financially well to do in Mexico, years of drought forced them to move to the United States and adapt to a new life as migrant farm workers. Her father ran away from home when he was 12 years old and worked as a mechanic's apprentice to assist his family. In Mexico, Islas-Hooker's mother did not receive her first pair of shoes until age 12, an example of the poverty that her mother's family experienced. She immigrated to the Central Valley at the age of 19, along with one of her sisters.

Because both her parents had limited educational opportunities, they were forced to work as farm laborers. Moreover, as immigrants, they lived very secluded from the rest of society, and Islas-Hooker explained that she grew up with no role models who were active in the community. This seclusion is what Islas-Hooker believes is at the root of preventing more Latinos from being actively involved in advocating for change.

SOUTH LOS ANGELES

Maxine Liggins, M.D.
Area Medical Director, Los Angeles County Department of Public Health

The Los Angeles County Department of Public Health is now a separate department from the Department of Health Services. This allows the public health department to focus on delivering traditional public health services. Los Angeles County is divided into service planning areas (SPAs), and Maxine Liggins is the area medical director responsible for SPA 5 and SPA 6. These two areas are dramatically different from each other but, she said, are also inextricably linked.

SPA 5, which covers Western Los Angeles, is predominantly white (63%), and only 10 percent of the population lives under the federal poverty

line. In contrast, SPA 6, which covers South Los Angeles, is an increasingly Latino community because of the impact of immigration. About two-thirds of the residents of South Los Angeles are Latino, and the number of African Americans in South Los Angeles has declined. South Los Angeles also has the highest percentage of residents under the age of 17, about 35 percent, which is the highest in all of Los Angeles County. This is consistent with other demographic data showing that in the United States the Latino population is younger than the rest of the population. In Los Angeles County, Latinos are the only racial or ethnic group that is increasing in size, growing from 20 percent of the population in South Los Angeles in the late 1960s to 67 percent of the population in 2008 and comprising 41.7 percent of the population in Los Angeles County in 2008.

The residents of South Los Angeles are also more likely to be poor and, therefore, to be covered by Medi-Cal, the state Medicaid program. Twenty-eight percent of the population in South Los Angeles has incomes below the federal poverty limit. Poverty is, stated Liggins, the major cause of health disparities. Beyond poverty, however, there is racism as well.

The homicide rate in South Los Angeles is also high; there are about two homicides per day, said Liggins. This makes homicide a serious health disparity issue as well as a major medical problem. Other serious health problems for the Latino and African American communities include obesity, diabetes, hypertension, and low birth weight (Table 4-1). Asthma is also a problem, but Liggins believes that many asthma cases remain undiagnosed

TABLE 4-1 Population Health Status

	SPA 6	SPA 5
Percent of Overweight Children in Grades 5, 7, and 9 (BMI* > 95th Percentile)	25.5	16.2
Percent of Children with Current Asthma	6	13
Percent of Adults with Diabetes	9.2	4.2
Percent of Adults with Hypertension	25.4	16.7
Percent of Low Birth Weight	7.3	6.4
Teen Births (Per 1,000 Live Births to Mothers 15-19 Years)	85.7	8.4
Infant Mortality (Per 1,000 Live Births)	6.5	3.7
Cancer Death Rate/100,000	209	150

*BMI = body mass index.

SOURCE: 2002-2003 Los Angeles County Health Survey (http://www.lapublichealth.org/wwwfiles/ph/hae/ha/keyhealth.pdf).

TABLE 4-2 Health Care Access

Access	Los Angeles County	SPA 6
Uninsured Percentage	21.8%	31.7%
No Regular Source of Care	19.8%	26.9%
Difficulty with Access	30.1%	43.9%
No Access to Dental Care 1 year	25.6%	35.1%

SOURCE: 2005 Los Angeles County Health Survey (http://publichealth.lacounty.gov/docs/Key05Report_FINAL.pdf).

and that in reality the number of individuals with asthma are far higher. Among African Americans in SPA 6, the teen birth rate is 10 times as high as that in SPA 5. Infant mortality rates are also far higher in SPA 6 than in SPA 5.

Access to health care services is another major disparity between SPA 6 and the county as a whole (Table 4-2). SPA 6 has the highest percentage of uninsured residents in Los Angeles County. Other access issues, according to Liggins, include no regular source of health care, difficulty with accessing care, and difficulty accessing dental services. Because no comprehensive hospital is located in SPA 6, residents also have no access to obstetric-gynecological care, trauma care, cardiac care, or other specialty care.

In considering quality-of-life issues (Table 4-3), in SPA 6, almost 18 percent of parents report that their children are in poor health, whereas the rate for the county is 13 percent. Similarly, 33 percent of adults living in South Los Angeles report being in fair to poor health, compared to 21 percent of adults in the county as a whole report being in fair to poor health. Of those adults in SPA 6 reporting that they are in fair to poor health, they reported that 3.3 days of activities per month were limited because of poor health. This is in comparison to 2.4 days for the county as a whole. Table 4-3 shows that the residents of South Los Angeles report nearly 8 (7.9)

TABLE 4-3 Health-Related Quality of Life

Health-Related Quality of Life	Los Angeles County	SPA 6
% of Children in poor health per parents	12.7%	17.6%
% of Adults reporting fair to poor health	20.6%	33.4%
Average # of limited activities due to poor health	2.4 days	3.3 days
Average # of unhealthy days in past month	6.4 days	7.9 days

SOURCE: 2005 Los Angeles County Health Survey (http://publichealth.lacounty.gov/docs/Key05Report_FINAL.pdf).

TABLE 4-4 Prevention and Health Outcomes

Cancer Death Rates	National	SPA 6
Lung	54.1%	46.0%
Breast	25.2%	27.8%
Colorectal	19.1%	23.2%
Cervical	1.3%	—
% PAP in 3 years	86.0%	83.3%

SOURCE: 2005 Los Angeles County Health Survey (http://publichealth.lacounty.gov/docs/Key05Report_FINAL.pdf).

unhealthy days per month, whereas the average for Los Angeles County is 6.4 unhealthy days per month.

Major differences in prevention and health outcomes exist as well. Table 4-4 shows that although the number of deaths from lung cancer in SPA 6 is lower than the national average, this is likely due to the fact that the population in South Los Angeles is skewed toward younger age groups as compared to the national average. Breast cancer rates, however, are higher than the national average, as are the rates of colorectal cancer.

In considering the years of potential life lost in Los Angeles County (Table 4-5), residents of the cities of Compton and Florence (SPA 6) have much higher rates of heart disease and stroke than the rates in either Los Angeles County or the wealthier areas of SPA 5, such as Santa Monica and Marina del Ray. In other words, the years of potential life lost are much higher in the poorer sections of Los Angeles than in either the county as a whole or the wealthy areas of the county. The lack of social capital in the geographic area of SPA 6, particularly the lack of economic opportunities, frequently outweighs any specific health problems. Liggins summarized these comparisons by noting that the major cause of racial and ethnic health disparities is poverty, combined with a lack of access to affordable health care.

TABLE 4-5 Years of Potential Life Lost

Community	Heart Disease and Stroke	Rank 1-129
Los Angeles County	1,183	NA
Compton	2,620	129
Florence	1,767	116
Marina del Rey	1,155	67
Santa Monica	749	26

NOTE: NA = not available.
SOURCE: Compiled from http://www.lapublichealth.org/epi/docs/CHR_CVH.pdf.

