

The Context of Health: What is the Role of Leadership?

A Summary of the Keynote Address Presented by Dr. Anthony B. Iton at the Second Annual Blue Cross Foundation Health Leadership Award Program

Dr. Anthony B. Iton, MD, JD, MPH, serves as director and health officer of the Alameda County (California) Public Health Department. His primary interest is the health of disadvantaged populations and the contributions of race, class, wealth, education, geography and employment to health status. Recognizing the enduring consequences of structural poverty, institutional racism and other forms of systemic injustice, Dr. Iton believes the only sustainable approach to eliminating health inequities is through the design of intensive, multi-sectoral, place-based interventions and policy change.

Dr. Iton began his keynote address by emphasizing the importance of changing what we *do* if we are to improve the health of disadvantaged populations: “The point is not to understand the theory or to acknowledge racism, classism and bias against immigrants, but to change our practice.” Speaking of how impressed he is in that regard with the work of this year’s recipient of the Blue Cross Foundation’s Health Leadership Award — Atum Azzahir, president and executive director of the Powderhorn Phillips Cultural Wellness Center — Dr. Iton noted that building culture is a critical piece of addressing health inequities.

Dr. Iton then reviewed the compelling evidence of health disparities in life expectancy. The gap in the health between African Americans and whites, for example, is not being eliminated but actually getting worse, with the impact of chronic disease as the greatest contributor to the gap: “These are the things that kill us all, but they have a bigger impact in the African American community.”

A Framework for Changing Practice

Introducing a “framework for changing practice” that served as the structure for his presentation, Dr. Iton examined the medical model of intervention and what he believes is the more effective socio-ecological approach.

Genetics and access to health care each explain only 10 to 15 percent of the variation in disease and injury rates between African Americans and whites, with the medical model attributing the remaining 70 percent to risk behaviors — such as smoking, nutrition and physical activity. “The medical model stops at the individual,” Dr. Iton said. “Our society is blind to community, acting as if it’s irrelevant. We talk as if individuals live in a vacuum.”

The medical model is complicated by the challenges of changing individual behavior. While California managed to reduce its smoking rate to 14 percent (50 percent better than the nation as a whole), for example, the gaps in the smoking rates of African Americans and lower socioeconomic groups have persisted. In the face of the persistence of health gaps one must ask the question: How much does place — the neighborhood and community context in which we live our lives — matter?

Neighborhood Conditions

Dr. Iton then reviewed data from Alameda and Hennepin counties showing the association between poverty rates and life expectancy. Every additional \$12,500 in household income, for example, buys a year of life in the San Francisco Bay area. “This is the true poverty tax,” Dr. Iton said. “The cost of being poor is earlier death.”

Census tract data for “high, intermediate and low trajectory communities” reveals the relationship between neighborhood characteristics — including rates of high school graduation, unemployment, poverty, home ownership and percentage of nonwhite residents — and life expectancy. “That we can predict life expectancy for children born in each of these communities is outrageous,” Dr. Iton noted in pointing out the similarities between “how our society lays down patterns of illness and death” and how we distribute education, income and employment.

While the medical model blames people for adopting high risk behaviors, an understanding of the impact of the places we live raises different questions. “I’m not saying individual responsibility doesn’t matter,” Dr. Iton emphasized. “It does — but there is so much more.”

We need to intervene at the neighborhood level to address the physical and social environment and residential segregation — issues that are outside the control of individuals and have real health consequences. The prevalence of smoking billboards, liquor stores and pollution in poor neighborhoods illustrates the point: “The message is, ‘you don’t matter, you have no value, we dump our garbage on you.’”

Institutional Power

Dr. Iton went on to discuss the contribution of institutions — including schools, corporations and businesses and government agencies — to health disparities. Striking data on racial and economic disparities in educational achievement, for example, indicate the scope of a problem that we have not yet found a way to change. Citing an NIH study that shows associations between education and health across a broad range of illnesses, Dr. Iton emphasized, “Educational attainment matters; this is a health problem.”

Disparities in household wealth, median family income and home ownership rates also have health implications, yet “we close our eyes to them and say that’s our system.” The home mortgage interest deduction is a federal subsidy, with those earning \$500,000 and above receiving the biggest subsidy. Comparing the \$81 billion this subsidy cost in 2008 to the \$30 billion that would support a high-quality, two-year preschool program for poor families, Dr. Iton stressed that “these are policy choices. We’re housing wealthy people at the expense of poor people.”

Social Inequalities

Social inequalities — race, ethnicity, class, gender and immigration status — are the final piece of the framework for changing practice. Recalling the impact of Hurricane Katrina and Chicago’s devastating 1995 heat wave on people of color and those with low income, Dr. Iton went on to speak of the “everyday emergencies” created by hazardous social conditions in “low trajectory communities.”

These communities have schools that contribute to “unlearning,” few jobs, rampant crime, segregation by race and income and low quality housing; they are places where we dump our garbage and toxins. “How much individual responsibility does a kid growing up in that community have?” Dr. Iton asked. “How does the medical model help that kid today?”

Intervening for Change

Quoting Nelson Mandela — “Like slavery and apartheid, poverty is not natural. It is man-made and can be overcome and eradicated by the actions of human beings.” — Dr. Iton considered how we can intervene effectively. The medical model posits that behaviors lead to diseases which lead in turn to death, while the socio-ecological model says that biased behaviors such as racism, classism and sexism lead to diseased societal decision making which in turn leads to communities on life support. “We need to intervene across the full range of the framework,” Dr. Iton said, “but right now we are spending most on the medical model.”

Culture can be health protective. Some immigrant groups can thrive in difficult situations largely because of their cultural practices. “We need to learn from them,” Dr. Iton said. “That’s how we’ll eliminate health disparities — by understanding the wisdom of communities and recognizing policies that are racist, classist, sexist.”

Just as we have interventions for the factors in the medical model, we also need interventions for the factors in the socio-ecological model. The intervention for dying communities, for example, is community capacity building. And policy advocacy is the intervention for “diseased” societal decisions. “We’ve learned that if you’re not at the table you lose the struggle,” Dr. Iton said. “and the freeway goes in your neighborhood.” Leadership can help to organize communities. Effective, sustainable leadership sometimes means working behind the community, rather than in front, and holding the system accountable.

Turning to the piece of the framework on biased behaviors (the “isms”), Dr. Iton acknowledged that he didn’t know what effective interventions would be in this area.

Healthy People 2010, current federal policy, calls for a multidisciplinary approach to achieving health equity by 2010. While this is a worthy goal, our current practice does not support it. “We need to develop a practice so we are working with people like Atum [Azzahir] and addressing root causes,” Dr. Iton said. “‘Til we understand how to do that, we’re lost.” Dr. Iton concluded by saying that Minnesota was better positioned than most states to add to our understanding of how to do this work: “We need to harness wisdom like Atum’s, believe it and use it.”