A CALL TO ACTION:

Advancing Health For All Through Social and Economic Change

Prepared by the

Minnesota Health Improvement Partnership
Social Conditions and Health Action Team

April 2001

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For more information, contact:
Health Systems Development
Phone (651) 296-9661
Fax: (651) 296-9362
http://www.health.state.mn.us/divs/chs/hsd.htm

MINNESOTA MDH DEPARTMENT OF HEALTH

Division of Community Health Services
121 East Seventh Place, Suite 460
St. Paul, MN 55164
Phone (651) 296-9661 Fax (651) 296-9362
TDD (651) 215-8980
http://www.health.state.mn.us

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Community dialogues co-hosted by the Urban Coalition and the Minnesota Department of Health added richness and depth to published research findings, and heavily influenced report recommendations. More than fifty people – representing health, housing, education, philanthropic, and advocacy sectors – participated in the dialogues, and many of their comments have been incorporated as textboxes throughout this report.

Joint meetings between the Action Team and the Minnesota Department of Health Minority Health Advisory Committee led to forthright discussion and deeper understanding of the connections between race, racism and health.

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Upon this gifted age, in its dark hour,

Rains from the sky a meteoric shower

Of facts...they lie unquestioned, uncombined.

Wisdom enough to leech us of our ill

Is daily spun; but there exists no loom

To weave it into fabric...

– Edna St. Vincent Millay

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Executive Summary

- Background
- Vision
- Summary of Key Findings
- Conclusions
- Recommendations

A CALL TO ACTION:

Advancing Health For All Through Social and Economic Change

BACKGROUND

This report is a multi-disciplinary, inter-sector Call to Action produced by the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership (MHIP).

The purpose of this report is to deepen understanding of the impact that social and economic conditions have on health, and identify recommendations with potential to help create more health-enhancing social and economic environments in Minnesota.

A unique contribution of this report is its focus on social and economic change as a strategy for health improvement and as a remedy to health disparity. This report examines the importance of social interactions and policies within settings (e.g., places where we live, work, learn, worship and play) and systems (e.g., education, criminal justice, human services) outside of the health sector that have a profound impact on health.

VISION: ***All people in Minnesota have an equal opportunity to enjoy good health.***

Minnesota ranks as one of the healthiest states in the nation, but mounting evidence shows that this great state of health is not shared by all – particularly American Indians, populations of color, foreign-born populations, and people with low income.

We are one Minnesota. Health disparities affect us all. Minnesota should commit to leading the nation in the health of *all* of its citizens, not only because this is the right thing to do, but because this will contribute to the overall health and prosperity of Minnesota.

Health is more than not being sick. Health is a resource for everyday life – the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. Health has physical, mental, social and spiritual dimensions.

Achieving this vision is bigger than our systems of public health and health care. All individuals, systems and institutions in the community share responsibility for – and reap the rewards of – improved health.

> ***America's strength is rooted in its diversity. Our history bears witness to that statement. E Pluribus Unum was a good motto in the early days of our country and it is a good motto today. From the many, one. It still identifies us – because we are Americans.*** —Barbara Jordan, former U.S. Senator

Minnesota Health Improvement Partnership

Association for MN Counties
Business for Social Responsibility, Upper Midwest Network
Center for Population Health
Consumer Member
Health Care Education and Research Foundation
League of MN Cities
Local Public Health Association
Maternal and Child Health Advisory Task Force
MN Business Partnership
MN Chamber of Commerce
MN Council on Disabilities
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Population Health Assessment Work Group
Prairie Regional Health Alliance
Rural Health Advisory Committee
State Community Health Services Advisory Committee
University of Minnesota
- **Center for Spirituality and Healing**
- **School of Public Health, Division of Epidemiology**
- **School of Public Health, Division of Health Services Research and Policy**

SUMMARY OF KEY FINDINGS

Health is a product of individual factors (such as genes, beliefs, coping skills, and personal behaviors) combined with collective conditions (factors in the physical, social and economic environment).

The social and economic environment is a major determinant of population health that has not been a focus of most health improvement efforts in Minnesota.

Key aspects of the social and economic environment that affect health include income, education, and income distribution; social norms; social support and community cohesion; living conditions such as availability of affordable housing, transportation and nutritious foods; employment and working conditions; and culture, religion and ethnicity. For example:

- People with a higher income generally enjoy better health and longer lives than people with a lower income. The rich are healthier than the middle class, who are in turn healthier than the poor. This is true for people of all racial and ethnic backgrounds.

- Disease and death rates are higher in populations that have a greater gap in income between the rich and poor. The effect of income inequality on health is not limited to people in poor and low income groups. The health of people in middle (and in some studies upper) income groups is worse in communities with a high degree of inequality when compared to communities with less inequality. The health of a population depends not just on the size of the economic pie, but on how the pie is shared.

- People are healthiest when they feel safe, supported and connected to others in their families, neighborhoods, workplaces and communities. More cohesive communities (those characterized by greater civic participation, volunteerism, trust, respect and concern for others) have lower rates of violence and death.

- Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe and there are ample opportunities for control, decision-making, advancement and personal growth.

- Culture, religion and ethnicity have an overarching influence on beliefs and practices related to health, illness and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about the type of provider or healer that should be sought.

More research is needed to understand precisely how these factors affect health and health disparities, and how to translate these findings into the most promising policies and programs. Studies conducted to date point to conclusions such as:

- Social and economic factors influence a broad array of opportunities, exposures, decisions and behaviors that promote or threaten health (e.g.,

availability of safe and convenient parks and trails encourage recreation and neighborhood connections; oppression and marginalization contribute to violence and apathy; high housing costs leave fewer resources for other necessities; transportation eases isolation; farmer's markets encourage eating fresh produce; family leave and quality childcare promote attachment and positive development; cultural insensitivity alienates community members; the concentration of liquor outlets in low income neighborhoods encourages alcohol use and abuse).

- Discrimination and racism play a crucial role in explaining health status and health disparities, through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, residential segregation (which can limit access to social goods and services), and chronic stress.

- People of color and American Indians do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). *At every level of income,* their health is worse than that of their white peers.

- People with low income do not experience worse health simply because of high risk personal behavior (although this is an important factor). In one recent study, health behaviors such as cigarette smoking, alcohol use, and physical inactivity explained less than 20 percent of the difference in death rates across income groups.

These findings challenge us to change the way we implement health improvement efforts, examine the health impact of social and economic forces at play outside the traditional health sector, and renew attention to the roles we play as individuals and organizations in creating and perpetuating these disparities.

CONCLUSIONS

Good health enables Minnesotans to lead productive and fulfilling lives, and contributes to the competitiveness, prosperity and social stability of the state.

Good health results from good systems of public health and medical care, from sound public policies that create social and economic conditions that support health, and from individual decisions and behaviors that value health. A comprehensive health improvement agenda addresses each of these determinants and recognizes the inter-relationships between them.

More supportive social and economic conditions are needed to eliminate disparities and achieve Minnesota's overall health improvement goals.

The links between health and factors such as income, education, living and working conditions, culture, social support and community connectedness are clear. But more research is needed to understand more precisely how these factors affect health, and how to translate these findings into the most promising policies and programs.

RECOMMENDATIONS

Minnesotans must stand together to assure that everyone has the resources and opportunities necessary to be healthy. In addition to access to health information, immunizations, and clean air and water, all people in Minnesota need a supportive social and economic environment. This includes a quality education, economic opportunity and adequate income for housing, food and other necessities; a sense of community connectedness, individual control, and personal safety; and opportunities to fully participate in the cultural and civic life of their communities.

Identify and Advocate for Healthy Public Policy

Policies and programs have health consequences though they may not have explicit health objectives. Since investments outside the health sector have consequences for community health, the potential impact of social and economic policies on the health of Minnesotans should be an integral part of policymaking processes.

- Develop and pilot tools for Health Impact Assessment in Minnesota
- Produce briefs that summarize emerging research on the health impacts of social and economic policies

The Minnesota Department of Health (MDH) and the MHIP should focus united advocacy and action behind social and economic policies and programs with significant potential to improve or diminish health and quality of life in Minnesota. Findings of Health Impact Assessment and other avenues of evaluation and research are needed to identify the most promising policies and programs. As this research moves forward, Minnesotans should capitalize on current evidence and experience to discuss and debate the potential health affects of current and proposed policies and programs to:

- Help people move out of poverty and meet their basic needs
- Promote optimal early childhood development and attachment
- Assure opportunities for quality education and lifelong learning
- Link economic development, community development and health improvement
- Elevate the standard of living and prospects for future generations

Build and Fully Use a Representative and Culturally Competent Workforce

The MDH and the MHIP member organizations should establish and adhere to practices to recruit, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served. The following strategies will increase diversity, promote cultural competence, and enhance organizational credibility and effectiveness.

- Create diverse applicant pools of qualified people
- Create an environment where all employees feel welcome, accepted and valued
- Increase the future pool of qualified applicants
- Retain people of color in the workforce
- Measure and report progress

Increase Civic Engagement and Social Capital

Health improvement programs often focus narrowly on a pre-determined disease, age group, or risk factor, for a one or two year time span. Yet research supports—and communities seem to want—programs that are more comprehensive, flexible, responsive, and enduring. Models of community development, civic engagement, and participatory evaluation and research have been developed to help communities draw on the resources and strengths of community members and organizations

as the foundation for prioritizing, designing, implementing, and evaluating community health improvement initiatives.

- Identify tools, policies and approaches that more actively engage community members and community groups in health improvement; Identify and act on obstacles to their broad implementation
- Develop culturally sensitive and linguistically appropriate health education materials
- Build mutually beneficial relationships between community based organizations and larger systems and institutions
- Recognize communities and organizations with rewards and incentives for their efforts in building on the ideas in this report

Re-orient Funding

The social and economic changes described in this report will not happen by chance. Stable funding and leadership are needed within a critical mass of organizations to support innovative, long-term collaborative efforts with potential to achieve and sustain change. Change is needed with regard to the amount of funding available to community-based organizations, as well as the terms on which it is available.

New mechanisms to deliver funding must be developed that balance accountability with maximum flexibility, community autonomy and efficiency. Because MDH operates numerous grant programs, the department is in a position to take immediate steps that will begin a long-term process of reorienting funding:

- Involve a greater variety of people in evaluating grant proposals
- Notify more community-based organizations from around the state of the availability of grant proposals
- Streamline administrative requirements
- Determine barriers to funding initiatives designed to eliminate disparities
- Require that grant applicants involve community-based organizations and/or representatives from the populations to be served in the preparation of the grant proposal, and in the implementation of the grant

Strengthen Assessment, Evaluation and Research

More rigorous use of population health data, and more sophisticated measures and indicators of health are needed to provide a comprehensive picture of the factors that affect health. MDH, MHIP member organizations, Community Health Service (CHS) agencies, the MDH Minority Health Advisory Committee, and the MDH Population Health Assessment Work Group, should work with other interested organizations to:

- Act on the future data initiatives recommended within the 1997 Populations of Color Health Status Report and the 1998 Report to the Legislature of the MDH Minority Health Advisory Committee
- Build on lessons learned through minority health assessment grants awarded during 2000; Leverage additional resources to support similar assessment and planning initiatives across the state

Public, private and non-profit organizational in Minnesota need to collectively act on this deeper understanding of the social determinants of health, at the same time that we increase access to culturally competent health care, promote healthy behaviors and strengthen the existing public health infrastructure. To do otherwise is to further limit potential and jeopardize the health and quality of life of all residents of the state.

Social Conditions and Health Action Team

Business for Social Responsibility, Upper Midwest Network
Center for Population Health
Chicanos Latinos Unidos En Servicio
CommonBond Communities
Council on Asian Pacific Minnesotans
Ford & Associates Insurance
Health Care Education and Research Foundation
Housing Finance Agency
Joint Religious Legislative Coalition
Legal Services Advocacy Project
Local Public Health Association
Macalester College
Medica Health Plans
Medtronic Foundation
Minneapolis Department of Health and Family Support
MN Business Partnership
MN Department of Children, Families and Learning
MN Department of Economic Security
MN Department of Health
MN Department of Human Services
MN Planning
MN State Senate
Neighborhood Health Care Network
St. Paul-Ramsey Department of Public Health
The Urban Coalition
University of Minnesota
- **Center for Spirituality and Healing**
- **Department of Pediatrics**
- **Institute on Race and Poverty**
- **School of Public Health, Division of Health Services Research and Policy**

- Expand traditional indicators of health to reflect the social and economic determinants of health; Collect and communicate baseline data on social and economic factors that contribute to health and health disparities
- Incorporate social and economic factors into planning and assessment processes at the state and local levels
- Link health indicators with measures of socioeconomic status and race/ethnicity. For example: Incorporate measures of income, education and race/ethnicity into health information systems; Take steps to overcome limitations of information systems that currently include some health, socioeconomic and race/ethnicity data; Assure uniform and accurate collection of socioeconomic and racial/ethnic data; Expand analysis and reporting of hospital discharge data, health plan enrollment and claims encounter data, and surveys of health plan member/patient satisfaction

Communicate and Champion the Findings and Recommendations

- Distribute this report to key leaders and organizations
- Champion the findings and recommendations throughout MDH and the organizations, systems and networks represented on MHIP
- Create opportunities for dialogue and action

Focus Coordinated Commitment on Priority Strategies

Many groups and individuals in Minnesota are dedicated to improving the social and economic climate in Minnesota, though they may not have fully realized the health implications of their actions and advocacy. MHIP members should work jointly to mobilize action and leverage the strength of these organizations.

Take This Work to the Next Stage

MHIP and MDH should bring overall leadership and direction to this work during the next year by expanding and re-convening partners, promoting accountability, issuing "calls to action," producing issue briefs, and positioning Minnesota to capitalize on research and related activities occurring nationally.

A Call To Action

- About This Report
- Background
- Determinants of Health: What Makes Minnesotans Healthy?
- Health Status in Minnesota: How Healthy Are We?
- Health Disparity In Minnesota: How Do Social and Economic Factors Contribute?
- Vision

About This Report

This multidisciplinary, intersector "call to action" was produced by the Social Conditions and Health Action Team of the Minnesota Health Improvement Partnership (MHIP). The report was submitted to the Commissioner of Health for the State of Minnesota in April, 2001. (For more information on MHIP, the Action Team, or the principles and assumptions that guided this work, see Appendices A, B and C).

The purpose of this report is to deepen understanding of the impact that social and economic conditions have on health, and identify recommendations with potential to create more health-enhancing social and economic environments in Minnesota.