Another problem, one that is particularly relevant to health care providers, is a lack of comprehensive health care planning. In addressing health disparities, Liggins noted, it is essential to work in collaboration with other agencies and organizations. For example, Los Angeles County is working with the state of California to open a comprehensive hospital in South Los Angeles. Other examples include collaborations in the African American community addressing the problem of depression (Healthy African American Families) and the work of the Community Health Councils to provide increased awareness of preventing cardiovascular disease and kidney disease.

Electronic medical records are another potential solution, according to Liggins, as the use of electronic medical records allows care to be standardized across all community and public clinics.

Richard Veloz, J.D., M.P.H.
Chief Executive Officer, South Central Family Health Center

Richard Veloz is the chief executive officer of the South Central Family Health Center and has worked on issues relating to the medically underserved during his entire professional life. He began his comments by describing the history and development of South Los Angeles.

With a long history of disenfranchisement and economic disparities, South Los Angeles has experienced many of the negative impacts described earlier by Fullilove due to urban renewal and disinvestment. The geographic area is also dissected by two major freeways.

Historically, during the 1940s, South Los Angeles was the only place where the African American population could legally purchase a home. Because of real estate development, increased immigration, and the growth in the number of non-unionized jobs, the African American population slowly began to spread out of the South Los Angeles area.

Veloz works with the South Central Family Health Center in SPA 6, the service planning area that Maxine Liggins described earlier. Since the early 1990s, the African American population in SPA 6 that is served by South Central Family Health Center has decreased by 37 percent, whereas the Latino population had increased by 49 percent. In 1990, for example, the area was 56 percent Latino and 42 percent African American. By 2005, 74 percent of the population was Latino and only 24 percent was African American. This dramatic shift was due in large part to immigration and the higher birth rates for Latino families.

In comparison to the findings for all of Los Angeles County, SPA 6 has the highest mortality rates, the highest prevalence of morbidity, and the poorest reproductive health outcomes (Table 4-1). Figure 4-1 shows that a large number of the Latino subpopulation residents in SPA 6 are uninsured

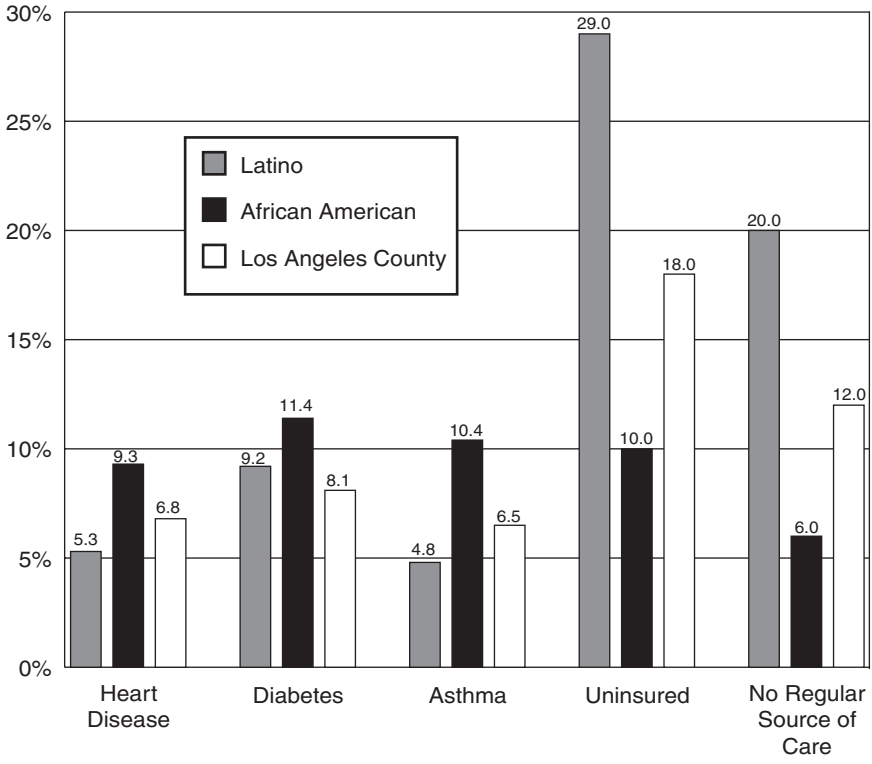

FIGURE 4-1 Los Angeles County prevalence of health disparities.
SOURCE: Compiled from http://publichealth.lacounty.gov/ha/LACHSDataTopics2005.htm.

and do not have a regular source of health care. For example, as Islas-Hooker described for her own family, as Latino immigrants live longer in the United States, they are more likely to develop chronic illnesses.

Other changes that have exacerbated the existing health disparities in South Los Angeles have taken place over the past several years. The Martin Luther King Hospital closed, but even before the closure, because of the changes described earlier and the subsequent increase in the numbers of uninsured individuals, more people were denied health care because of an insufficient health care capacity in SPA 6. In response to this need, the Southside Coalition of Community Health Centers was formed in 2004. The Coalition consists of the seven federally qualified health centers that are located in South Los Angeles and was formed to evaluate best practices and share scarce resources. The Coalition saw over 90,000 unique patients

in 2006 and had more than 300,000 patient encounters. The primary goal of the Coalition is to ensure that patients in SPA 6 have sufficient access to quality primary health care services.

The Coalition has identified three areas of priority for its patient population: access to specialty medical care, access to mental health services, and access to dental health care. Access to specialty care was a particular problem, with the waiting period for access to specialty care at county facilities being 6 months to 2 years. Working with a number of supporting organizations, including The California Endowment, the Southside Coalition was able to establish an Early Diagnostic Intervention Center. The Coalition also created a podiatry clinic, which reduced the previous 6-month waiting time to no more than a week for its patients.

Relying on collaborations among community health centers, the Coalition has focused on improving health information technology and telemedicine. Because each individual community health center does not have enough resources, the centers must work together to ensure access for poor and hard-to-reach people in the community.

Marqueece Dawson
Executive Director, Community Coalition

Marqueece Dawson is executive director of the Community Coalition, a grassroots, community-based organization that is 18 years old. The Community Coalition does community organizing across racial lines and has about 4,000 members, primarily African Americans and Latinos.

Echoing the comments of the previous two speakers, Dawson mentioned the demographic shift in South Los Angeles that has resulted in changes in the proportions of Latinos and African Americans. However, he noted, the geographic boundaries have not shifted, with people of color still living within these geographic boundaries. This is true of all big cities in the United States, Dawson stated. South Los Angeles is characterized by violence and crime, economic disinvestment, and a lack of social capital. If these social and economic conditions are not addressed, health care outcomes cannot be improved for any racial group.

There are other ways to look at the data regarding this demographic shift, Dawson noted. Often, even though the raw number of people in one racial or ethnic subgroup grows, their proportion relative to another racial or ethnic group may fall. In other words, the number of African Americans living in South Los Angeles may not have declined, but the demographic shift might instead be due to the rapidly increasing numbers in the Latino population.

Dawson explained that three factors account for the lack of growth in the African American population in South Los Angeles. First, the prison

population in California is disproportionately African American. The state prison system has 175,000 prisoners, and 45 to 55 percent of them come from Los Angeles County. Of that 45 to 55 percent, about two-thirds come from South Los Angeles. Dawson noted that the number of African Americans entering the prison system would be considered a migration pattern by scientists studying demography.

The second factor for the lack of growth in the African American population in South Los Angeles is the voluntary departure of black families for the suburbs. These families see this move as a step up and a move away from a dysfunctional community where the social costs of living are high.

The third factor is a psychological one. The Latino community in South Los Angeles tends to be made up primarily of first-generation immigrants. They view their life in South Los Angeles as transitory and believe that as soon as their economic status improves, they will move on. This is a mindset very different from that of the older, more established African American community in South Los Angeles.

Dawson terms one of the negative impacts of immigration in South Los Angeles "super exploitation." By bringing in large numbers of Latinos to work in low-skill jobs—for example, as housekeepers at a hotel—the lowest levels of the working class are destabilized. In the past, virtually any cleaning woman in a Los Angeles hotel would have been African American. Now, it would be difficult to find an African American cleaning woman at any hotel in Los Angeles County. This is true in almost every big American city. Dawson described this as "outsourcing without moving" on the part of the hotels. Rather than moving the hotel to Latin America, they replaced their low-wage African American workers with other workers with a weaker bargaining position.

The issue of violence also affects relations between the African American and Latino communities in South Los Angeles, Dawson said, describing violence as the biggest health issue of all. The number of homicides in Los Angeles (204) is only slightly less than the number of soldiers who died in Iraq (221) from January through July 2008. Iraq is seen as an international crisis, whereas the mayor and police chief in Los Angeles celebrated the fact that 204 homicides was less than the number in any year in the past 25 years.

As a community organizer, Dawson believes that conditions in places such as South Los Angeles, Fresno, and East Palo Alto will change only through mass social movements because mass social movements such as the civil rights movement and the women's movement are what led to widespread changes in society.

Because many of the new Latino immigrants moving into South Los Angeles are from Central America, where there have been political revolutions in many nations, they come to the United States with direct experience

in political action. Dawson noted that these recent immigrants can aid with community organizing efforts in creative ways that might not occur to the native-born African American community. He concluded by saying that the outlook for the use of community organizing as a strategy for making widespread changes in South Los Angeles is bright.

Discussion, South Los Angeles

After the presentations from the South Los Angeles panel, Vickie Katz from the University of Southern California described her own work and asked the panelists a question. Katz described research that she conducted in which she looked at both new and old immigrant communities in 1998 and in 2005. She noted that the African Americans in South Los Angeles had the highest levels of community belonging, civic engagement, and neighborhood pride of any of the groups studied. Additionally, she commented on the history of engagement from the perspective of the civil rights movement among individuals in the African American community and how that history of engagement is an inherent strength of the community.

Given that South Los Angeles has two separate sets of networks made up of community organizations and other services—the Latino network and the African American network—Katz asked the panel to comment on the challenges and the efforts that are being made to engage people from the two networks to talk about health disparities and other issues.

Marqueece Dawson noted that it is true that there are separate networks of people that are divided along racial lines. In particular, places of worship are among the most racially segregated places where networks congregate; this is especially troubling because places of worship are likely the community institution that has the most contact with its membership.

Dawson also speculated that people do not come together across networks because they perceive it as being too difficult. For example, "block clubs" are organized by people who knock on their neighbors' doors and invite them to a neighborhood meeting. However, if a person cannot speak the same language as his or her neighbor, it is easy to give up. He noted that community organizations that are larger and better able to deal with logistical issues such as this one need to step in and create a presence.

TONY ITON, DISCUSSANT

Presentation Themes

Tony Iton is the public health director for Alameda County in Northern California. He was asked to comment on and react to the community panel's presentations. Iton noted that his job as a public health practitioner

is to look at the issues and try to shape solutions from a public health perspective. He described six different themes that he used to categorize the presentations: the notion of place, cultural influences, policy, hidden disparities, media and communications, and power and democracy.

Place

The first theme that Iton used was the notion of place. Echoing the comments made by Marqueece Dawson, he focused on the idea that the demographics in a community may change and evolve, but the community conditions themselves remain stable. Place matters because it is the home of those conditions, and this, Iton stressed, is the most relevant focus for public health.

The field of public health still views communities as simply a collection of individuals and considers that what is needed is to provide services to each individual. Rather, Iton said, what needs to be evaluated are the macro forces that are shaping the lives of the people within the community.

In considering the importance of place, Iton noted that it is now possible to use data to more accurately reflect the relationship between health outcomes, educational attainment, housing, economic opportunities, and so on. The advent of the geographic information system technology allows different data sets to be linked to consider these relationships as they flow through the notion of place. Before these new technologies were available, race was seen as the defining variable; now, the context of race in society can be evaluated.

Iton commented upon Keith Kelley's description of the Central Valley as the "breadbasket of the United States," a place that feeds all of us, yet residents there have difficulty finding fruits and vegetables at the grocery store. Oakland, California, is a similar example, in that it is the home to the fourth largest port in the United States and is thus responsible for bringing inexpensive consumer goods into the region. However, the actual cost of these inexpensive electronics and other items is high because diesel emissions from ships, trucks, and trains directly harm the residents of West Oakland living near the port. In other words, West Oakland residents get all of the costs and very few of the benefits. Similar to the Central Valley, the port of Oakland plays a role in feeding the rest of the United States, but in West Oakland, it is difficult to find fresh fruits and vegetables at the grocery store.

Another interesting example of the importance of place was described by Douglas Fort in his comments about East Palo Alto. He said that the environment in which they live infects young people but the rest of the local residents do not pay attention to this. Similarly, there is the idea, described by Dawson, that different people have different relationships

with the same place. For example, the African Americans in a community see it as a place where they plan to stay and live and raise children and grandchildren. Others living in the same place, however, plan to leave as soon as possible. This affects efforts to organize people and affects power issues among residents.

Culture

The idea of seeing culture as an asset is a new idea for the field of public health, Iton said. He cited the East Palo Alto example of the Tongan, Latino, and African American communities all working together. Another suggestion is to encourage African American kids living in South Los Angeles to learn Spanish. That would have a positive economic benefit for those children and would expand their perspective on their community. In other words, the pubic health community needs to begin to see the concept of culture as an asset.

Another aspect of culture can be seen in the immigrants coming to the United States. Many are refugees from authoritarian regimes and have a high level of distrust of any government. This is a critical theme for public health practitioners to keep in mind, Iton noted, as it affects how practitioners provide services to this population.

Similarly, the notion of conflict between government institutions and cultural communities, that is, the professional approach versus the indigenous or intuitive approach, is another theme that public health practitioners and researchers need to consider. Researchers in particular, Iton stated, tend to go in to a community, observe the community, figure out what is going on, and then leave to publish papers about it. The community is often left wondering what they got out of this experience. This is the notion of "cultural humility."

Iton cited the examples of Stanford University and its relationship to East Palo Alto and Johns Hopkins University in East Baltimore, Maryland. What is the responsibility of these institutions to the communities they work in? These questions are not often asked; so the culture of science, professionalism, and research can be seen as very paternalistic and exploitative.

Policy

The initial policy issue that Iton discussed was the notion of structural issues. For example, in places where farm workers are the majority of the population, they must still fight for farmer's markets so they may access fresh fruits and vegetables. This is, Iton, said, a basic structural injustice and one that is exacerbated by the fact that farm workers cannot live on the wages that they are paid for feeding the rest of the nation. This is a major

economic and political issue and is one that the public health community needs to be concerned about.

In his comments about Fresno, Keith Kelley spoke of the importance of developing the economic argument for investment in low-income areas. This is, Iton said, a kind of framing; it is taking an issue of structural injustice and reframing it in terms of benefits to companies making investments in that place.

Another example of a structural policy was the decision by policy makers in East Palo Alto to formally incorporate. This effort to take control of a community is a way to resist the displacement that is all too common in low-income communities. Iton recommended that researchers should consider investigating this issue of incorporation and its effects on the potential to avoid gentrification.