A deceptively simple story speaks to the complex set of social and economic conditions that shape the health of Minnesotans:[1]

"Why is Jason in the hospital?
Because he has a bad infection in his leg.
But why does he have an infection?
Because he has a cut on his leg and it got infected.
But why does he have a cut on his leg?
Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.
But why was he playing in a junk yard?
Because his neighborhood is kind of run down. A lot of kids play there and there is no one to supervise them.
But why does he live in that neighborhood?
Because his parents can't afford a nicer place to live.
But why can't his parents afford a nicer place to live?
Housing is really expensive. His Dad already works two jobs and his Mom is sick a lot.
But why ...?"

As this story and the findings contained in this report illustrate, health improvement is about even more than health care and public health programs and services. It's also about more than individual behaviors and genes.

This report concludes with several recommendations designed to create more supportive social, cultural, and economic environments, and thereby contribute to the elimination of health disparities and improved health for all Minnesota residents.

This report marks an important step toward achieving health for all in Minnesota. Yet much work remains to strengthen and nurture the necessary partnerships, disseminate and debate research findings, and build the collective will to boldly act on these recommendations.

Factors such as housing, income, education, culture, community connectedness and equal opportunity affect health in fundamental and lasting ways.

Background

All children deserve nurturing, stimulating, caring and safe environments; nutritious food; safe, stable shelter; and opportunities to participate in community-based recreation and learning activities.[2]

Good health results from good systems of public health and medical care, from sound public policies that create the social conditions that support health, and from individual decisions and behaviors that value health.

A unique contribution of this report is a focus on social and economic change as a strategy for health improvement and as a remedy to health disparity. This report examines the importance of social interactions and policies within settings (e.g., places where we live, work, learn, worship and play) and systems (e.g., education, transportation, revenue, welfare, public safety) outside of the health sector that have a profound impact on health. This emphasis on social and economic conditions is not intended to minimize the importance of health care or personal health decisions. Health care, personal behavior, genetics and the environment are all interrelated considerations in a comprehensive health system. This report will show some of the ways in which health care and individual behavior are influenced by broader social and economic conditions.

Awareness and concern about the link between health status and the social and economic environment has been increasing in the health sector for the past several years.[3] In 1998, the MHIP formalized commitment to the issue by creating a developmental public health improvement goal to "foster understanding and promotion of the social conditions that affect health."[4] This report marks a significant step toward achieving the objectives of this goal, and reinforces work already underway to eliminate health disparities.[5]

Yet in a historical context, the social and economic environments are not a new concern for public health. To the contrary, in some respects these developments signal a return to the "roots" of the field. Nearly a century ago, one of the first U.S. Surgeon Generals concluded, "The fact is, poverty is the greatest problem in public health. A living wage is essential to a healthful standard of living."[6]

Health is a product of individual factors (genes, health practices and coping skills) and collective conditions (the environment, the health care system).[7, 8] By some estimates, individual behaviors and environmental factors are responsible for about 70 percent of all premature deaths in the United States.[8] This research reminds us to look at the big picture, to examine factors both inside and outside the health care system that affect our health.

A comprehensive health improvement agenda will address each of these determinants and will recognize the relationships between them. For example, economic forces largely determine access to health care, and important social forces determine the cultural responsiveness and equality of that care. Social norms, the media, role models and mentors, tax policies and countless other aspects of the social environment described in this report shape attitudes, beliefs and behaviors that can protect or risk health. For example, communities across the country have come together in dozens of ways to create environments that promote physical activity and healthy foods (e.g., expanding the amount and availability of green space [parks and trails], making neighborhoods more walkable and bicycle friendly [improved safety, new or better lit sidewalks], and supporting farmer's markets).

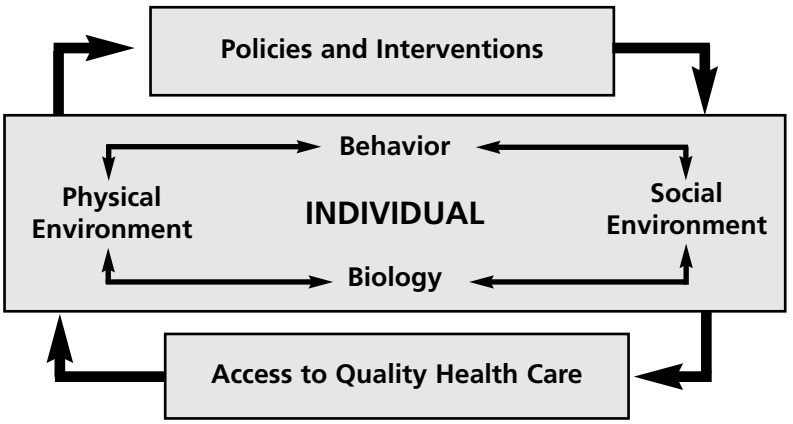
DETERMINANTS OF HEALTH

Health is a product of inter-related individual factors and collective conditions such as:

For example: **To achieve optimal mental health in Minnesota, actions are needed to:[9]**

DEFINITION	APPLICATION TO MENTAL HEALTH
Social and Economic Environment	
Interactions with families, friends, co-workers and others that shape everyday experiences in neighborhoods, communities, and institutions (such as schools, the workplace, places of worship, government agencies, etc.). This means that individual and community socioeconomic factors; social norms, social support and community connectedness; employment and working conditions; living conditions; and culture, religion, and ethnicity shape health. The social and economic environment of a community is created by the individual and combined actions of its members and is unique because of social norms and cultural customs.	Strengthen family, school and community relationships: reduce stigma associated with mental disorders; eliminate poverty; promote adequate, stable, safe and satisfying employment; increase school attendance and success; promote healthy infant, child and youth development; promote norms discouraging underage access to alcohol, tobacco and other drugs; reduce interpersonal violence.
DEFINITION	**APPLICATION TO MENTAL HEALTH**
Physical Environment	
The safety, quality and sustainability of the environ ment, which provides basic necessities such as food, water, air, and sunshine; materials for shelter, clothing and industry; and opportunities for recreation.	Provide safe housing; create and maintain safe environments that support physical exercise and facilitate social mobility; assure the sustainability of natural environment for beauty and recreation.
DEFINITION	**APPLICATION TO MENTAL HEALTH**
Health Practices and Coping Skills	
Individual health-promoting and health-compromis ing attitudes, beliefs and behaviors, and the ways in which people cope with stress.	Educate the public regarding mental health promo tion behaviors as an integral component of overall health, including informal supports and referrals for help; teach and support skills to make positive changes in one's life, cope with adversity, resolve conflict, and build and maintain social connections.
DEFINITION	**APPLICATION TO MENTAL HEALTH**
Genes/Biology	
Genetic makeup, family history, and physical and mental health problems acquired during life (aging, diet, physical activity, smoking and drug use, stress, injury, and infections affect one's biology over the lifecycle).	Provide mental health information, prevention, screening, referral, assessment and treatment to people with family history of mental and substance abuse disorders; promote research regarding mental health and genetics and associated risks and protective factors.
DEFINITION	**APPLICATION TO MENTAL HEALTH**
Health Care Services	
Access to and quality of health services to promote health and prevent and treat disease and other threats to health.	Promote mental health as an integral component of overall health; integrate mental health promotion and mental health care in primary care; substance abuse and other treatment settings; expand mental health screening, assessment, treatment and support for people with mental health concerns, reduce stigma associated with mental disorders; assess and promote quality of life for people with mental disorders.

Figure 1
Determinants of Health: What Makes Minnesotans Healthy?



Source: *Healthy People 2010: Understanding and Improving Health.* (2000)
http://www.health.gov/healthypeople

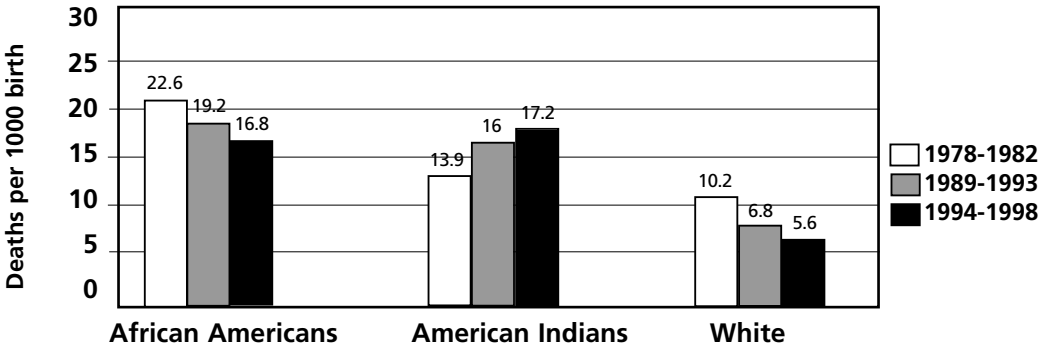
Health Status in Minnesota: How Healthy Are We?

Minnesota frequently ranks as one of the healthiest states in the country. We typically fare well on health indicators ranging from infant mortality, life expectancy and health insurance coverage, to teen pregnancy, overweight and violence. On the surface, this is great news.

If all racial groups in Minnesota shared the infant mortality rate of African Americans in Minnesota, an additional 3,356 babies – mostly white children – would have died during the years 1994-1998.

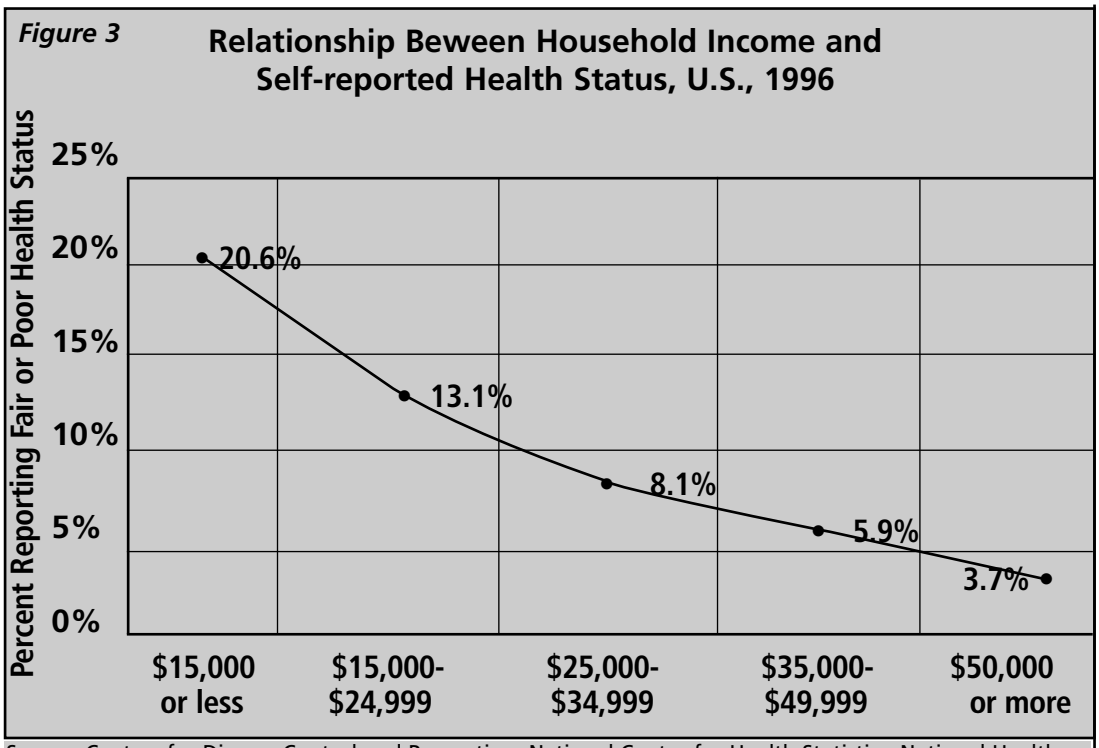
However, as presented in the *Populations of Color Health Status Report,* broad averages mask significant differences in health status. For example, populations of color are at greater risk of several leading causes of death, including cancer, heart disease, stroke, diabetes, homicide, suicide, unintentional injury and HIV/AIDS. The overall mortality rate for American Indians, African Americans and Latinos is consistently high-up to 3.5 times higher than for white Minnesotans. The infant mortality rate among African Americans and American Indians is more than twice as high as any other major racial/ethnic group in the state, and the rate among American Indians has been steadily *increasing.* (*See Figure 2*).

Figure 2
Infant Mortality Rate By Racial Group, Minnesota 1978-1998



Source: Minnesota Department of Health, Center for Health Statistics

Figure 3



Source: Centers for Disease Control and Prevention, National Center for Health Statistics. National Health Interview Survey. (Reproduced from *Healthy People 2010: Understanding and Improving Health*. (2000) http://www.health.gov/healthypeople.)

Evidence from many studies indicates that the association between income and health generally takes the form of a gradient. This means that while people of lowest income have the worst health outcomes, even people with mid-level incomes have worse health than people making higher incomes. This gradient has been consistently documented for many health indicators and for other measures of socioeconomic status (such as education). For a more complete discussion of socioeconomic status and health, as well as measurement issues related to socioeconomic status, see the *Socioeconomic status and health chartbook. Health, United States, 1998* at http://www.cdc.gov/nchs.

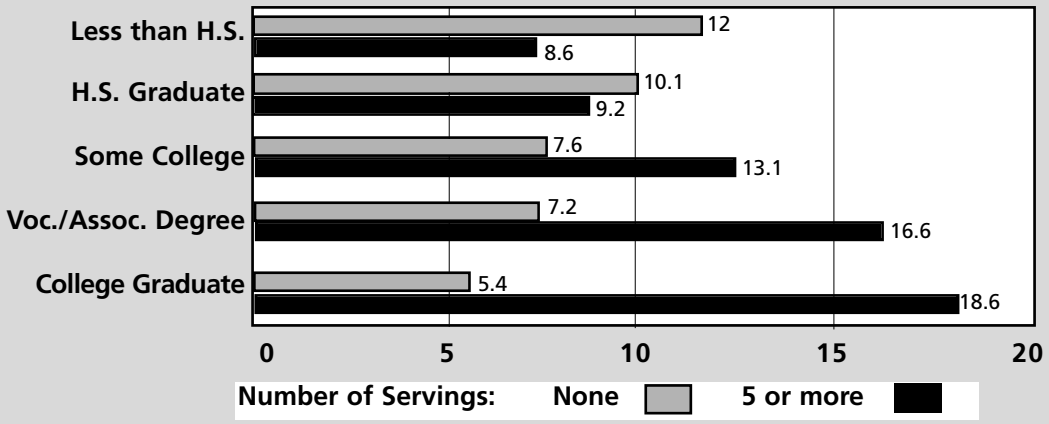
People of color in Minnesota do not receive the same access to health care. They are less likely to have health insurance of any kind, less likely to have protective childhood vaccinations and less likely to receive early prenatal care.[10] Barriers to these services include cultural and spiritual differences, inadequate finances, lack of transportation, and mistrust.