Hidden Disparities

Iton's fourth theme was that of hidden disparities. He mentioned the health issues affecting Pacific Islanders, Native Americans, and individuals with limited English proficiency and the discouraging data showing the shortened life spans for immigrants in the South and Southeastern states as compared to residents in other areas of the United States. This is primarily due to obesity and chronic disease rates growing in the South and Southeast.

In some ways, Iton said, racial and ethnic groups such as Pacific Islanders, African Americans, Native Americans, and Latinos are the "canaries in the coal mine" for the future of the United States. This is another way of framing the argument so that people can see their own self-interest in addressing the health concerns of racial and ethnic minorities.

Media and Communications

Echoing the earlier comments of Lori Dorfman, Iton described the tendency of the media to focus on conflicts rather than solutions. He noted the example from Ruben Abrica's experience in which the media asked him questions only about why he was not reelected and whether it was because he was Latino as opposed to why he, as a Latino, was elected in the first place in the then majority African American community of East Palo Alto. Public health professionals need to be aware of the media's tendency to focus on conflicts and manipulate public health stories accordingly.

Power and Democracy

Ultimately, Iton said, the discussion is about democracy. Many of the day's speakers talked about health care, health insurance, and access to health care; yet the places that the community panelists are from are places that have the greatest need but that are experiencing the greatest disinvestment in health care resources. Health insurance companies are reluctant to insure people who are already sick and prefer to insure wealthy, healthy people; health care institutions are beginning to do the same. In Oakland, for example, health care institutions are looking to move to the suburbs, where there is a better payer mix. These policies are the direct result of a lack of democracy, Iton stated.

Furthermore, citing the example of Islas-Hooker and her focus on educational achievement, it is important to keep in mind that in a democracy, the people do have control. Iton summarized this idea by saying that "America is an experiment" and that outcomes are not preordained. This idea, in turn, can help motivate people.

The BARHII Framework

Iton's efforts to frame public health more broadly led to the development of the Bay Area Regional Health Inequities Initiative (BARHII). The framework of BARHII is designed to assist public health professionals in seven Northern California counties with making decisions about how to devote resources to the complex problem of reducing health inequities (Figure 4-2).

The three boxes on right side of the framework in Figure 4-2 represent the traditional medical model, which is based on the idea that individual health behaviors shape the risk of disease, which in turn shapes the likelihood of premature death. A more recent conceptualization of this model focuses on downstream factors as they affect health status.

The boxes on the left side focus on upstream factors, or what Iton refers to as the socioecological context of health. This includes factors such as social status and the quality of the neighborhood. For poor brown and black people, Iton said, there is a place in every major urban area where they are consigned to live.

Public health needs to devote resources to building social, political, and economic power in these neighborhoods, Iton noted. However, public health also needs to move upstream and look at the causes of these upstream factors, such as the policies that have resulted in 175,000 African American men being in prison and therefore not being productive members of the economy. Public health professionals, Iton emphasized, need to intervene to

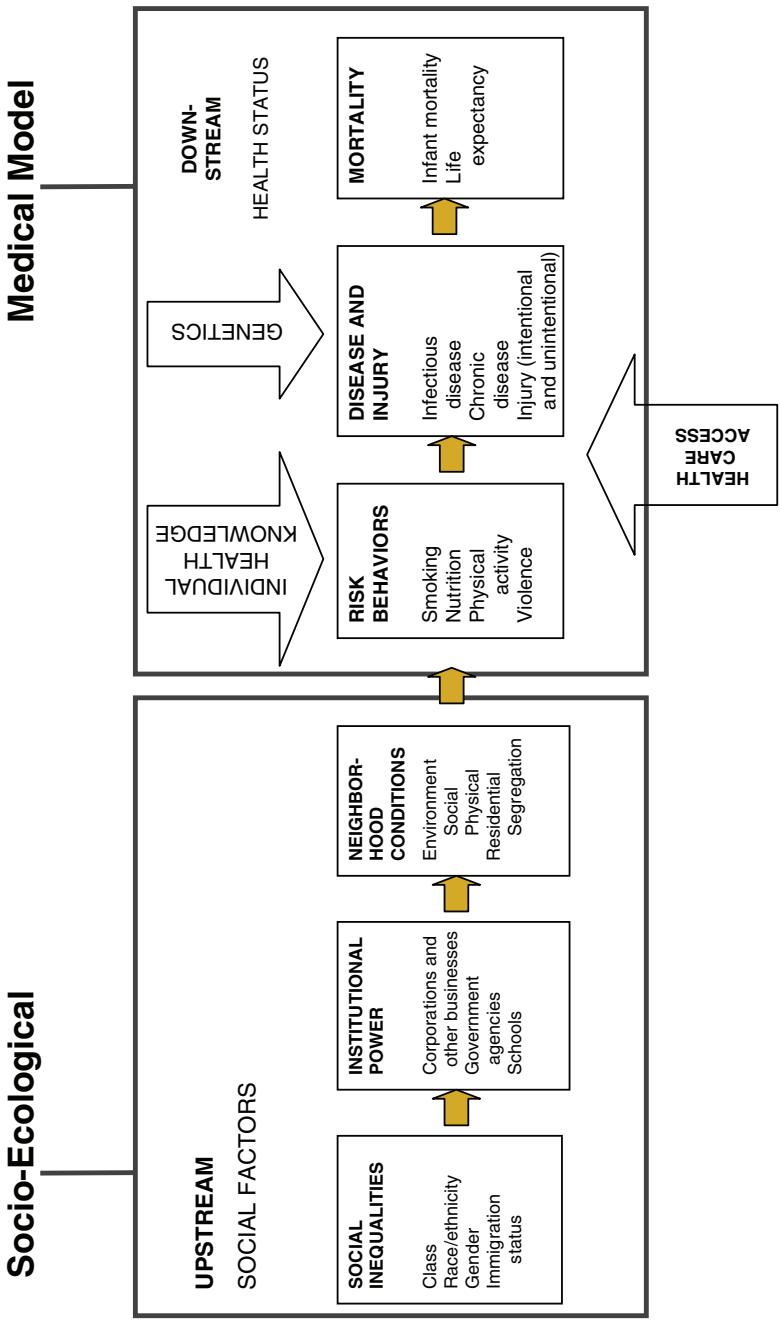

FIGURE 4-2 Framework for understanding and measuring health inequities.
SOURCE: Bay Area Regional Health Inequities Initiative.

change these racist, classist, and discriminatory policies by arguing for the more equitable distribution of resources at the policy-making table.

Finally, it must be noted that it is written into the U.S. Constitution that some people are less equal than others. Iton describes this as being an "indelible stain." To begin to erase this stain, Iton said, there must continue to be discussions about race, the consequences of discriminatory belief systems, and policies that distribute resources in an inequitable fashion. This, too, needs to be a part of public health; public health departments, Iton noted, need to try to change the status quo by using their power.

OPEN DISCUSSION

The discussion that took place after Iton's comments primarily focused on the question of the role of public health and public health departments in advancing policy solutions to reduce disparities. Manal Aboelata of the Prevention Institute in Oakland, California, noted that even if all health care providers were providing culturally competent and linguistically appropriate care, this may still be insufficient to equalize health outcomes or achieve health equity. Thus, he asked about the role of leadership in health departments and in public health as a whole.

Maxine Liggins, a health department member, stated that the role of the health department should include starting a dialogue with a community, convening organizations that can function as collaborators, helping to identify resources, functioning as advocates, and being the custodian of data. In short, she said, it should be an institution with a goal and a vision for all of the residents of a community.

An example of this role for a health department, offered Liggins, can be seen in the issue of tobacco. It took more than one branch of the government to solve that problem. Similarly, with alcohol, success was achieved only by collaborating with Mothers Against Drunk Driving, decreasing the number of liquor outlets, and enforcing laws that govern the purchase of both alcohol and cigarettes. Richard Veloz added that Los Angeles County has a responsibility to work and interact with the community groups trying to solve problems relating to prevention and primary care.

Douglas Fort offered an example from San Mateo County in California. He noted that the indigenous peoples of the city of East Palo Alto met with the county mental health directors, and in this way, several city nonprofit organizations were given funding to provide mental health care services to underserved clients. Ruben Abrica followed up by adding that city governments must make health one of their top priorities.

Roundtable member William Vega asked the panelists about the adequacy of the health care that the young men and women who are circulating through the correctional system receive. Marqueece Dawson responded

that this is an issue that came up in a federal lawsuit against the state of California. He went on to explain that some African American residents of South Los Angeles violate the terms of their probation so that they will be sent back to prison because in prison, they can receive the health care or surgery that they need but that they believe they do not have access to outside of prison.

Nicole Lurie concluded the discussion by raising several provocative questions for the group to consider for the remainder of the day. She noted that there are predictable cycles of community development and migration, which in turn lead to patterns of health disparities that are also predictable. She suggested that a computer model could be created to look at this problem and predict where the next waves of disparities will occur around the country. Knowing this, how may the conversation be framed for the next generation? How do we change the trajectory of these future cycles? How does the public health community plan for this?

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5

Discussion and Moving Forward

BREAKOUT SESSIONS

The workshop attendees were split into five different groups to discuss the following general topics for discussion and questions:

- Briefly talk about the demographic transitions that have occurred over the past 10 to 15 years in your community. Are there "old" versus "new" ethnic groups in your community? What, if any, has been the impact of immigration on your community?
- What assets have your community's newer ethnic groups brought to the community?
- Have attitudes about race and expressions of racism changed with the arrival of new community members?
- Describe the major health and health disparity concerns in your community.
- How has the community worked to address these health and health disparity concerns? Specifically, how has your framing of these issues affected your progress?
- Have the different racial and ethnic groups worked together? What have been your successes in addressing these concerns? What have been your challenges in addressing these concerns?
- What suggestions on how to frame health disparity issues do you have for other communities?

After the small-group discussions, each group reported back to the larger group. Will Crimi summarized the themes outlined by the small groups, as described below.

Working Across Racial and Ethnic Groups

Several participants noted the difficulties in bringing together groups that have their own interests to work together. One person suggested finding a common goal to bring groups together, for example, focusing on reducing poverty or supporting immigrant rights. Certainly, one area of common ground is the issue of health equity.

Another approach to encourage working across groups is to highlight the idea that health disparities are a shared problem and a multicultural issue. Therefore, finding the solution requires all groups to take responsibility together so that no one suffers. Health disparities, one participant said, need to be framed as a community problem rather than an individual problem. In this way, more people within a community will have ownership of the problem.

One participant suggested that it is easier to effect change by using the infrastructure already present in the community rather than starting from scratch. For example, working with the media and working with local fast-food outlets within the community can create an environment conducive to behavior change.

The Importance of Framing

A second theme that emerged from the small-group discussions was the importance of reframing the issue of health disparities so that the message appeals to a broader constituency. Several groups discussed the role of the media in framing issues; and the topic of how to take advantage of new forms of media, such as blogging, was raised. One participant, echoing Lori Dorfman's comments, suggested that it is essential to encourage the media to pay attention to the context as well as the individual.

Roundtable member Sam So, in describing his work in the Asian American community in Northern California, noted the importance of framing hepatitis B and liver cancer as community problems rather than as health disparities. Dr. So also worked with the media to promote health messages to the community.

Systemic Issues

A third theme that emerged from the discussions is that health disparities will never be reduced until broad systemic issues are addressed. One

group raised the importance of working across domains by engaging, for example, the housing policy community and the transportation policy community. Similarly, another group noted that investment is needed in a wide array of sectors within communities, from investing in health care systems to investing in education and economic development. In short, it is essential to build a range of diverse partnerships to successfully address health disparities.

The role of policy decisions in producing and reinforcing health inequities was another aspect of systemic issues that was discussed. One speaker noted that "health inequities were created and reproduced by a set of policy issues." It is only by identifying those policies and changing them that health disparities will be addressed.

Tony Iton noted that to address disparities, it is critical to build a movement to encourage policy makers to focus on public health. The idea of creating a movement was raised throughout the day, with one participant noting that such a movement needs a shared vision of striving for health equity. This shared vision, in turn, should provide a road map for entering into political dialogue at the local, state, and federal levels.

Another key issue to promoting health equity involves thinking about and understanding the need to work with governments at various levels, particularly the federal government, because the federal government is able to offer so many more potential funding opportunities than other levels of government are. One participant noted that the federal government also has power as well as funds.

A number of the small groups discussed the conditions that facilitate disparities, in particular, classism, racism, oppression, and poverty. William Crimi noted that attention needs to be paid to both urban oppression (a lack of transportation, a lack of jobs that pay a living wage) and rural oppression (the conditions facing agricultural workers). Poverty not only leads to fewer available resources but also leads to less access to health care services.

America Bracho stated that the issues surrounding racism should be used as a device to frame any discussion of health disparities. She noted that immigrants in particular are victims of racism, classism, and discrimination. Another participant talked about the importance of language in dealing with health disparities: if people do not have access to providers who can communicate with them, they cannot be properly treated and diagnosed.

Among the other comments from participants reporting back included a need to focus on social determinants and their role in health inequity. In particular, the development of a simpler language that may be used to talk about social determinants is important to get communities to focus on health inequity.

Many of the small groups discussed immigration. Immigrants, for

example, are more likely to be poor and therefore to have less access to health care. Another workshop participant, promoting the need for immigration reform, noted that the link between immigration and foreign policy needs to be made.

Workshop presenter Genoveva Islas-Hooker echoed the need for immigration reform, adding that until immigration reform happens, immigrants will be vulnerable to exploitation. Workshop presenter Ruben Abrica added that because immigrants typically make very little money, they often operate in an underground economy. The communities in which these immigrants live and work need to facilitate their economic integration into the community to help revitalize the community's economy. In fact, another attendee noted the importance of immigrant integration initiatives to encourage immigrants to become a part of the broader community.

One workshop participant discussed the importance of monitoring demographic changes so that the changes occurring in individual communities are known. In particular, better data on racial and ethnic subgroups need to be collected, and the collection of these data needs to be ensured. Roundtable member Sam So added that it is also essential to collect data on U.S.-born versus foreign-born members within the same ethnic group to get a truly accurate picture of health disparities.

Apartheid?

During the reporting back from the small groups, keynote speaker Mindy Fullilove described what she called "the American apartheid system" and stated that "we need to talk about apartheid in America," which is a system that disconnects and divides different ethnic and racial groups. In particular, she said, the destabilization of minorities has been especially devastating to those groups who have been in the United States for a long time, namely, Native Americans and African Americans. Another participant added that the United States has the same problems with apartheid that were previously seen in South Africa.