Scores of studies also show a strong relationship between socioeconomic status and health.[11] Although more population-level Minnesota-specific data need to be assembled, collected and analyzed, state and regional data have been used to explore the relationships between health status and health risk behaviors and income,[12] as well as education and occupation.[13]

For example, the Bridge to Health Survey conducted in 16 counties in northeastern Minnesota and northwestern Wisconsin found a pattern that generally links poverty and low income (i.e. living at or below 200 percent of the poverty line) with a higher prevalence of chronic physical and mental health problems and health-compromising behavior, and a lower prevalence of protective health behavior, preventive screenings and health insurance coverage.

Figure 4

Daily Servings of Fruits and Vegetables, by Education, NE Minnesota and NW Wisconsin, 2000.



Source: Block, D.E., Kinney, A.M., Sundberg, L., Peterson, J.M., G.L. & Bridge to Health Collaboratives (2000). Bridge to Health 2000: Northeastern Minnesota and Northwestern Wisconsin regional health status survey.

Eliminating Health Disparities: More than Just Personal Behavior

"We need to address the question of why these behaviors are disproportionately concentrated among persons with fewer socioeconomic resources. Differences in the life circumstances of high- and low- SES persons in the United States are substantial. Higher socioeconomic position may directly influence health through income-and education-related differences including having knowledge and time to pursue healthy behaviors, having sufficient income to assure access to comfortable housing, healthy food, and appropriate health care, access to safe and affordable locations to exercise and relax, and living and working in a safe, healthy environment. In addition, a more direct connection may exist in that persons whose attention and energy are focused on attaining economic security, or dealing with the lack of it, may have few resources, financial and emotional, for pursuing healthy lifestyles and obtaining preventive health care. It has also been suggested that simply being at a lower position on the economic distribution exacts an emotional or psychological cost that translates into poorer health practices, or simply poorer health. This latter explanation may also apply to the effects of racial and ethnic discrimination, proposed by some as a contributor to the poorer health outcomes experienced by many minorities even after adjusting for differences in their socioeconomic profile."[11]

More data and careful analysis are needed to understand differences in health status among different groups of Minnesotans (e.g., differences according to income, education and race/ethnicity, as well as area of residence, gender, disability, and sexual orientation). This important work is challenging since many of these characteristics are inter-related. For instance, people living in poverty are more likely to be a member of a racial/ethnic minority group, a child or an older person with a high school education or less.

Foreign-born populations also experience inequalities in health status (e.g., hepatitis, tuberculosis, mental health) and often face unique barriers to health services (e.g., language, belief systems, religion). Many individuals in refugee populations experienced personal trauma before or during their flight from war torn countries of origin. The stress of making a life in a new country can exacerbate untreated trauma. Trauma and stress-related problems such as nightmares, flashbacks, depression, or post-traumatic stress disorder, can go unnoticed in traditional health assessments.

Health Disparity in Minnesota: How Do Social and Economic Factors Contribute?

Numerous studies have directed specific attention toward racial/ethnic and socio-economic health disparities, and suggest that several underlying, interrelated factors in the social and economic environment explain much of the difference in health. These factors include income, education, race, stress, opportunity, and discrimination.[14,15]

- Income is a major determinant of health status. People with higher income generally have better health and longer lives than people with lower income. This is true for people of all racial and ethnic backgrounds, and at all income levels. (In other words, high income Minnesotans are generally healthier than middle-income Minnesotans, who are in turn healthier than low-income Minnesotans.)[16]
- People of color do not experience worse health simply because they are more likely to have a lower income (although this is an important factor). *At every level of income,* the health of people of color is consistently worse than that of their white peers.[14]
- People of color and lower income do not experience worse health simply because of high risk personal behavior (although this is an important factor). In one recent national study, health behaviors explained less than 20 percent of the difference in death rates across income groups.[17]
- National data on stereotypes reveal that whites view blacks, Hispanics and Asians more negatively than themselves. To many, this high level of acceptance of negative stereotypes signals widespread societal discrimination.[14]
- Health disparities stem from social inequalities in access to resources, opportunities, and power. Individuals and groups who are exploited, dominated, or excluded have less resources and less control over them.[16,18] Health disparities should be considered within the context of the sociopolitical and economic history of American society, which includes slavery, forced migration and segregation.[19,20]
- Racism, discrimination and chronic race-related stress play a crucial role in explaining racial disparities in health status. Racism has been defined as "an ideology of inferiority that is used to justify the unequal treatment (discrimination) of members of groups defined as inferior, by both individuals and social institutions." Racism can adversely affect health through factors such as restricted socioeconomic opportunities and mobility, limited access to and bias in medical care, and residential segregation (which can limit access to social goods and services).[21]

It is essential to address these and other aspects of the social and economic environment in order to eliminate disparities. Efforts to improve access to culturally competent health care and promote healthy choices are also essential to achieve this goal.

Broader efforts focused at social and economic opportunity promise not only to alleviate health disparities, but also to improve the health and quality of life of the whole community.

These findings challenge us to change the way we implement health improvement efforts, examine the health impact of social and economic forces at play outside the traditional health sector, and renew attention to the roles we play as individuals and organizations in creating and perpetuating these disparities.

In addition to emerging research findings, common sense tells us that domination, coercion, hostility, resentment, and submission limit health and quality of life; whereas support, friendship, cooperation, sociability and equal opportunity promote the health and quality of life of individuals and communities alike.

"What is it that makes us sick? People in our community are saying that what makes us sick is the stress we are under from racism."

As stated during a community meeting October 2000. (See Appendix D)

Racism Threatens Health.

Racism can occur at multiple levels, and each level should be confronted in a comprehensive approach to eliminate health disparities.[22]

Institutionalized racism is defined as differential access to the goods, services, and opportunities of society by race. Institutionalized racism is normative, sometimes legalized, and is often evident as inherited disadvantage and inaction in the face of need. This form of racism manifests itself both in material conditions and in access to power.

Personally mediated racism is defined as prejudice and discrimination, where prejudice means differential ***assumptions*** about the abilities, motives, and intentions of others according to their race, and discrimination means differential ***actions*** toward others according to their race. This form of racism can be intentional as well as unintentional, and it includes acts of commission as well as acts of omission. Examples include lack of respect, suspicion, devaluation, scapegoating and dehumanization.

Internalized racism is defined as acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth. Evidence of internalized racism can include self-devaluation, resignation, helplessness and hopelessness.

Paraphased from: Jones, CP. (2000). Levels of racism: A theoretic framework and a gardener's tale. *American Journal of Public Health,* 90, 1212-1215.

VISION:
All People in Minnesota Have an Equal Opportunity to Enjoy Good Health

These health disparities affect all of us. Minnesota should commit to leading the nation in the health of *all* of its citizens, not only because this is the right thing to do, but because this will contribute to the overall health and prosperity of Minnesota.

Health is a resource for everyday life — the ability to realize hopes, satisfy needs, change or cope with life experiences, and participate fully in society. This dynamic, holistic view of health encompasses physical, mental, social and spiritual dimensions; and emphasizes that health is not just the absence of disease.

Personal well-being is shaped by personal behaviors, yet these actions are influenced to a large degree by underlying forces in the social and economic environment. This means that individual and community health are shaped by both individual and collective actions. Viewed from this perspective, health improvement is a shared responsibility of all individuals, organizations and institutions taking part in the life of the community. Health improvement must be a mutual effort that harnesses the resources of the public, private and nonprofit sectors.

To realize this vision, Minnesotans must stand together to assure that everyone has the resources and opportunities necessary to be healthy (such as a good education, adequate income for housing, food and other basic needs, a sense of community connectedness and personal safety), and to be full participants in creating healthy communities. Community health is essential for a productive and prosperous society.

A healthy community is continually creating and improving the physical and social environments and expanding the community resources which enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.[23]

A critical review of current approaches to health improvement is needed to assure that all Minnesotans reap the rewards of improved health.

Summary of Findings

- **Individual and Community Socioeconomic Factors**
- **Social Support and Community Cohesion**
- **Living Conditions**
- **Employment and Working Conditions**
- **Culture, Religion and Ethnicity**

SUMMARY OF FINDINGS

Research findings in fields ranging from medicine and epidemiology to economics, political science, history and sociology, have transformed our understanding of the connection between health status and social and economic factors. Although these factors have not been a major focus of the health sector in the past, our vision for a future health system and collaborative health improvement initiatives should reflect this expanded view. This section briefly summarizes research that establishes the connection between social and economic factors and the health of populations.

During October 2000, the Urban Coalition and the Minnesota Department of Health (MDH) jointly convened three community dialogues to discuss the meaning of a "healthy community" and to explore social and economic forces that shape health. More than 50 people—representing health, housing, education, philanthropic, and advocacy sectors—attended one or more meetings as a representative of a community-based organization. Several quotes from these dialogues are highlighted throughout this report. A summary of the community meetings, entitled *Voices from the Front Lines: Social and Economic Forces are Key to Community Health,* is included in Appendix D.

Individual and Community Socioeconomic Factors

In many respects, Minnesota enjoys an enviable economy. During the 1990s, the poverty rate fell, median family income grew, and the average wage of low-wage and median-wage workers grew as well. Minnesota consistently fares better than the national average in important areas like unemployment, median income, income inequality, and poverty.[24]

"I have one lady who is working 70 hours a week and she makes $21,000… Is she ever going to move out of poverty? The answer is no. Not at that level. Can she even look for another job when she is doing these two jobs? No. Can she spend any time with her kids? No."

Despite these hopeful signs, other indicators raise concern:

- Minnesota's overall poverty rate has declined to approximately 9.5 percent, but more children live in poverty (14 percent) than any other single age group.[24]

- Many jobs in Minnesota (19 percent) continue to pay poverty-level wages ($8.19 per hour, approximately $17,000 per year). This is the wage needed to lift a family of four above the poverty line with full-time, full-year employment.[24]

- People making the median wage in 13 of the 25 fastest growing occupations in Minnesota cannot afford a typical one-bedroom apartment in the Twin Cities. [25]

- The federal poverty line may no longer accurately reflect an adequate household income. Developed over 30 years ago, the federal poverty line assumes a family of three can survive on an annual income of roughly $13,000. As an alternative to using this poverty line, the JOBS NOW Coalition has prepared a "minimum family budget," based on the costs of household necessities and work-related expenses to achieve a "no frills" standard of living. According to this method, a Minnesota household would need an income of $28,733 – 224 percent above the poverty

line – to cover a minimum family budget for a single-parent family of three with one full-time year-round worker.[26]

- Socioeconomic and racial segregation has increased in most urban centers around the country, including the Twin Cities metropolitan area. According to the 1990 census, twenty-eight percent of the metropolitan population lives in the central cities, compared to sixty percent of the metropolitan poor and sixty-five percent of the metropolitan people of color.[34] Concentration of poverty, defined as an area in which a high percentage of residents (e.g., 30-40 percent) live below the federally defined poverty line, signals more than the aggregation of people living in poverty. When concentration occurs, the well-being of the entire neighborhood is affected by the abandonment of those individuals and investors with the capacity to leave. Concentrated poverty limits access to those institutions, markets and networks (e.g., good schools, safe neighborhoods, high-paying jobs, affordable housing, role models) by which the majority are able to secure an adequate standard of living and pursue social and economic advancement.[27]

- The problem of socioeconomic and racial segregation is not limited to the Twin Cities metropolitan area. As noted in a minority health assessment report recently completed by Olmsted County Community Health Services: "Minority populations in Olmsted County have been demonstrably segregated into certain areas of the county. The dissimilarity index measures segregation as the percent of a specific population that would need to move in order to be evenly spread throughout a given area. For example, only three percent of Rochester males (a population not subject to residential segregation) in 1990 would have needed to move in order to be evenly dispersed. In contrast 24 percent of American Indians, Asians, Blacks and Hispanics would have needed to move in 1990 for their populations to be evenly dispersed. More recent analysis shows that in 1998, 32 percent of Asian, Hispanic and Black students in Rochester public schools would need to move in order to be evenly scattered throughout the city."[28]

"The usefulness of wealth lies in the things that it allows us to do—the substantive freedoms it helps us to achieve."[40]

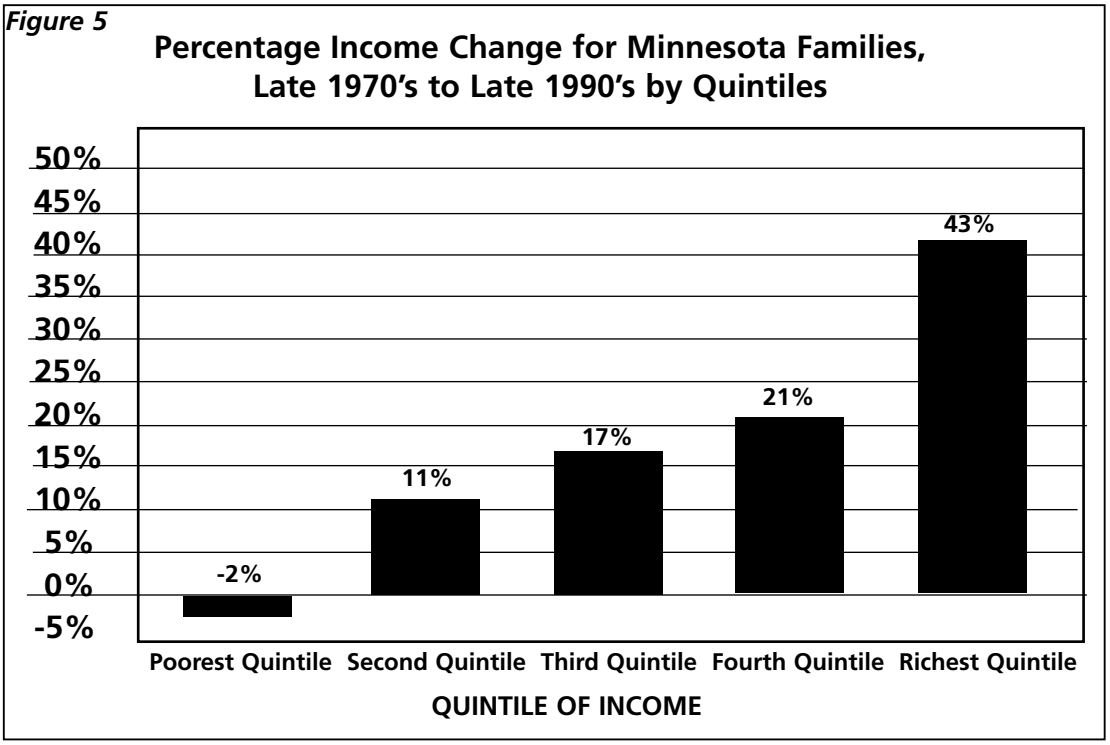
Amartya Sen, Nobel Laureate in Economics.[31]

- From the late 1970s to the late 1990s, the average income of the top fifth Minnesota families increased by 43 percent ($43,000); the average income of the bottom fifth of Minnesota families *decreased* by 2 percent ($300). The income of the wealthiest 20 percent of Minnesota families is currently nine times that of the poorest 20 percent of families. See Figure 5

- Income inequality in Minnesota continued to grow during the 1990s (albeit at a slower pace than during the 1980s). An increase in income inequality is not inevitable. During this same period, income inequality decreased in several states, including Colorado, Indiana, South Carolina, Missouri. In these states the income of the poorest 20 percent of families increased at a faster rate than the richest 20 percent of families.[29]

- Wealth inequality is also notable. The U.S. Bureau of the Census reports that in 1995 the net worth for households with a white householder was $49,030; for households with an African American householder, it was $7,703; and for those with a Hispanic householder, it was $7,255.[30]

Figure 5



Source: Economic Policy Institute, Center on Budget and Policy Priorities. http://www.epinet.org

THESE ECONOMIC CONDITIONS HAVE IMPLICATIONS FOR THE HEALTH OF MINNESOTANS.