However, another workshop attendee, Vickie Katz, raised objections to the use of the word "apartheid" to describe the situation in the United States. As a native South African, she grew up under the apartheid system and believes that the word "apartheid" refers only to "a very specific regime that involved the systematic movement and destruction of 95 percent of the population by less than 5 percent." Additionally, the oppressing minority had a sense of manifest destiny and the belief that "God had given them this right." Katz found the use of the term "apartheid" to describe the situation in Los Angeles to be dangerous and divisive and cautioned the group to be careful about how the word is used.

Disparities That Need to Be Addressed

One group outlined the disparities that it believed are present in the California communities profiled at this workshop. Mental health, poverty, violence, obesity, and a lack of spirituality were all mentioned as disparities that need to be solved. Tony Iton further suggested that if the true desire is to reduce or eliminate health disparities, the *Healthy People 2010* report should be used as the road map.

MOVING FORWARD

Nicole Lurie, chair of the roundtable, again outlined the goal of the workshop: to talk about framing and how framing is used to talk about race and racial and ethnic health disparities. Frames, she summarized, are mental structures that are used as cues to "fill in the blanks" in our thinking. The conversation about health disparities should be reframed so that it is a discussion about health equity, Lurie said.

Disparities do not come out of thin air but arise from all of the social determinants discussed during the day, Lurie said. Each of us is born into a community, and every community has its own history. All too often, this history has been destructive to health. These social determinants are a part of the landscape and history of the communities in which people live. It is this landscape of the community whose modification must be thought about as health disparities are addressed.

Lurie continued that another way to focus on reframing is through reframing interactions with the government. Rather than thinking of government as the enemy, it also needs to be acknowledged that the government uses its influence to act on people's behalf as well. We also need to think about our own roles as individuals in our communities. Lurie noted that individuals and communities have opportunities to influence the way the government acts on our behalf.

The final comment of the day, from keynote speaker Mindy Fullilove, reminded the participants that things are getting worse for many people. This should, she said, be a reminder to keep working toward the goal of eliminating health disparities.

Appendix A

Agenda

America in Transition, a View from California: Implications for Addressing Health Disparities

Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

Public Meeting
Center for Healthy Communities
The California Endowment
1000 N. Alameda Street
Los Angeles, CA 90012

July 28, 2008

Goal of Meeting: To discuss how the framing of health disparities in diverse communities influences public debate about improving health outcomes.

7:30 a.m. – 8:00 a.m.	**Registration**
8:00 a.m.	**Welcome** *Nicole Lurie, Chair* Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, Institute of Medicine Senior Natural Scientist and Paul O'Neill Alcoa Professor RAND Corporation *Alicia Dixon, Member* Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, Institute of Medicine Program Officer The California Endowment

8:15 a.m.	**The Changing Face of American Communities: Implications for Framing Discussions About Health Disparities** *E. Richard Brown, Ph.D.* Director, Center for Health Policy Research University of California, Los Angeles
	Unity or Apartheid: The Implications of Diversity for U.S. Society *Mindy Thompson Fullilove, M.D.* Professor of Clinical Psychiatry and Public Health Columbia University
9:15 a.m.	**Framing Health Disparities: More Than a Message** *Lori Dorfman, Dr.P.H.* Director, Berkeley Media Studies Group
10:00 a.m.	**Break**
10:30 a.m.	**Panels—Case Communities: How Have Communities in Transition Framed Health Disparities for Action?**
	East Palo Alto *Ruben Abrica* City Council Member, East Palo Alto
	Melieni Talakai, R.N. Vice Chair, Board of Directors Ravenswood Family Health Center
	Luisa Buada, R.N., M.P.H. Chief Executive Officer, Ravenswood Family Health Center South County Community Health Center, Inc.
	Douglas J. Fort For Youth, By Youth, Inc. Founder and Director, Intervention/ReEntry/ Street Team Services

Fresno
Keith Kelley
President and Chief Executive Officer
Fresno West Coalition for Economic Development

Lue Yang
Fresno Center for New Americans

Genoveva Islas-Hooker, M.P.H.
Regional Program Coordinator
Central California Regional Obesity Prevention Program

South Central Los Angeles
Maxine E. Liggins, M.D.
Area Medical Director, Public Health Division of the Los Angeles County Department of Health Services

Richard A. Veloz, J.D., M.P.H.
Chief Executive Officer
South Central Family Health Center

Marqueece Dawson
Executive Director
Community Coalition for Substance Abuse Prevention and Treatment

Comments and Reaction
Anthony Iton, M.D., J.D., M.P.H.
Alameda County Health Department

1:00 p.m. **Lunch**

2:00 p.m. **Breakout Sessions with Case Community Representatives: Challenges and Opportunities in Framing Health Disparities to Stimulate Action**

3:30 p.m. **Report from Small Groups: Lessons Learned**

4:30 p.m. **Summing Up, Conclusions, and Observations**

Appendix B

Speaker Biographies

Ruben Abrica was born and raised in Mexico and immigrated as a teenager to California. He is a member of the City Council of East Palo Alto, California, where he has lived for 29 years. Abrica was involved in the movement for incorporation and was elected to the first city council in 1983. During the 1990s he served on the board of directors of the Ravenswood School District. He has also served on the boards of or been a member of various organizations, such as the Drew Health Clinic Board, Senior Center, YMCA, and Committee Latino. Abrica's professional background is in teaching and educational research. He designed and conducted an evaluation, the Educational Exchange Program for Nurses in the Pacific Basin, for the University of Hawaii. As mayor of East Palo Alto in 2006, Abrica convened a Community Health Roundtable with the purposes of (1) gathering specific information on the health situation of East Palo Alto residents, (2) exploring the social and environmental justice issues that affect the health of the community, and (3) identifying ways for city government to become a stronger advocate for health issues. The Community Health Roundtable continues to serve as a vehicle for discussion and advocacy for health issues affecting all the diverse communities in East Palo Alto.

E. Richard Brown, Ph.D., is a professor at the School of Public Health, University of California, Los Angeles (UCLA). He is also the founder and director of the UCLA Center for Health Policy Research. Brown received a Ph.D. in the sociology of education from the University of California, Berkeley. Brown's recent research focuses on health insurance coverage; the lack of coverage; and the effects of public policies, managed care,

and market conditions on access to health care services, particularly for disadvantaged populations, ethnic minorities, and immigrants. The UCLA Center for Health Policy Research, which he founded in 1994, is supported by grants and contracts that total more than $8 million a year. Brown is also the principal investigator for the California Health Interview Survey (CHIS), one of the nation's largest ongoing health surveys. Brown served as a full-time senior consultant to the President's Task Force on National Health Care Reform, for which he cochaired the work group on coverage for low-income families and individuals. He has served as health policy adviser to two members of the U.S. Senate, where he was a Senate fellow and developed legislative proposals for major health care reform. He was health policy adviser to several candidates for U.S. president. Brown has also developed legislation for the California Legislature and advised members on a variety of health policy legislative issues. He has presented invited testimony to numerous committees in both houses of the U.S. Congress and in the California Legislature and has provided consultation services to many private, state, federal, and international agencies. He has also served on several study committees of the National Academies. He is a past president of the American Public Health Association.

Luisa Buada, R.N., M.P.H., has 27 years of experience in health care administration, management and organizational development. She was the founding executive director of both Clinicas de Salud in the Salinas Valley and the Berkeley Primary Care Access Clinic. She cofounded Life Long Medical Care in Berkeley, California, as part of a merger with the Over 60 Health Center in 1996. She participated as a consultant in the development of Ravenswood Family Health Center (RFHC) in East Palo Alto and in November of 2003 became the chief executive officer of RFHC. As a consultant, Buada worked with community health centers on strategic and financial planning, organizational development, architectural planning, and bilingual board training. She received a bachelor of science degree in nursing from the University of California, San Francisco, School of Nursing in 1977 and a master's degree in public health policy and administration from the University of California, Berkeley, in 1990.