Population groups that experience the worst health status are also those that have the lowest income and least education. Higher socioeconomic position (a reflection of income, education, occupation and prestige) is directly related to lower levels of disease and death, meaning that people with a high income are generally healthier than people with middle-income, who are in turn healthier than those with low income. This is true for almost all causes of death, and is not fully explained by differences in health behavior or access to medical care.[15, 32]

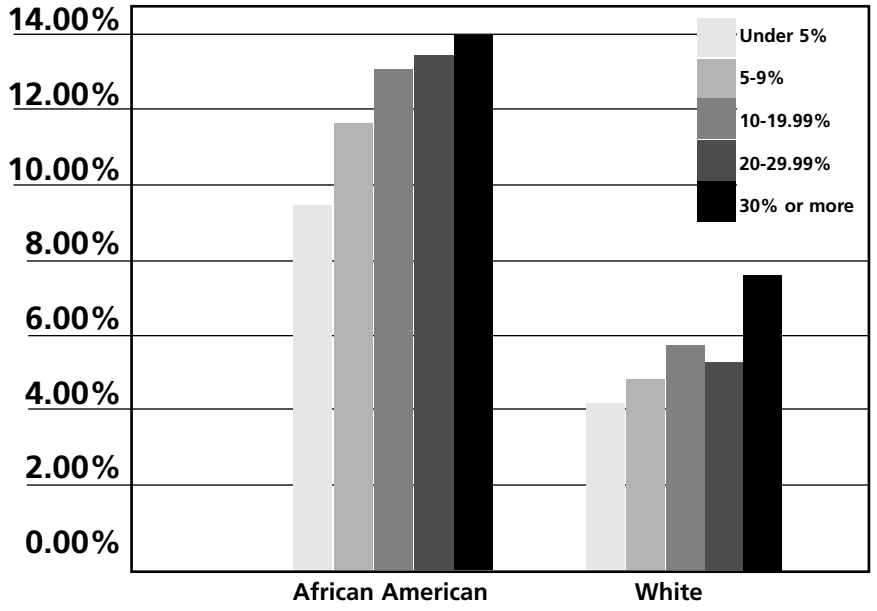
Socioeconomic status can also be measured at the community level, using data from the census to characterize neighborhoods on the basis of the average level of education and income, or the percentage unemployed. These community-level socioeconomic factors affect health, even when controlling for individual characteristics.[34] This means that when comparing the health status of people making the same income, those living in low income neighborhoods will experience worse health than those living in higher income neighborhoods. See Figure 6.

Disease and death rates are higher in communities (metropolitan areas, states and countries) that have a greater gap in income and wealth between rich and poor. Among developed countries, it is not the richest societies that have the best health, but those with the smallest income differences. The health effect of income inequality appears greater among those with low income, but is also significant for other income groups.[35,36] In a recent landmark study, income inequality and poverty together accounted for approximately one-quarter of the state variations in the death rate, and just over half of the variation in homicide rates.[36,37] In other pioneering studies, researchers have identified strong relationships between mortality and socioeconomic[38] and racial[39] segregation in metropolitan areas of the U.S.

Education and health are closely connected. People with higher levels of educational achievement generally have healthier lifestyles, more opportunities and higher incomes. As a result,* Healthy People 2010 *includes a health improvement goal to increase the high school graduation rate.[33]

Figure 6

Percentage of Low Birthweight Babies by Racial Group and Poverty Status in Metro Census Tracts, 1989-1993



Source: U.S. Bureau of the Census (1990) and Minnesota Department of Health

This analysis uses census and birth certificate data to examine the relationship between a community characteristic (the percentage of people in a census tract who live below the poverty line) and a health outcome (the percentage of babies born with low birthweight). For both white and African Americans, the percentage of babies born with low birthweight is highest in census tracts with a high percentage of residents living below poverty. The percentage of babies born with low birthweight gradually declines as the percentage of people living in poverty declines.

The percentage of African American babies born with low birthweight is substantially higher than the percentage of white babies, *regardless of census tract poverty levels.* Racial/ethnic disparities in health status are due to more than differences in individual or community socioeconomic status.

Public health agencies in the Twin Cities metro area and Olmsted county have begun to consider the extent and health implications of socio-economic and racial segregation.

The potential for positive health outcomes can therefore provide additional motivation for policymakers to help people climb out of poverty and meet their basic needs (i.e., decrease material deprivation); reduce economic inequality which appears to undermine community cohesiveness and contributes to apathy, hostility, and violence (i.e., decrease relative deprivation), and strengthen school, family, and community relationships as a way to link people to support, services and opportunities.[40]

Welfare Reform in Minnesota:
Indications of Success and Continuing Challenges:

The Manpower Demonstration Research Corporation (MDRC) evaluated a pilot project of the Minnesota Family Investment Program (MFIP) implemented in seven Minnesota counties from 1994 to 1997. This pilot–which sought to reduce the number of people on welfare and help families move out of poverty and become self-sufficient-provided working families with Medicaid, childcare assistance, and cash benefits to supplement their earnings and bring them to 140 percent of the federal poverty level. The evaluation suggests that this package of incentives increased employment, continuous health care coverage, use of formal childcare, and marriage; while at the same time decreasing domestic violence and below-average performance in school.[43] MFIP was expanded statewide in January, 1998, although benefit levels were reduced.

A 2000 report of the Department of Economic Security concludes: "The analysis confirms that many Minnesota welfare recipients are entering employment situations but that progress and self-sufficiency require much more than simply a job. Most continuing recipients are single mothers with family responsibilities, low levels of job readiness, and other personal difficulties standing in the way of employment success. Many are now building a work history in jobs that require minimal levels of preparation, skills and responsibility. Time will tell how quickly they can advance to "better jobs," that is, jobs with career ladders, better pay leading to economic self-sufficiency, job security, more flexible work schedules, better working conditions, and so on."[43]

Social Support and Community Cohesion

Dozens of national and international studies have documented the adverse health effects of isolation, as well as the health benefits of social support and community cohesion (a "sense of community").[45] People are healthiest when they feel safe, supported, and connected to others in their families, neighborhoods, workplaces and communities. More cohesive communities (e.g., those characterized by greater civic participation, volunteerism, trust, respect, and concern for the well being of others) have lower rates of violence and death.[46]

Social support and community cohesion are closely related to individual and community economic factors. Cohesive communities tend to be relatively more egalitarian (i.e. have a smaller gap in income and wealth between the richest and poorest members).[47] On a more individual level, an important factor contributing to the successful transition from welfare to work, is having a role model–a personal relationship with someone succeeding in the workforce.[48]

In a rare social experiment in Gary, Indiana, from 1971 to 1974, a negative income tax increased incomes to the poverty level for half of 1,799 eligible families. Results indicated an increase in birth weight of 0.3 to 1.2 pounds in the income supplemented group, thought primarily to be caused by increased maternal nutrition.[41]

Public health research suggests that disease occurs more frequently among those who have fewer meaningful social relationships, have little social status, and disconnected from their cultural heritage.[44]

Just as community cohesion and social support promote health, social exclusion threatens it. There are many aspects of social exclusion, including legal or regulatory exclusion, failure to provide social goods or services (e.g., facilities for the disabled, language interpreters), and limited access to expected opportunities (economic, educational, recreational, etc.).[49] Discrimination is arguably a form of social exclusion. Discrimination involves not only socially derived beliefs that each group holds about the other, but also patterns of dominance and oppression which can be viewed as expressions of a struggle for power and privilege."[50]

Entire groups-not just individuals-experience the stress, insecurity, hopelessness and disempowerment of social exclusion. In the case of geographic segregation for example, residents of areas that are comprised predominantly of people with low income or people of color are often isolated from opportunities that people living in other areas may take for granted (e.g., inviting libraries, good schools, attractive parks, safe neighborhoods, stable and affordable housing, etc.). This is especially relevant in Minnesota, where the Twin Cities region is among the most racially and socioeconomically segregated metropolitan areas in the U.S.[51]

Having a safe and affordable place to live is a basic prerequisite to health and quality of life. The issue of affordable housing reaches across the whole community, touching people across the lifespan–from children in homeless families, to working parents struggling to afford rent in the vicinity of their jobs, to couples dreaming of owning a home, to retired seniors trying to live independently on a fixed income. Communities that offer a variety of housing options for a range of income levels encourage the academic performance of children, economic prosperity and growth, community stability, and family security.

Many scholars and activists are calling for action to strengthen connections between children, families and communities. Community health and quality of life can be improved by adding breadth and depth to social networks, building more trusting relationships with institutions, and creating more opportunities and incentives for civic participation, mentoring, volunteering and service learning.[48] These connections and networks are essential ingredients for building "civil society" and "social capital."[52]

Minnesota is regarded as a national leader in public/private and interagency collaboration. Minnesotans are also nationally recognized for a capacity to care for one another.[53] This history is a prime asset as the state strives to further strengthen social support and community cohesiveness.

Living Conditions

To assure health and quality of life, people need convenient access to affordable options for housing, nutritious foods, and transportation. Safe, affordable housing may be the centerpiece of supportive living conditions, and is highlighted as an example here. A complete discussion of Minnesota's housing situation is far beyond the scope of this report, but the adjacent sidebar article highlights recent data on homelessness, transitional housing, and affordable housing in Minnesota. A more complete discussion would also explore housing issues such as living independently and living on a fixed income.

Healthy housing is affordable (i.e., housing costs no more than 30 percent of household income), safe (e.g., free from lead paint and rodents), aesthetically pleasing (e.g., landscaped with flowers and trees; free from litter, debris, and abandoned buildings), surrounded by neighborhood assets and services (e.g., libraries, parks, sidewalks, businesses, cultural organizations, grocers, transportation systems), located in cohesive communities (e.g., with mentoring programs, senior centers, after-school programs, public meeting places, etc.), and conducive to independent living.

Many Minnesotans working in our communities pay more for their housing than they can afford. For many, this may mean fewer resources are available for other essentials such as food, clothing, health care and medicine; frequent moves; and/or resorting to substandard and/or overcrowded conditions. A report co-authored by Boston Medical Center and Housing America[54] links the lack of affordable housing and substandard living conditions to asthma (due to infestation by mice, cockroaches and other pests), malnutrition, anemia and stunted growth (due to an inability to afford both rent and food), lead poisoning, and house fires (e.g., due to faulty electrical heating and equipment).

Housing, education and health are inter-related. Based on evidence that student mobility affects school attendance and performance, the Kids Mobility Project reviewed school records and conducted family interviews to identify the leading risk factors for frequent moves. Two major reasons emerged: insufficient safe, affordable housing, and family instability (e.g., job loss, divorce, abuse). The resulting report emphasizes the strained support systems and physical and emotional stress that result from family and housing instability, and calls for more concerted efforts to build and maintain stability by (a) connecting people to resources in their neighborhoods; and (b) increasing the supply of safe, quality, affordable housing.[55] Successful efforts to improve school attendance and school performance ultimately promote health, since health status improves with increasing levels of educational attainment.

One strategy to address the shortage of affordable housing and reduce the growth in socioeconomic segregation, is through tenant-based rental voucher programs. Vouchers (such as federal section 8 vouchers) are rent subsidies that enable low-income families to obtain housing in the private market by typically paying 30 percent of their income for rent. The government pays the landlord the difference between the tenant's contribution and the fair-market rent for the apartment.

The Task Force on Community Preventive Health Services developed the analytic framework included in Appendix E to guide a systematic review of the research literature for evidence of effectiveness of such voucher programs in improving health outcomes.[56] This framework suggests tenant-based rental voucher programs could improve health by reducing household income spent on housing to no greater than 30 percent (thereby freeing resources for other necessities and reducing the likelihood of having to move), and providing families choice in relocating to neighborhoods with a higher socioeconomic status (thereby increasing the likelihood of employment opportunities, quality public services, neighborhood safety and order, and heterogeneous social networks). Ultimately, these opportunities and services contribute to community cohesion and support health (e.g., less violence, less stress, etc.).

More frameworks are needed to analyze housing and other social and economic factors that affect health, and to anticipate the potential impact of policies and programs to improve health.

Housing Issues in Minnesota: A Beginner's Look

On any given night in Minnesota, there are 8,600 homeless people – more than double the state's homeless population in 1991. Homeless children today outnumber Minnesota's entire homeless population in 1991.[57]

Historically, transitional housing services have provided a bridge for families between permanent housing and emergency and battered women's shelters. These services are no longer sufficient. Transitional housing services in Minnesota more than quadrupled during the 1990s, but the number of homeless turned away grew faster than this growth in shelter capacity.[57]

A more comprehensive system of flexible and supportive services is needed to provide shelter, connect homeless families to community services, and more fully assist families in making the transition to independent living.[58]

A lack of affordable housing is a significant barrier to successfully moving from transitional housing programs. But the lack of affordable housing affects not only families in transition, but also tens of thousands of families across the state.