Marqueece Dawson has been a dedicated activist for more than twenty years. He completed his bachelor's degree at Morehouse College and while there, cut his activist teeth on several important community issues including South African apartheid, police brutality, and youth and family services. Currently, he is the Executive Director of Community Coalition, a community-based organization in South Los Angeles. Dawson is the organization's second Executive Director, following its founder, current California State Assembly Member Karen Bass. The organization is best

known for leading grassroots campaigns to close more than 200 liquor stores and other nuisance businesses in South Los Angeles and winning the struggle to obtain college prep courses for all LAUSD high school students. For 5 years, Dawson ran the Community Coalition youth project, South Central Youth Empowered thru Action, as Program Director. During that time, he led a campaign to expose poor learning conditions at South Los Angeles High Schools. As a result of Dawson's focused leadership and the student's tenacity, they won $153 million in repairs for their schools. In addition to his work at Community Coalition, Dawson has extensive experience in electoral politics and is a key participant in the Progressive Movement in Los Angeles. Marqueece was a delegate to the United Nations World Conference Against Racism (2001, Durban, South Africa) and the World Festival of Students and Youth (1997, Havana, Cuba) and serves on a myriad of boards, committees, and organization affiliations. Recently, Dawson received a certificate in nonprofit management from Stanford's Graduate School of Business.

Lori Dorfman, Dr.P.H., directs the Berkeley Media Studies Group (BMSG), a project of the Public Health Institute. Dorfman oversees BMSG's research on news and advertising, media advocacy training for advocates, and professional education for journalists. Her research examines portrayals of various public health issues including children's health; nutrition and agriculture; food and beverage marketing; paid family leave; racial discrimination; violence; and alcohol, tobacco, and other drugs. Dorfman coauthored major texts on media advocacy: *Media Advocacy and Public Health: Power for Prevention* and *News for a Change: An Advocate's Guide to Working with the Media* (Sage Publications). She conducts media advocacy training for grassroots groups and public health leaders, consults for government agencies and community programs across the United States and internationally, and publishes articles on public health and mass communication. She edited *Reporting on Violence: A Handbook for Journalists*, which helps reporters include a public health perspective in their reporting on violence and is part of an interdisciplinary team that has conducted workshops on the reporting of violence for newspapers and local television news stations. Outside of BMSG, Dorfman is a lecturer at the University of California, Berkeley, School of Public Health, where she teaches mass communications and public health. She serves on the advisory board for the Center for Media Justice and on the Board of Trustees for Voices for America's Children. Dorfman's publications are available from www.bmsg.org.

Douglas J. Fort has a lifetime of experience dealing with ex-offenders and at-risk youth. Growing up in the at-risk community of East Palo Alto, California, Douglas Fort was at risk himself. In 1992, his hometown became

the murder capital of the United States of America. Fort survived being shot twice in the face. Determined not to become another statistic in an already bleak situation, Fort was the first and only sibling of four to graduate from high school. After graduating from high school, Fort received a bachelor's degree in criminal justice at Jackson State University, graduating magna cum laude in May 2000. In 1998, Fort started For Youth, By Youth (FYBY) which is successfully finding avenues that allow inner-city youth to use their natural talents and interests to improve their own community and serve other youth. Today, FYBY has grown into a community of young people who practice "life-giving choices." The FYBY leadership has a passion to work together to influence and direct youth and young adults who are likely to be involved in or affected by neighborhood violence. FYBY's motto is "Dedicated to the Street!"

Mindy Thompson Fullilove, M.D., is a research psychiatrist at the New York State Psychiatric Institute and a professor of clinical psychiatry and public health at Columbia University. She was educated at Bryn Mawr College (bachelor of arts degree, 1971) and Columbia University (master's degree, 1971; doctor of medicine degree, 1978). She is a board-certified psychiatrist, having received her training at New York Hospital—Westchester Division (1978–1981) and Montefiore Hospital (1981–1982). She has conducted research on AIDS and other epidemics of poor communities, with a special interest in the relationship between the collapse of communities and the decline in health. From her research, she has published *Root Shock: How Tearing Up City Neighborhoods Hurts America and What We Can Do About It* (2004) and *The House of Joshua: Meditations on Family and Place* (1999). She is also coauthor of Rodrick Wallace's *Collective Consciousness and Its Discontents: Institutional Distributed Cognition, Racial Policy and Public Health in the United States* (2008). She has also published numerous articles, book chapters, and monographs. She has received many awards, including inclusion on best doctors lists and two honorary doctorates (from Chatham College in 1999 and from the Bank Street College of Education in 2002). Her work on AIDS is featured in Jacob Levenson's *The Secret Epidemic: The Story of AIDS in Black America*. Her current work focuses on the connection between urban function and mental health.

Genoveva Islas-Hooker, M.P.H., is the regional program coordinator for the Central California Regional Obesity Prevention Program (CCROPP). CCROPP addresses environmental- and policy-level factors that contribute to the escalating incidence of obesity in the central California counties of Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, and Tulare. Islas-Hooker was born in Fresno, California, and grew up in small rural communities in central California, including Orange Cove, McFarland,

Delano, Lost Hills, and Wasco. She comes from a migrant farm worker background. Islas-Hooker earned a bachelor of science degree in health science with an emphasis in community health from California State University, Fresno. She received a master's in public health degree in health education and promotion from Loma Linda University. Her experience in public health spans over 18 years in both the public and the private sectors. She has worked in the arenas of HIV/AIDS education, HIV case management, medical managed care, cultural and linguistic services, and diabetes prevention and control.

Anthony (Tony) Iton, M.D., J.D., M.P.H., is the Alameda County Public Health Department director and health officer. Iton's primary interest is the health of disadvantaged populations and the contributions of race, class, wealth, education, geography, and employment to health status. He has asserted that in every public health area of endeavor, be it immunizations, chronic disease, HIV/AIDS, sexually transmitted diseases, obesity, or even disaster preparedness, local public health departments must recognize that they are confronted with the enduring consequences of structural poverty, institutional racism, and other forms of systemic injustice. He further asserts that the only sustainable approach to eliminating health inequities is through the design of intensive, multisectoral, place-based interventions that are specifically designed to identify existing assets and build social, political, and economic power among a critical mass of community residents in historically underresourced communities. Iton received a medical degree at Johns Hopkins University Medical School and subsequently trained in internal medicine and preventive medicine at New York Hospital, Yale University, and the University of California, Berkeley, and is board certified in both specialties. Iton has also received a law degree and a master's of public health degree from the University of California, Berkeley, and is a member of the California Bar. In 2006, he was awarded the prestigious Milton and Ruth Roemer Prize for Creative Public Health Work, awarded by the American Public Health Association to a U.S. local health official in recognition of outstanding creative and innovative public health work.