Despite the booming economy and low unemployment rate, housing costs in Minnesota are rising faster than wages, leading to a widely recognized crisis. The Office of the Legislative Auditor estimates that approximately 18 percent of all Minnesota households had lower incomes and spent at least 30 percent of their income on housing in 1989. Using more recent housing and income data, the Metropolitan Council estimates that approximately 23 percent of all households in the 13-county Twin Cities metropolitan area had both lower incomes and spent at least 30 percent of their income on housing in 1998.[59]

Housing is generally considered affordable if it costs less than 30 percent of a household's income. By this measure, the Office of the Legislative Auditor estimates that in 2000, a single wage earner in the metro area had to work full time and make at least $12.77 per hour to afford an average one-bedroom apartment ($664), or $15.67 per hour to afford an average two-bedroom apartment ($815). By comparison, approximately half of all jobs in Minnesota paid less than $13.50 per hour in 1999, including 32 percent that paid less than $10.00 per hour. Moreover, people making the median wage in 13 of the 25 fastest growing occupations in Minnesota (e.g., retail salespersons, cashiers, home health aides, receptionists, and food service workers), would have to spend more than 30 percent of their income on rent to live in an average one bedroom apartment in the Twin Cities.[59]

The limited affordable housing in the Twin Cities metropolitan area is often not located where it is most needed-in suburban areas with the greatest job growth. This forces longer commutes and more traffic. These trends are common nationwide, but are exacerbated in the Twin Cities where the metropolitan area is among the most racially and economically segregated regions in the U.S.,[51] the rental vacancy rate is among the lowest in the nation (less than two percent), and the transportation costs are among the highest.[60]

Whereas the effects of the affordable housing shortage in the metro area may get more attention because of its population, communities all across Minnesota need more housing. More than 300,000 households in greater Minnesota are paying more for housing costs than is considered affordable. Rental vacancy rates are less than three percent statewide. The number of affordable housing units being built isn't keeping up with current demand or projected needs that are based on anticipated job growth, economic expansion and household growth projections.[61]

Some communities and employers are solving this problem together. For example, in Hoffman, a town of 639 in Grant County, the Economic Development Authority (EDA) converted the city's old school building into affordable housing with the help of several local employers. The EDA launched a campaign that recruited more than 11 local businesses to contribute a total of $32,000 in grant funds for the 8-unit project. Greater Minnesota Housing Fund is matching the employer commitment with a $30,000, 0 percent interest deferred loan. Under the leadership of the local EDA, these employers took a proactive approach to providing affordable housing for Hoffman.[61]

Affordability contributes to stability. Academic achievement is higher in children who live in housing affordable to their families. Stability in housing, and home ownership in particular, can create an anchor to the community that enables stronger social attachments and greater civic involvement. Owning a home is the "American dream" and provides the primary way American families generate wealth.

There is no single answer. The Minnesota Housing Fund calls for a comprehensive continuum of supportive housing services for those in transition from emergency shelters to stable long-term living situations:[62]

- Stabilize the existing supply of transitional housing and to add new units,
- Increase rent subsidies to private landlords that provide transitional housing, and
- Provide on-site services to reduce barriers to employment for supportive housing residents (e.g., child care, transportation and employment support).

With regard to a more general need for affordable housing, many recommend a comprehensive approach that includes actions such as:[51,59,63]

- Break down exclusionary zoning laws (e.g., minimum lot sizes, maximum densities; floor area minimum requirements; two car garage requirements; and bans on manufactured housing),
- Change government policies and practices to reduce the cost of building housing and investing in rental property,
- Preserve (and increase) federally subsidized housing,
- Leverage private dollars for housing construction, and
- Provide funding to rehabilitate distressed properties.

Work can provide not only income, but also benefits, a sense of identity and purpose, and opportunities for social support and personal growth. Employment and working conditions have implications for health even beyond occupational safety, employee assistance programs, health care coverage, and worksite wellness activities.

Employment and Working Conditions

The majority of Minnesotans spend several hours a day in volunteer or paid work. In fact, labor force participation in Minnesota has never been higher. [64]

Employment and working conditions intersect with health in multiple ways:[65]

Access to employment
Access to employment is a critical issue given Minnesota's tight labor market, and covers issues such as education and training, affordable housing in the vicinity of job opportunities, employment discrimination, and accessibility of the workplace to people with disabilities. Recent reports have addressed some of these access issues in great detail.[63,64,66]

Employment conditions
Employment conditions pertain to health in a variety of ways including work and family policies, company norms, health and safety, wages, the physical work environment, workload, time demands, level of stability, and work schedules. Some Minnesota businesses offer employee benefits to create more favorable working conditions. Examples include: telecommuting (5 percent), job sharing (7 percent), and flexible schedules (30 percent). Law requires up to twelve weeks of unpaid time off for family-related reasons (e.g., maternity leave) at Minnesota firms with over 20 employees. A limited number provide paid and/or unpaid time off beyond these requirements.[67]

Macro-economic influences
Broad macro-economic influences include income distribution, rates of unemployment and underemployment, and other labor market trends (e.g., high demand for skilled workforce, demographic changes). Recent years have witnessed far-reaching change in the nature of work (e.g., greater emphasis on the service sector, information processing and technology) and the workforce itself (e.g., more women in the labor market, more short-term and part-time jobs, and more frequent job changes). Some macro-level changes have adverse implications for health. Examples include: experiencing the stress of role overload [particularly among women], the limited availability of well-paying jobs for workers with a high-school education, having to work multiple jobs to provide adequate income for basic necessities, and earning fewer benefits in part-time and short-term positions.

Changing parental work patterns are transforming family life. Growing numbers of young children are being raised by working parents whose earnings are inadequate to lift their families out of poverty, whose work entails long and nonstandard hours, and whose economic needs require an early return to work after the birth of the baby. The consequences of the changing context of parental employment for young children are likely to hinge on how it affects the parenting they receive and the quality of the care giving they experience when they are not with their parents.[68]

Health plans and worksite health promotion
Most businesses in Minnesota (77 percent) offer health insurance to their employees; fewer than half (47 percent) offer dental insurance to employees. Almost all businesses that offer health plans to employees also offer them to dependents.[67] Many health plans exclude clinical preventive services, despite the significant potential to curb costs, promote health, and/or prevent disease.[69] Approximately 12 percent of businesses in Minnesota offer wellness programs designed to assist

employees in achieving and maintaining a healthy lifestyle.[67] Comprehensive worksite health promotion programs can be cost-effective[70] and have demonstrated potential to increase job satisfaction, reduce employee turnover, decrease absenteeism, reduce workers compensation and disability costs, and improve productivity.[71]

Job Strain and Health

Workers are healthiest when they believe their job is secure, the work they do is important and valued, the workplace is safe and supportive, and there are ample opportunities for control, decision-making, advancement and personal growth.

Generally people are healthier when they have a job, because of the adverse financial and psychological consequences of unemployment. Yet not all jobs enhance physical and mental health. This is especially true for jobs that impose unpredictable and uncontrollable demands (including the monotony of machine-paced work), leave relatively little room for individual decision making, underutilize skills and abilities, and provide limited opportunity for personal growth.[7]

Mounting research shows that health is affected by the combination of the physical, mental and emotional demands of a job, as well as the amount of control, or autonomy, that workers have to solve problems and go about their work.[72] Low-control, high-demand working conditions pose a significant threat to health through "job strain." Positions noted for having high levels of job strain include lower middle management and support staff positions. Job strain is associated with absenteeism, increased utilization of medical services, decreased performance and productivity, increases in health damaging behaviors (alcohol abuse, cigarette smoking), and increased prevalence of cardiovascular disease. Despite extensive and growing evidence that higher levels of control at work are associated with better health and other positive outcomes, there is little published research evaluating programs designed to reduce job strain.[73]

Two scholars have shared their vision for workplace change in the form of a "health-promoting double-attack." They favor reducing overload decision demands among professionals at the "top" of the hierarchy, and increasing decision-making opportunities and skill discretion at the "bottom end."[74]

"Taking care of people, therefore is one way of taking care of business…You cannot hire a part of a person. You get the sore back along with the skillful hands. You get the anxious heart along with the educated brain. So your policies and programs will only be effective if they bow to this reality and address the whole human being…the bottom line is that our efforts to support employees' work-family priorities are good business. These are neither 'perks' nor 'giveaways.' These tools will help us attract, motivate, and retain people who are more likely to be more dedicated, more focused, and more productive."[75]

Culture, Religion and Ethnicity:

"I would like to see more community-based services that are culturally appropriate. It is very difficult for me, as a nurse, to encourage a family to put a demented elderly Hmong woman at an adult day care center that is specifically all English speaking-all Western food-am I doing her more harm than good?"

From its origins as a land inhabited uniquely by American Indians, this state began with the heritage of the Native people and from those who long ago settled in what became Minnesota. From our beginning as a state, our history records that there have always been immigrants who came to Minnesota from other parts of the world. Today, Minnesota has among the largest Hmong, Somali and Liberian communities in the U.S., as well as a rapidly growing Latino population.

It is not possible to isolate the aspects of culture, religion and ethnicity that shape a person's world view. Each is part of the other, and all three are united within the person.

Research affirms what many have known intuitively from experience-good health requires that people have the opportunity to freely express and share their heritage.[44]

Stronger cultural ties are not just a side benefit, but a central strategy in cutting edge Minnesota programs that promote youth resilience and drug prevention.[79]

As a result of this immigration, Minnesota's foreign-born population is estimated to have risen at least 50 percent in the 1990s. Largely as a result of immigration, in the year 2025 approximately 15 percent of Minnesota's population will be comprised of racial/ethnic minority groups-compared to 9 percent today. The stress of adapting to new social conditions is a major determinant of health status for many population groups.

There is no single definition of culture. Some have described culture as "the sum total of socially inherited characteristics of a human group that comprises everything which one generation can tell, convey or hand down to the next;" in other words, the nonphysically inherited traits we possess.[76] Some have characterized culture more concretely as "luggage" that each of us carries around for our lifetime.[77] For immigrants, the prevailing norms, beliefs, values, customs, rituals and social institutions in Minnesota represent the "host" culture, in contrast to those of cultures of origin.

For foreign-born populations as well as long-term residents of the state, culture, religion and ethnicity have an overarching influence on beliefs and practices related to health, illness and healing. This includes perceptions of health and illness, beliefs about the causes of health and illness, decisions about whether to seek a health care provider, and decisions about the type of provider or healer that should be sought.

Strength of faith and religious commitment are related to physical and mental health indicators such as immune function, experience of depression, blood pressure level, and life expectancy. Faith and religious commitment are believed to promote health and prevent disease through increased social support, improved coping skills, and more positive self-appraisals. Religious involvement may also discourage behavior that increases health risks.[78]

Ethnicity is a "complex and elusive" term, but is often used to indicate a set of characteristics shared by a group (such as geographic origin, race, language and dialect, religious faith and/or migratory status). There are at least 106 ethnic groups and more than 200 American Indian groups in the U.S.[77] Cultural misunderstanding and ethnocentrism (belief in the superiority of one's own ethnic group) can lead to stereotypes, prejudice and discrimination, which in turn threaten health and quality of life. Research increasingly points to discrimination as a key factor underlying racial/ethnic disparities in health status (see page 17).

A more complete discussion of the combined influence of culture, ethnicity and religion on health is beyond the scope of this report. Future attention should be directed toward the inter-relationships between health, acculturation, assimilation, discrimination, heritage consistency, culture-bound syndromes, religion and faith.

Implications and Conclusions

IMPLICATIONS

Given the strength of the evidence regarding the relationship between social and economic conditions and health, the Institute of Medicine (IOM) recently completed a rigorous review of research to determine the most promising approaches to improve health through behavioral and/or social change.[80] This analysis led to several recommendations and a call for more research to evaluate the relative potential of social and economic interventions to improve health. Some overarching recommendations are summarized below:

- The next generation of prevention interventions must focus on building relationships with communities, and derive from the communities' assessments of their needs and priorities.

- Health improvement efforts must recognize that many diseases have numerous behavioral and social risk factors in common. So rather than continuing on the current path in which disease-specific prevention efforts predominate (e.g., diabetes, breast cancer, suicide), efforts should be refocused toward the cross-cutting fundamental determinants of health (i.e., social determinants such as income, education, social support and community cohesiveness, and behavioral determinants such as physical activity, nutrition, and tobacco use).

- Health improvement efforts should integrate multiple approaches (such as education, social support, laws, and incentives), and address multiple levels of influence simultaneously (the individual level; the interpersonal level of families and support networks; institutional and community levels represented by settings such as schools, worksites and places of worship; and broader public policy levels).

- Health improvement efforts should take account of the special needs and assets of target groups (e.g., identified by age, gender, race, ethnicity, or social class); involve a variety of sectors that have not traditionally been associated with health promotion efforts (including law, business, education, social services and media); and take the "long view," since changes often take many years to become established.

These and other findings and recommendations within the Institute of Medicine report-along with comparable findings and recommendations outlined by others-provide important context and justification for this report. Although more research is clearly needed, research conducted to date points the way toward promising, largely untraveled paths toward community health.

"Serious effort to apply behavioral and social science research to improve health requires that we transcend perspectives that have, to this point, resulted in public health problems being defined in relatively narrow terms . . . Models of intervention must consider individual behavior in a broader social context, with greater attention to the…ways in which social and economic inequities result in health risks."

Institute of Medicine, 2000, p. 28.

"Comprehensive community change initiatives attempt to rebuild the social and economic fabric of a community or neighborhood by implementing a holistic strategy involving a full range of resources. A core philosophical tenet of these projects is that all aspects of community are closely inter-related, and therefore, in order to bring about lasting change, many of those inter-related components must be tackled simultaneously."[81]

CONCLUSIONS

These findings have far-reaching implications. In addition to access to health information, immunizations, and clean air and water, all people in Minnesota need a supportive social and economic environment, which includes a quality education, economic opportunity, and a fair chance to fully participate in the cultural and civic life of their communities. The synthesis of these findings represents a critically important step forward.

MHIP urges action on the following recommendations, which are based on empirical data coupled with expert opinion. MHIP further encourages the MDH and the MHIP to anticipate, disseminate and mobilize action around new findings on the health impacts of social and economic policies expected from the National Institute of Health,[82] the Institute of Medicine,[80] and the Centers for Disease Control and Prevention (CDC).[83]

Inaction is not a responsible alternative. The inequalities in health status across racial and ethnic groups in Minnesota are pervasive, sizeable, and in some cases growing. Inequalities in health across income across have also been widely noted. Together, these findings suggest that all people in Minnesota do not currently have equal access to opportunities for health.

The challenge is clear: public, private and non-profit organizations in Minnesota need to collectively act on this deeper understanding of the social determinants of health, at the same time that we increase access to culturally competent health care, promote healthy behaviors, and strengthen the existing public health infrastructure. To do otherwise is to further limit potential and jeopardize the health and quality of life of all residents of the state.

Recommendations and Strategies For Implementation

- Identify and Advocate for Healthy Public Policies
- Build and Fully Utilize a Representative and Culturally Competent Workforce
- Increase Civic Engagement and Social Capital
- Re-orient Funding
- Strengthen Assessment, Evaluation and Research
- Communicate and Champion the Findings and Recommendations
- Create Opportunities for Dialogue and Action
- Focus Coordinated Commitment on Priority Strategies
- Take This Work to the Next Stage

RECOMMENDATION:

IDENTIFY AND ADVOCATE FOR HEALTHY PUBLIC POLICIES

STRATEGIES

Health Impact Assessment
Policies and programs have health consequences though they may not have explicit health objectives. Since investments outside the health sector (e.g., in the areas of housing, transportation and economic development) have consequences for community health, the potential impact of social and economic policies on the health of Minnesotans should be an integral part of policy making processes.[84]

Health Impact Assessment (HIA) is an emerging approach to policy development and program planning designed to assure that current and future policies, programs, and/or organizational structures contribute toward meeting public health improvement goals-or at least do not hamper achievement of those goals.

The MHIP should convene the partners necessary to develop and pilot tools for health impact assessment in Minnesota:

- Begin modeling the intersector implications of state and local policy. *For example*: MDH should collaborate with other agencies and administrators to provide legislative testimony in support of initiatives that promise to create healthier social and economic environments.
- Convene state agency fiscal analysts, the legislative auditor, representatives of the Finance Department and others to deepen understanding of assumptions underlying fiscal impact statements and other tools for fiscal analysis in Minnesota.[85]
- Identify a range of existing models for HIA.
- Consult with experts in order to determine the state-of-the-science and benefit from practical lessons learned elsewhere.
- Engage a diverse array of stakeholders that represent numerous sectors, disciplines and communities to explore HIA (e.g., what it is, how it has been used, and how it might work in Minnesota).
- Identify political and organizational barriers to HIA, then identify strategies to overcome them.
- Develop a HIA tool and methodology and use it to evaluate the health implications of pending legislation and/or an existing policy or program.
- Develop and test methods for estimating the resources spent (and saved) in some sectors or programs as a result of investing (or not) in others.
- Broadly disseminate these tools to policy makers and other interested groups.
- Create legislative language to require use of these tools.

The findings and recommendations of this report are similar to those of minority health needs assessments conducted in Rice, Winona, Todd, Olmsted, Otter Tail, and Goodhue counties, as well as in the seven county metropolitan area. Issues such as discrimination, housing, wages, and employment opportunities surfaced in assessments conducted in both metro and Greater Minnesota counties.

Health Impact Assessment elevates system-level change, identifies intersector costs and benefits, and signals a shift from public health policy toward healthy public policy.

Information into Action

Findings of Health Impact Assessment and other avenues of evaluation and research are needed to identify the most promising policies and programs. As this research moves forward, Minnesotans should capitalize on current evidence and experience to discuss and debate the potential health affects of current and proposed policies and programs. The list of policies and programs below is intended as a starting point.

The MDH and the MHIP should focus united advocacy and action behind social and economic policies and programs with significant potential to improve or diminish health and quality of life in Minnesota.

Increase Opportunities for Optimal Early Childhood Development

- *Examples*: Combine affordable, high quality childcare with supportive family and community connections (e.g., home-visits by public health nurses, parent education, transportation, referrals to health and social services); increase availability of paid family leave.

Early Childhood Education: An Opportunity for Health Improvement:

Research findings are especially persuasive on the potential long and short-term benefits of programs and policies to support positive early child development and of the need to act on these findings.[86] For example:

- "It is the strong conviction of this committee that the nation has not capitalized sufficiently on the knowledge that has been gained from nearly half a century of considerable public investment in research on children from birth to age three."[87]
- "The quality of young children's environment and social experience has a decisive, long-lasting impact on their well-being and ability to learn."[88]
- The Task Force on Community Preventive Health Services developed the analytic framework included in Appendix E to guide a comprehensive review of the research literature on the health effects of model early childhood development programs. Based on its review of the evidence, the Task Force strongly recommends early childhood development programs for low-income children aged 3-5 years as a strategy for health improvement.[89]

Increase Opportunities for People to Move Out of Poverty and Meet Basic Needs

Examples: Increase affordability and accessibility of housing and dependent care; augment low wages by expanding the earned income tax credit and raising the minimum wage; help welfare recipients seek, retain and advance in their jobs by providing subsidized childcare, transportation and housing; remove financial, legal, cultural, structural and other barriers that hinder equal access to social goods such as a quality education, quality health care, safe neighborhood, affordable housing, and convenient parks or recreation.

Increase Opportunities for Quality Education and Lifelong Learning

Examples: Assure adequate public investment in education; focus career counseling and work force development in secondary schools; increase flexibility to pursue post-secondary education while on MFIP; provide training and support systems to facilitate the transition from welfare to work; provide incentives for service learning, internship and mentoring programs (e.g., sponsorships and other relationships between schools, businesses, business associations, and other groups); connect new immigrants with career education and vocational training opportunities; encourage higher education institutions to tailor programs and curriculum to meet current and emerging employment need; enhance opportunities for high school students to get higher education and work force experience by expanding internship opportunities and the post-secondary enrollment options program that allows students to take college level courses; create incentives for business to partner with higher education to offer customized training programs.

Link Economic Development, Community Development and Health Improvement

Examples: Expand incentives for local development patterns that serve broader regional interests (e.g., regional tax base sharing and the 1995 Livable Communities Act which offers financial incentives to communities that build affordable housing); link local and regional planning, particularly in the areas of land use, transportation, housing, and economic development; package sustainable development as part of a health improvement agenda; elevate equitable opportunity as a central element of community planning.

Increase Opportunities to Elevate Standard of Living and Prospects for Future Generations

Examples: Expand availability of Individual Development Accounts (IDAs) through programs such as Family Assets for Independence in Minnesota;[90] increase affordability of post-secondary education; increase opportunities for home ownership.

Getting from Here to There

As a bridge from identifying to advocating for healthy public policy, the MHIP and the MDH should convene partners necessary to:

- Produce and disseminate periodic briefs that summarize evidence-based and promising policy approaches.
- Assess barriers and opportunities to change in terms of public and private systems and institutions, community dynamics, and/or public policy.
- Identify and act on next steps to overcome these barriers and capitalize on policy making opportunities.

RECOMMENDATION:

BUILD AND FULLY USE A REPRESENTATIVE AND CULTURALLY COMPETENT WORKFORCE

There are many pressing reasons why Minnesota needs to build a culturally competent work force that reflects the racial and ethnic diversity of its residents (e.g., the pervasive and sizeable income and health disparities across racial/ethnic groups, the opportunity to improve the quality of services, and projected demographic changes). A more diverse and culturally competent[91] work force is urgently needed in the health sector to overcome existing nonfinancial barriers to public health and health care services (e.g., language and communication barriers, mistrust or fear of health care and government institutions, and limited knowledge about how to navigate large agencies and systems).[92]

"In the Twin Cities, we have close to over 80,000 Hmong individuals and we have less than 20 Hmong nurses. Why is that? We have five doctors. Why is that? Why are we not building on the capacity for the Hmong community to serve its own?"

The effort to attract and retain a diverse work force is a process, not a program. This process requires that the MDH and the MHIP member organizations establish and adhere to practices to recruit, retain, and promote personnel who reflect the cultural and ethnic diversity of the communities served. Furthermore, this process involves integrating practices of equal opportunity (preventing discrimination), affirmative action (efforts to correct imbalances), and diversity (managing relationships of difference). The following strategies are believed to increase diversity, promote cultural competence, and enhance organizational credibility and effectiveness.

STRATEGIES

- Create an environment where all employees and customers feel welcome, accepted and valued.

  Establish clear expectations that work force diversity is a core value; take actions to demonstrate that harassment and discrimination will not be tolerated; regard a diverse work force as a strategic business initiative.

- Ensure that the functions of the organization are accessible to a diverse range of employees.

  Consider religious holidays when planning major meetings; assure accessibility; provide multi-cultural competency training for all employees on an on-going basis; assess organizational policies and procedures to determine the extent of equal opportunity and cultural responsiveness.

- Create diverse applicant pools of qualified people.

  Recruit from historically black colleges and universities; establish internship and student worker pipelines into professional level positions; develop recruitment/marketing materials that depict diversity with clear statements of a commitment to a diverse work force; encourage diverse employees to disseminate job information to their networks; use minority media to advertise positions; have diverse staff representation at recruiting events where diverse job-seekers are expected; promote the organization's employment on websites frequented by diverse candidates.

- Increase the future pool of qualified applicants.

  Encourage youth of color to consider careers in fields of public health and health care; support trained immigrants and refugees seeking certification or licensure in the U.S.; create a public health fellowship at the University of Minnesota for students of color; ensure applicants of color are given full consideration in the hiring process; use diverse interview panels to make hiring decisions; measure the degree to which equal opportunity is practiced in the hiring process.

- Retain people of color in the work force.

  Develop support systems and networks so that diverse employees are not culturally isolated; analyze separations to determine any patterns; conduct 6-month retention surveys and exit interviews.

- Measure and report progress.

  Report progress organization-wide and by business unit to employees; integrate diversity measures into annual performance reviews for managers and supervisors; conduct annual assessments of hiring and separation patterns.

"Very, very few positions are opening up for people (of color) to be in places where decisions are being made or opinions are being shared about what is health."

RECOMMENDATION:

INCREASE CIVIC ENGAGEMENT AND SOCIAL CAPITAL

Social scientists, community leaders, and others have called for an overhaul of health improvement services and programs that are not culturally competent, that focus on needs rather than strengths, and that create fragmentation and dependency. Health improvement programs often focus narrowly on a pre-determined disease, age group, or risk factor, for a one or two year time span. Yet research supports-and communities seem to want-programs that are more comprehensive, flexible, responsive, and enduring.[93,94]

"A lot of the health concerns that we see I think comes from our own personal lifestyle habits and the disconnection that we have from each other and the disconnection that we have from our families."

Community development and participatory research emphasize community participation, empower people to make their own choices, and involve people in the political processes that affect their lives.[95] These approaches have demonstrated success by engaging community members and relying on a community's own resources and strengths as the foundation for prioritizing designing, implementing, and evaluating such community change initiatives.[96,97]

The Institute of Medicine recently concluded, "The next generation of prevention interventions must focus on building relationships with communities, and derive from the communities' assessments of their needs and priorities."[80] Along with more traditional risk reduction activities, building civic engagement and social capital are increasingly regarded as priorities for health improvement.

STRATEGIES

Through the MHIP, the MDH should convene a group charged with identifying opportunities, as well as barriers and solutions, to broadly support the implementation of health improvement programs that use principles of community development, civic engagement and participatory research and evaluation. Group membership should be comprised of representatives of community-based organizations, the MHIP, the MDH Minority Health Advisory Committee, the State Community Health Services Advisory Committee, and the Commissioner of Health.

Specific attention should be directed toward recommending strategies, policies, and/or programs to accomplish the following activities:

- Implement health improvement programs that are comprehensive, flexible, responsive and sustainable, while at the same time assuring that such programs are equitable, likely to achieve desired outcomes, and accountable.

  For example, it is important that the community affected by the issue being addressed is intimately involved in assessing its own needs and assets, and that it has the authority to make decisions based on its assessment about what is done in the community. Yet, in order to achieve the desired outcome, the strategies used must be science- and/or evidence-based and there must be mutual accountability to the community and to the funding source. Effective management of this tension is crucial to success.

- Coordinate health improvement activities with initiatives originating outside the traditional health sector (e.g., funding for affordable housing, the location of new bus routes, restructuring tax codes) that nonetheless contribute to health improvement goals by creating more favorable social and economic environments.

- Create conditions in which community-based health improvement initiatives can be strengthened and expanded (e.g., responsive systems, technical and mutual assistance, streamlined access to public and private resources and expertise, broad-based coalitions, intersector leadership, leadership development, networking, mentoring).

- Build mutually beneficial relationships between community-based organizations and larger systems and institutions. An important step in this process is to make the work force of the larger systems and institutions reflect the community-at-large. Other examples include: connect mentors who understand multiple sectors and organizations and who can help to bridge the organizational and cultural gaps; identify common goals and approaches; clarify roles and levels of decision-making authority; learn about each others' programs and priorities; provide training on collaboration for persons and organizations working together.

- Recognize communities for having an infrastructure and plan in place for intersector, multi-cultural collaboration for health improvement. A

model for this effort could be the Minnesota Star City program, which recognizes communities that come together to create an economic development plan. A second phase of this recognition system should be directed toward model state and regional policies and programs that help to create social and economic conditions favorable to health.

- Build an incentive system like one developed by the Health Care Coalition on Violence to recognize organizations that demonstrate through their actions a commitment to promote the social conditions that improve health.

RECOMMENDATION:

RE-ORIENT FUNDING

The social and economic changes described in this report will not happen by chance. Stable funding and leadership are needed within a critical mass of organizations to support innovative, long-term collaborative efforts with potential to achieve and sustain change.

Change is needed with regard to the amount of funding available to community-based organizations, as well as the terms on which it is available. The foundation for these changes rests on a philosophy of shared responsibility for health, and a style of government leadership which supports community-led initiatives and works to build cooperation between the public, private, and nonprofit sectors.

Although health is about individuals, families and communities, most grant programs were initiated by Congress or the Minnesota Legislature to address specific diseases or issues. Policymakers have traditionally funded competitive, categorical grants because of budgetary constraints and the belief that they produce better programs and better results. The authorizing legislation generally includes certain requirements and restrictions, and the administering federal or state agency will usually make additional requirements about the use of the funds. As a result, most grants are designated for a specific program area, leading to a patchwork of fragmented funding for Community Health Boards and community-based organizations working to improve health.

While people of color and American Indians are served in a general sense from current grant programs, there has not been a specific focus related to the gaps and disparities to bring equity through prevention and health promotion activities.

Moving forward with the reorientation of funding that is envisioned requires empowering communities to make decisions and ensuring that they have the capacity to do so. At the same time, state and local government public health agencies will continue to be accountable to elected officials and taxpayers for the use of public resources. To achieve meaningful change, new and innovative funding delivery mechanisms must be developed which achieve maximum flexibility, community autonomy, and efficiency in government grant programs, while assuring that administrative requirements are met and that MDH has the information it needs to demonstrate state-level accountability.