Keith Kelley is the founding executive of the Fresno West Coalition for Economic Development and is responsible for its operation, administration, and financial management. Under his direction, the organization has grown from one to eight employees, who coordinate five program areas. Kelley is recognized both locally and nationally as a leader in community and economic development. He is currently a member of the board of the National Congress of Community Economic Development, based in Washington, DC, and of the Collaborative Regional Initiative's Innovative Culture Committee. He has been tapped locally as the community cochair

for the city of Fresno's successful bids to be an Empowerment Zone and All-American City, as well as part of Mayor Alan Autry's advisory committee. Keith's accomplishments were recently recognized when he became the recipient of the NAACP—Fresno Chapter 2005 Image Award for economic development. Kelley's community activities include the following: past president of the African American Historical and Cultural Museum of the San Joaquin Valley and past vice president of the Fresno Chamber of Commerce's Leadership Fresno. Other areas of civic and community involvement include being a member of the Care Fresno Board of Directors, the Salvation Army Advisor Committee, the Fresno County Economic Opportunities Commission's Round Table Committee, the Fulton/Lowell Implementation Committee, the City of Fresno's Dr. Martin Luther King, Jr., Unity Committee, and Congressman Calvin M. Dooley's Race Relations Committee. Kelley is completing work on a master of administrative leadership degree from Fresno Pacific University. He also holds a bachelor of arts in management and organizational development.

Maxine E. Liggins, M.D., has served as an area medical director for the Public Health Division of the Los Angeles County Department of Health Services since 2000. The service planning areas in which she works include the wealthiest and the poorest residents of Los Angeles County. Public health's mission of "improving the quality of life for the residents of Los Angeles County" serves as a yardstick by which the quality of health services provided in Los Angeles County is measured. Liggins' personal mission is the prevention of all vaccine-preventable illnesses and achievement of a greater understanding of the factors that contribute to the chronic diseases that detract from the quality of the lives of all Americans. Liggins was the first African American to receive a bachelor's degree in chemistry from the University of Washington in Seattle in 1979. She later received a doctor of medicine degree from the University of Washington in 1985. She completed an internship and residency in internal medicine at the Los Angeles County/University of Southern California Medical Center in Los Angeles and Emmanuel Hospital in Portland, Oregon, in 1989. Liggins is a specialist in infectious diseases and public health medicine. As an infectious disease fellow, Liggins worked as a sub investigator for the AIDS Collaborative Treatment Group at the University of Southern California from 1989 to 1992. That research group enrolled the largest numbers of HIV-infected patients in the initial clinical studies evaluating the first medications marketed for the treatment of HIV infection and AIDS. Liggins has served as the principal investigator for the first national AIDS study dedicated specifically to the treatment of women in 1999. Liggins is currently an investigator on three Centers for Disease Control and Prevention studies on sexually transmitted diseases. Liggins works for the day when Americans

can achieve a health status that allows each of us to reach our potential as physically fit, mentally healthy, and spiritually balanced individuals.

Melieni Talakai, R.N. If you tune in to a biweekly health education radio program for Tongans on KEST (1450 AM), you hear a voice that has the warmth of a South Sea island breeze. The host is Melieni Falemaka Talakai, a nurse who was born and raised in Tonga and received her nursing and nurse midwife training in New Zealand. In 1982, Talakai immigrated to the United States. From 1984 to 2001 she was a home health and hospice nurse. She then joined the staff of San Mateo County Health Services, where she currently works as the clinical case manager and as a staff nurse for the Mobile Clinic of San Mateo County, California. Talakai knows more about the history of the clinic than any other board member. She was there at its inception in 1998, when a blue ribbon advisory committee met to lay out the blueprint for a community health center. From 2002 through 2004, she served as the chair of Ravenswood Family Health Center's board of directors.

Richard A. Veloz, J.D., M.P.H. With more than 30 years of health care and public health experience, Veloz has served on the front lines of providing care to the leadership of organizations organizing and delivering health care. Since 2002, Veloz has served as the chief executive officer of the South Central Family Health Center. Before assuming the leadership at SCFHC, he worked as the interim chief executive officer of the Community Health Foundation of East Los Angeles, a 330 federally qualified health center, during its bankruptcy reorganization. Veloz also served as the first director of government relations and public affairs at the Los Angeles Care Health Plan, a health maintenance organization public entity initially created to serve Medicaid beneficiaries, mostly women and children in Los Angeles County. Veloz was appointed by President Bill Clinton to be a special assistant to the administrator of the National Highway Traffic Safety Administration. He was also appointed by President Clinton to the Task Force on Health Care Reform as a senior health policy advisor. As the staff director of the House of Representatives Select Committee on Aging, Veloz directed all legislative activity for the 68-member committee and its four subcommittees. Veloz serves as chair of the Southside Coalition of Community Clinics, is an executive committee member and treasurer of the California Primary Care Association, finance chair of Health Care Los Angeles, and is a member of the board of the Community Clinic Association of Los Angeles County. He also serves as an executive committee member and secretary for the Board of Trustees for the Charles R. Drew University of Medicine and Science. Veloz received a juris doctor degree from the University of California, Los Angeles (UCLA), School of Law, and a master of public

health degree from the UCLA School of Public Health. He graduated from California State University, Los Angeles, with a bachelor of arts in history and from East Los Angeles Community College with an associate of arts degree in history.

Lue Yang has been the executive director of the Fresno Center for New Americans since 1993. His leadership at this organization has taken on educational and advocacy roles and critical issues in the community, such as employment, health, student performance, civic engagement, and grassroots leadership development. His organization has had extensive health education projects that serve Southeast Asian refugees in Fresno, California. Yang has been a committee member on the Fresno County Local Child Care Planning Council and the HIV Planning Council of Sierra Community Medical Center. He served as chairperson of the Central California Forum on Refugee Affairs, family advisor for Valley Children's Hospital, and as a board member of Central Valley Regional Center (an organization that works with mentally and physically challenged individuals). Yang is a Hmong clan leader (cultural leader) and has tremendous experience with the Hmong culture and background, a setting in which he is highly respected for his leadership and cultural broker skills.

Appendix C

Resources

The following list, categorized by chapter, is provided for those interested in learning more about resources mentioned throughout the workshop. The Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities does not endorse any particular program, publication, or website.

CHAPTER 2

UCLA Center for Health Policy Research, www.healthpolicy.ucla.edu/
California Health Interview Survey, www.chis.ucla.edu/
Amy Hillier, http://www.sp2.upenn.edu/people/faculty/hillier/index.html, http://cml.upenn.edu/redlining/
Passing Poston, www.passingposton.com
HOPE VI, www.hud.gov/offices/pih/programs/ph/hope6/
David Harvey, davidharvey.org
Highlander Center (Highlander Research and Education Center), www.highlandercenter.org
United Electrical Radio and Machine Workers of America, www.ueunion.org/

CHAPTER 3

Berkeley Media Studies Group/Public Health Institute, www.bmsg.org/, www.phi.org

CHAPTER 4

Ravenswood Family Health Center, www.ravenswoodfhc.org/
Fresno West Coalition for Economic Development, www.fwced.com/
Fresno Bee, http://www.fresnobee.com/
The Measure of America: American Human Development Report 2008–2009, http://www.measureofamerica.org/2008-2009-report/about/
Social Compact, www.socialcompact.org
Fresno Center for New Americans, www.fresnocenter.com/
Central California Regional Obesity Prevention Program, http://www.csufresno.edu/ccchhs/institutes_programs/CCROPP/index.shtml
Los Angeles County Department of Public Health, publichealth.lacounty.gov/
South Central Family Health Center, www.scfhc.org/
Southside Coalition of Community Health Centers, http://lahealthaction.org/index.php/directory/detail/1022
Community Coalition, http://cocosouthla.org/
The California Endowment, www.calendow.org/
Bay Area Regional Health Inequities Initiative (BARHII), www.barhii.org/

CHAPTER 5

Healthy People 2010, www.healthypeople.gov/