"...that's something that we need to go back to the Department of Health and say . . . some of that money needs to be sent to the communities where people are actually doing the work. People who are actually doing the work of providing better health to people need to be supported, need to be uplifted and need to be given some of the funds that are being sent to some of the other places where the actual work is not being done."

STRATEGIES

Because the MDH operates numerous grant programs, the department is in a position to take immediate steps that will begin a long-term process of reorienting funding. The steps taken should include:

- Involve a greater variety of people and organizations during evaluation of grant proposals.
- Examine lists of organizations that are notified of funding opportunities to ensure that they include community-based organizations from around the state, particularly those serving populations with disparate health status.
- Review the information requested at each stage of the grant process and eliminate all information that is not absolutely necessary.
- Make administrative requirements consistent across all grant programs.
- Provide grant applications with data on the health status and needs of populations of color and American Indians.
- In light of the recommendations of this report, reexamine the current funding formula and criteria used to evaluate proposals.
- Require organizations seeking grant funds to demonstrate the involvement of people from groups with disparate health status in planning and implementing the proposal.

State agencies should continue work through the Governor's State Agencies Focused on Effectiveness (SAFE) Council to achieve better interagency coordination in grant application and reporting requirements. That group should explore ways to link funding between state agencies to address the social and economic conditions that affect health.

The MDH and all MHIP and Action Team members should take action to inform congressional representatives and legislators about the difficulties posed by fragmented categorical funding and present realistic alternatives to those types of grants.

The next phase of MHIP work on the Social Conditions and Health should explicitly seek to strengthen linkages with foundations (Minnesota-based and national) that have identified a focus on social and economic factors and/or health.

RECOMMENDATION:

STRENGTHEN ASSESSMENT, EVALUATION AND RESEARCH

More rigorous use of population health data, and more sophisticated measures and indicators of health are needed to provide a comprehensive picture of the factors that affect health. This is particularly important as we deepen understanding of the social and economic factors that affect health (income and wealth, economic inequality, racism and discrimination, housing, community connectedness, etc), and as the population of Minnesota becomes older and more diverse.

"[Health] is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion, and the elimination of discrimination."[98]

STRATEGIES

The MDH and the MHIP member organizations should take immediate steps to act on the future data initiatives recommended within the *Populations of Color Health Status Report*[10] and the *Minority Health Report* submitted to the Legislature by the MDH in 1998. Relevant data recommendations from these previous reports are incorporated below.

"...there is not enough data, especially in the Asian community, to really go to the funder and say that we need more money to do this program. When you say 'I know this is what needs to be done' but there is no hard data to back it up—they don't see a need for it."

The MDH and the MHIP member organizations should build on lessons learned through the process of funding minority health needs assessment grants during 2000, and leverage additional resources to support similar assessment and planning initiatives across the state.

Community Health Service (CHS) Agencies should incorporate social and economic factors into the next cycle of community health assessment plans completed in 2004. The assessment and planning processes should be done with significant participation from community members, including those representing populations of color, foreign-born populations, and people with low income. Avenues for participation include advisory groups, focus groups, key informant interviews, and timely opportunities for review and comment.

The Commissioner of Health should ask the MHIP, the Minority Health Advisory Committee, and the Population Health Assessment Work Group to identify the next steps toward conducting a comprehensive, multi-sector assessment that will provide state-specific baseline data on the social and economic factors that contribute to health and health disparities. Invited consultants should include the Institute on Race and Poverty, the Urban Coalition, the Roy Wilkins Center for Social Justice, and others as desired.

The MDH and CHS agencies should expand traditional indicators of health to include social and economic factors.

Carver County Community Health Services produced a report describing their collaborative efforts with Carver County Planning and Zoning, Ridgeview Medical Center, and the University of Minnesota Extension to collect information about the health of the county. Participants in this process have concluded:

- When several community indicators are viewed collectively, they can provide insight into overall health and quality of life, thereby reflecting the values and vision of a community.
- It is important to include a broad representation of the community when determining which indicators best reflect the overall health of the community.

The MDH Center for Health Statistics should work jointly with the Population Health Assessment Workgroup, the MHIP and other interested groups to strengthen capacity at the state and local level to link traditional health indicators with measures of socioeconomic status and race/ethnicity. For example:

- Incorporate measures of income, education, and race/ethnicity into information systems that address aspects of physical and mental health.
- Overcome limitations of information systems that include some health, socioeconomic, and race/ethnicity data (e.g., reduce missing data and improve data accuracy).
- Circumvent the current lack of individual-level socioeconomic data in most health-related information systems by assigning population-level data (e.g., build on the work of the Minnesota Center for Health Statistics and others who have used census data to analyze the effect of community characteristics [such as neighborhood poverty] on health outcomes [such as low birthweight]).
- The MDH should work jointly with the Institute on Race and Poverty, the Metropolitan Council and other interested parties who are evaluating the distribution of social and economic opportunity in the Twin Cities metropolitan area, and analyzing the consequences for health.
- The MDH should work jointly with the Population Health Assessment Work Group and others who represent Minnesota's racial/ethnic communities to assure uniform and accurate collection of socioeconomic and racial/ethnic data, and to expand analysis and reporting of administrative data. Specific sources of administrative data include:

  –Hospital discharge data collected by the Minnesota Hospital and Healthcare Partnership

  –Enrollment and claims encounter data collected by health plan companies

  –Surveys of health plan member satisfaction and patient satisfaction conducted by the Minnesota Health Data Institute

The MDH should actively communicate the findings of these assessment, evaluation and research activities to the general public, policy makers, and organizations working toward Minnesota's health improvement goals.

RECOMMENDATION:

COMMUNICATE AND CHAMPION THE FINDINGS AND RECOMMENDATIONS

Broad dissemination is essential to build understanding about (1) the power of the social and economic environment to shape patterns of overall health and health disparity, and (2) the types of societal, system-wide and organizational changes needed to eliminate disparities and make further progress toward health improvement goals. This dissemination should draw on the communications plan and tools included in Appendix F to assure a consistent overall message, and to tailor communications for specific audiences (e.g., public health leaders and workers, populations experiencing health disparities, business leaders, government officials and policy makers, and the media).

STRATEGIES

Upon its publication, the MDH should actively disseminate and champion the findings and recommendations of this report to public, private and non-profit organizations working to improve health in Minnesota. Specifically, Commissioner Malcolm should provide a briefing on this report and its implications to Governor Ventura, the Health Policy Council, relevant legislative committees, the Governor's State Agencies Focused on Effectiveness (SAFE) Council, the Metropolitan Council, regional bodies and the MDH Health Steering Team.

Members of the MHIP and the Social Conditions and Health Action team should assume leadership to disseminate and champion report findings and recommendations more fully throughout their respective organizations and systems.

RECOMMENDATION:

CREATE OPPORTUNITIES FOR DIALOGUE AND ACTION

The findings and recommendations of this report demand a fundamental shift in the way we think about health and health improvement in Minnesota-from indicators of a healthy community, to our strategies for health improvement. Proactive opportunities to discuss and reflect on these findings and recommendations are needed to:

- Elevate the visibility of these findings and recommendations.
- Promote understanding of the individual and collective roles that Minnesotans can play.

- Help people imagine new possibilities. The recommendations of this report cut across conventional political, professional, jurisdictional, and sectoral boundaries.

- Set an agenda for action.

STRATEGIES

During 2001, the MDH, members of the MHIP, and members of the Social Conditions and Health Action Team should periodically and systematically create the time and place for these much-needed discussions.

In addition to internal dialogue, each organization should initiate or expand dialogue within the broader systems and communities served, including partners and potential partners from multiple sectors.

RECOMMENDATION:

FOCUS COORDINATED COMMITMENT ON PRIORITY STRATEGIES

Many groups and individuals in Minnesota are dedicated to improving the social and economic climate in Minnesota, though they may not have fully realized the health implications of their actions and advocacy. MHIP members should work jointly to mobilize action and leverage the strength of these organizations.

"...the name of the game is follow-through. Its not just about having a dialogue, it's about building relationships."

RECOMMENDATION:

TAKE THIS WORK TO THE NEXT STAGE

MHIP and MDH should bring overall leadership and direction to this work during the next year by expanding and re-convening partners, promoting accountability, issuing "calls to action," producing issue briefs, and positioning Minnesota to capitalize on research and related activities occurring nationally.

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October, 2000: http://www.profbriefings.co.uk/events/impact.htm; The International Health Impact Assessment Consortium at the University of Liverpool: www.liv.ac.uk/~mhb; The Canadian Handbook on Health Impact Assessment: http://www.hc-sc.gc.ca/ehp/ehd/oeha/hia/

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Appendices

APPENDIX A

MINNESOTA HEALTH IMPROVEMENT PARTNERSHIP

The purpose of the Minnesota Health Improvement Partnership (MHIP) is to develop coordinated public, private and nonprofit efforts to improve the health of Minnesota residents. Its work is grounded in the vision of health as a shared responsibility; and focused on achieving jointly developed health goals and priorities through the use of evidence-based strategies. The charge to the MHIP is twofold:

To identify and promote health improvement activities among Minnesota's public, private and nonprofit sectors.

To advise the Commissioner on activities that the Minnesota Department of Health (MDH) should take to facilitate public/private/nonprofit health improvement efforts and advance the vision of health as a shared responsibility.

In 1997 and 1998, the MHIP developed health improvement goals for Minnesota *(Healthy Minnesotans 2004).* During 1999 and 2000, MHIP directed considerable attention toward goal 18, which is a developmental goal to "foster the understanding and promotion of the social conditions that support health."

MHIP Member Organizations

Association of Minnesota Counties
Business for Social Responsibility, Upper Midwest Network
Center for Population Health
Consumer Member
Health Care Education and Research Foundation
League of Minnesota Cities
Local Public Health Association
Maternal and Child Health Advisory Task Force
Minnesota Business Partnership
Minnesota Chamber of Commerce
Minnesota Council on Disabilities
Minnesota Council of Foundations
Minnesota Council of Health Plans
Minnesota Council of Non-Profits
Minnesota Department of Children, Families and Learning
Minnesota Department of Employee Relations
Minnesota Department of Health
Minnesota Department of Human Services
Minnesota Environmental Health Association
Minnesota Hospital and HealthcarePartnership
Minnesota Medical Association
Minnesota Planning
Minnesota Public Health Association
Neighborhood Health Care Network
Population Health Assessment Work Group
Prairie Regional Health Alliance
Rural Health Advisory Committee
State Community Health Services Advisory Committee
University of Minnesota, Center for Spirituality and Health
University of Minnesota, School of Public Health, Division of Epidemiology
University of Minnesota, School of Public Health, Division of Health Services Research and Policy

APPENDIX B

SOCIAL CONDITIONS AND HEALTH ACTION TEAM

Charge

The charge of the action team was to develop strategies and tools that public, private and nonprofit organizations can use to:

Deepen understanding of the social conditions that affect the health of Minnesotans, and

Identify action steps the MHIP member organizations and the MDH can take to address these issues.

Membership

The Action Team was comprised of representatives of the public, private and nonprofit sectors who were knowledgeable and experienced in many fields, including housing, Head Start, welfare reform, public health and health care, ethics, law, research, economic security, and public relations. Their work was conducted over the course of eight meetings between October, 1999 and January, 2001. This included joint meetings with the mmbership and staff of the Minority Health Advisory Committee of the MDH.

Membership and Staff Support

Lynn Abrahamsen
Neighborhood Health Care Network

Mila Aroskar
School of Public Health, Division of Health Services Research and Policy, University of Minnesota

Carol Berg
Center for Population Health

Cathy Borbas
Health Care Education and Research Foundation

Becky Buhler
Minnesota Planning

Janel Bush
Minnesota Department of Human Services

Lazette Chang-Yit
Medica Health Plans

Barbara Collins
Legal Services Advocacy Project

Rick Ford
Ford and Associates

Jesse Bethke Gomez
Chicanos Latinos Unidos En Servicio

Connie Greer
Minnesota Department of Children, Families and Learning

Anita Hoffmann
Local Public Health Association

Penny Hunt
The Medtronic Foundation

Todd Johnson
Minnesota Business Partnership

Gavin Kearney
Institute on Race and Poverty, University of Minnesota Law School

Mary Jo Kreitzer
Center for Spirituality and Healing, University of Minnesota

Gabrielle Lawrence
(Co-chair) Macalester College

Jane Liu
The Urban Coalition

Becky Lourey
Minnesota State Senate

Kevin Lynch
Business for Social Responsibility, Upper Midwest Network

John Morrison
Minnesota Department of Human Services Food Stamp Program

Gretchen Musicant
(Co-chair) Minneapolis Department of Health and Family Support

Michael Resnick
Department of Pediatrics, University of Minnesota

Denise Rogers
Housing Finance Agency

Brian Rusche
Joint Religious Legislative Coalition

Helene Shear
CommonBond Communities

Heidi Stennes
Minnesota Department of Economic Security

Danie Watson
Business for Social Responsibility, Upper Midwest Network

Betty Windom-Kirsch
Local Public Health Association

Kay Wittgenstein
House Calls St. Paul-Ramsey Department. of Public Health

David Zander
Council on Asian Pacific Minnesotans

ALTERNATE MEMBERS
Ann Stehn
Local Public Health Association

Diane Thorsen
Local Public Health Association

MDH Staff to Action Team

Debra Burns
Peggy Malinowski
Kim Miner

APPENDIX C

GUIDING PRINCIPLES

In preparing this report, the Social Conditions Action Team has adapted guiding principles set forth in the *Healthy Minnesotans Public Improvement Goals 2004.*[1] These include:

Focus on the greater good and respond to diverse populations. This report, like the Minnesota public health improvement goals, focuses activity toward conditions that affect the health of all members of the community; however, an appropriately balanced discussion of focusing on the greater good must also consider the pressing need to be responsive to health disparities among population groups. Minnesota must focus on eliminating disparities in health status in order to make further progress toward Minnesota's health improvement goals.

Take individual and collective action. Individual and community health are shaped by both individual and collective actions. Every Minnesotan has a responsibility to take steps necessary to achieve his or her full potential and to contribute to community life. At the same time, all Minnesotans must stand together to assure that everyone has the resources and opportunities necessary to fully participate in society. Together, state and local health departments must fulfill their governmental responsibilities for public health, and communities must foster alliances among business and other public and private organizations to improve the health of Minnesotans.

Maximize return on investment. Success in targeting approaches to these issues demands rigorous attention to the needs of population groups, balanced by sensible decision making within limited resources.

Enhance healthy years of life. This report is shaped by a desire to increase the length of healthy life for all Minnesotans.

Give priority to prevention. The long-standing commitment to the principle of giving priority to prevention is an investment in our future.

Anticipate the future. The process of determining how Minnesotans' health can be improved includes building the capacity to measure and track important health indicators, deciding which health conditions will be tracked over time, committing resources to analyze and disseminate data, and using the data to guide development, implementation and evaluation of policies and programs.

Emphasize science and acknowledge community priorities. Epidemiologic methods of collecting, analyzing and sharing information about an entire population's health status provide the cornerstone for public health practice and policy. However, community and organizational norms and values also come into play as communities and organizations develop priorities to guide decisions about the allocation of resources.

Highlight underlying conditions affecting health. In order to have the greatest impact on improving the health of Minnesotans, a focus is needed on the underlying causes of good health, as well as disease, disability and premature death.

ASSUMPTIONS

In addition to these guiding principles, the Social Conditions Action Team operated upon a number of underlying assumptions, including:

1. Good health enables Minnesotans to lead productive and fulfilling lives, and contributes to the increased prosperity and social stability of the state. The overall health attained by all Minnesotans is an important measure of the success of our state.

2. The movement toward more healthful social conditions requires multiple approaches, as well as the mobilization of understanding, concern and commitment of multiple groups and sectors.[2] Successful mobilization will require trust, communication and collaboration.[3]

3. The elimination of health disparities is a priority [4] and will require changes in the political, economic and social environment.

4. A health-enhancing social environment benefits all Minnesotans.[5 6]

[1] Minnesota Department of Health, Community Health Services Division. (1998, September). *Healthy Minnesotans: Public health improvement goals.*

[2] Smedley, BD & Syme, SL (Eds.) (2000). *Promoting health: Intervention strategies from social and behavioral research.* Washington, DC: National Academy Press. Available: www4.nas.edu/iom/iomhome.nsf.

[3] *Voices from the Front Lines: Social and Economic Forces are Key to Community Health.* (December, 2000). A report jointly produced by the Urban Coalition and the Minnesota Department of Health following co-sponsorship of three community meetings during October, 2000. (Appendix D)

[4] Minnesota Department of Health Strategic Directions (www.health.state.mn.us) and Minnesota Health Improvement Partnership. (1998, September). *Healthy Minnesotans: Public health improvement goals. (*www.health.state.mn.us*)*

[5] Lynch, J. W., Kaplan, G. A., Pamuk, E. R., et al. (1998). Income inequality and mortality in metropolitan areas of the United States. *American Journal of Pubic Health,* 88, 1074-1080.

[6] World Health Declaration. Adopted by the world health community at the 51st World Health Assembly in May, 1998. Reproduced in: World Health Organization, Regional Office for Europe. (1998). Health 21 – *Health for all in the 21st century.* (European Health for All series 5). Copenhagen: WHO.

APPENDIX D

VOICES FROM THE FRONT LINES: Social and Economic Issues are Key to Community Health

This report stems from three community meetings jointly convened in October 2000 by the Urban Coalition and the Minnesota Department of Health (MDH).

Participants Represented

African American Family Services (2 participants)
Affirmative Options Coalition
American Indian Family Center
American Red Cross-Minneapolis
Blue Cross Blue Shield Foundation
Center for Victims of Torture
Children's Defense Fund
Circle of Health
City Inc.
Clues-Mankato
Commonbond Communities
Frogtown Catholic Charities (3 participants)
HACER
Hispanic Health Network
Hmong Minnesotan Pacific Association
Indian Health Board of Minneapolis (representative attended 3 meetings)
MCN
Minneapolis Foundation
Minneapolis Public Schools
Minneapolis YWCA
Minnesota Housing Partnership
Multicultural Resource Center – Mankato
Neighborhood House
Office of Senator Paul Wellstone
PICA HeadStart
Pilot City Health Center (2 participants)
Powderhorn Phillips Cultural Wellness Center
Somali Community of Minnesota
St. Paul Coalition for the Homeless (representative attended 2 meetings)
UCare Minnesota
University of Minnesota Extension Services – Minneapolis
University of Minnesota Extension Services – Sleepy Eye
West Side Health Center

For more information or to request meeting transcripts, contact:
Jane Liu with the Urban Coalition at (612) 348-8550, ext 225, jane@urbancoalition.org
Kim Miner with the Minnesota Department of Health at (651) 296-8294, kim.miner@health.state.mn.us.

VOICES FROM THE FRONT LINES: Social and Economic Issues are Key to Community Health

Introduction

During October 2000, the Urban Coalition and the Minnesota Department of Health (MDH) jointly convened a series of three meetings to explore the social and economic factors that shape health and quality of life in Minnesota. Although Minnesota ranks very high nationally in overall health status, the health of some groups (populations of

color, people with low incomes, and immigrants and refugees) lags far behind. The goal of these meetings was to provide an opportunity to identify and explore the underlying issues in Minnesota that help to create these gaps and explore solutions to narrow them.

Candor, passion, and occasional skepticism characterized the meetings, which benefited from diverse representation from community-based organizations that serve greater Minnesota, communities of color, refugee and immigrant communities, and people with low incomes. Approximately 140 community-based organizations were invited to send a representative to one of three 2-hour meetings held at the offices of the Urban Coalition. These organizations were identified through the networks of the Urban Coalition and the Refugee Health Program of the Minnesota Department of Health. More than 50 people – representing health, housing, education, philanthropic, and advocacy sectors in the state – attended one or more meetings. Yusef Mgeni, President of the Urban Coalition, and Gayle Hallin, Assistant Commissioner at the MDH, co-facilitated each meeting. Discussion questions used to guide the meetings included:

- What do you believe are the 2-3 most important characteristics of a healthy community?
- What do you believe are the 2-3 most important issues that must be addressed to have a healthier community and better quality of life?
- What is currently happening to address these issues?
- What community strengths can we build on?
- What's keeping your community and/or organization from being more successful?
- What are the most important things we can do to improve the health and quality of life of your community?
- What other important issues/concerns should we discuss?
- Where do we go from here?

This report summarizes themes that emerged in each of the meetings, and also highlights discussion generated within each separate meeting.

This report was used to brief Governor Ventura and the Minnesota Health Improvement Partnership. Summaries will be distributed broadly to those who participated in these meetings and to other agencies and organizations working to improve the health and quality of life of people living in Minnesota.

The findings of this report bring a human touch to the rapidly growing body of research on the social and economic conditions that shape the health of populations. Individual and community socioeconomic factors (e.g., income, education, and income inequality), social support and community connectedness, living and working conditions (e.g., opportunities for quality and affordable housing, transportation, daycare, recreation, and nutrition), and culture all affect health in fundamental and lasting ways, and should be a focus of action and advocacy among those working to achieve Minnesota's health improvement goals.

These findings have far-reaching implications. In addition to access to health information, immunizations, and clean air and water, all Minnesotans need equal oppor-

tunities for a supportive social and economic environment. This means that to enjoy good health, all people in Minnesota need a quality education, economic opportunity, opportunities to participate fully in the cultural and civic life of community, and opportunities to develop their full potential.

It is our hope and expectation that this report will provide important context and direction to organizations and individuals working to improve health in Minnesota. However, this report should not be regarded as the "final word" from the community. To the contrary, meetings of community-based organizations, community leaders, government agencies, policymakers, and numerous other groups need to become commonplace if Minnesota is to create social and economic conditions that are more favorable to health of people of color and low-income groups.

Overall Summary

Participants were straightforward and clear about what makes a healthy community. The common expectation was that a healthy community would 1) prioritize the well-being of the most vulnerable (children and youth, older adults, persons with mental health problems, people living on low income); 2) assure equal access and opportunity for all (this includes culturally responsive health care, quality education, and economic mobility); and 3) view community members as equal partners in health improvement.

Things that need to change in order to realize this vision of a healthy community include: the dehumanization of people through racism, classism, prejudice, and discrimination; organizations/ funding agencies outside the community imposing "one size fits all" programs and services; no sense of urgency for those with the most resources/power; lack of representation and diversity among those in power; exclusive systems meant to keep people out (for example, systems oriented toward providing services to narrowly defined eligible groups), and failure to value and support (fund) the strengths of new and established communities.

Despite the adversity faced by many immigrants and refugees, people of color, and low-income groups, there are numerous opportunities to build on community assets. These include: numerous community-based programs and organizations that are doing the "real" work (stretching scarce resources on the front lines in marginalized communities); community-run businesses, schools, health care services, and centers that engage their constituents (examples include a Hmong charter school, the Mercado business district, and HeadStart); skilled individuals with nontraditional training but real community connections; minority media, leadership networks and faith-based organizations; cultural traditions.

Major themes emerged to provide direction for future action:

- Minnesota needs a diverse, representative workforce. Organizations need to recruit, retain and promote professionals of color, immigrants and refugees, and people with low incomes.
- All systems must be accessible to all: culturally, linguistically, financially and logistically.
- Integration and cooperation is needed within and between different community sectors (health, housing, education, human rights, crime and justice, etc.). This is true for assessment, programming, evaluation and funding.
- More trust and cohesion is needed within and between different communities in order to achieve common goals.
- More flexible funding should be directed toward community-based organizations to support creative projects that are driven by community members and leaders.

MEETING SUMMARIES

Meeting #1: Wednesday, October 18, 2000, 6-8 PM

Important characteristics of a healthy community include:

- Well-being of the "weakest" is high priority (e.g., children, older adults, people with disabilities, people in poor physical and mental health). "We have to judge [a society] by – such as a football team – you are only as strong as your weakest link."
- Equal access and opportunity for all (e.g., employment, housing and education).
- Violence-free.
- Community members are seen as equal partners in finding solutions.
- Draws on strengths and skills of community members; looks for possibility and potential.
- Respect.
- Mutual dependence.
- Shared resources.

** It should be noted that 2 or 3 of the 6 participants specifically indicated having difficulty envisioning a healthy community because this is so far from their reality. "I don't live in a healthy community—how would I know what one looks like?"

Issues that must be addressed to improve health and quality of life include:

- Dehumanization of people in poverty.
- Classism, economic factors leading to/associated with poverty.
- Racism, prejudice, discrimination: on a personal as well as institutional/organizational level (workforce homogeneity, leadership development, etc.).
- Family unification.
- Unequal access to resources.
- Nothing seems to change (inertia).

- No sense of urgency (complacency). "There's not a sense of urgency to solve the problems…even at the meetings, there is no sense of urgency – we can wait for months, we will have another meeting, Joe has to go on vacation…"
- Doing "for" people causes alienation and/or creates dependency on services: a cycle of dependency.
- Organizations outside the community impose "one size fits all" programs and services.

Factors that keep the community from doing what needs to be done to improve health and quality of life include:

- Learned helplessness, hopelessness, psychological dependency.
- Limited access to services as a result of:
  - Lack of information
  - Lack of outreach
  - Services themselves are limited because of limited funding. "We all go downtown [to fundors] and get told 'no,' one at a time, or we all wind up with just enough to take a little tiny nibble out of a single issue…"
  - Racism, prejudice, discrimination.
  - Services aren't culturally competent (either developed by/for white people or assumption is made that services designed for one minority racial/ethnic group will work for all).

To improve health and quality of life, the community is taking actions such as:

- Hmong charter school.
- Mercado; community-run businesses.
- Peer education.
- Common Bond Community: integrating/linking resources to communities (not limited to just housing or health).

Strengths to build on include:

- Cultural traditions. ("Acculturation is bad for [one's] health.")
- Pledge to remain optimistic and committed to achieving change. ("When you say you're going to deal with disparities, you're opening a big Pandora's box. I'm skeptical. I don't think you're going to do anything. But I'll come to meetings. I'm not going to give up.")

Factors that keep the community-based organizations from doing what needs to be done include:

- Serious lack of collaboration across agencies and organizations (state level as well as community-based).
- Isolation in "boxes."
- Funding streams perpetuate superficial, ineffective piecemeal approaches.
- No one likes to fund innovative, new ideas, so communities are stuck with the old, ineffective methods. "The same old established (white) organizations get funding, but these agencies aren't equipped to serve our communities." "They [these organizations] don't know what they don't know."

- Staff is stressed from stretching limited resources to meet great need; Constant difficult choices of who to "serve" with limited funds can be very stressful for staff.

Some of the most important things we can do to improve health and quality of life include:

- Promote innovation.
- Hire (retain, promote) people of color into all positions.
- Develop leaders.
- Support asset-based community building. "A lot of people are saying, 'Forget about going to the hospital, we have our own way of medicine.'"
- Overhaul existing government regulations and zoning codes that perpetuate the status quo.
- Promote collaboration between government agencies and other organizations at the state and local levels.

MEETING #2: MONDAY, OCTOBER 23, 2000, 12-2 PM

Important characteristics of a healthy community include:

- Culturally responsive, community-based services, organizations, staff, etc.
- People of color/underserved people in decision-making positions (representative workforce), but majority buys in as well (not just tokenism).
- Good, stable, affordable housing. "If [a child is] in a shelter [s/he is] five times more likely to have an infectious disease, three times more likely to be hospitalized for asthma and six times more likely to have stunted growth…Homelessness among children is increasing rapidly in Minnesota."
- Cultural traditions/practices are valued.
- Safe.
- Economic mobility and opportunity, especially for youth.
- Celebrations.

Issues that must be addressed to improve health and quality of life include:

- Unequal access and opportunity.
- Lack of decent, affordable housing.
- Lack of health care coverage through some employers.
- Mental health services are underfunded and ignored due to "Minnesota Nice." "Yes, [mental health] is something that we have not really addressed or talked about - and because we have not talked about it and say that it is a problem - then there are not resources to really address the issue."
- Lip service to prevention but no action.
- We all must face the fact that poverty and other problems keep people employed—it's an economic issue. "Are we being honest that we want to eradicate issues that provide jobs for people?"
- Imbalance of power: majority/minority, "child/parent."

Factors that keep the community from doing what needs to be done to improve health and quality of life include:

- Culturally unresponsive services, no accountability to provide. "There [is] no accountability especially in the rural areas where clinics have a sign saying: 'Bring your own interpreter' – and they get the money from the federal government."
- Few trained health professionals of color/bilingual professionals in decision-making positions.
- Disproportionate incarceration of men of color (esp. African Americans) means absent fathers, more violence, teen pregnancy, etc.
- Youth are denied hope for the future, especially youth of color/immigrant youth. "There is a lot of youth very excited about their future. But they know that they cannot be excited or it is not all right to be excited because there is no future for them. 'I'm a bright student. I'm a great student. I participate in all of the school activities and I get involved in the community but now I am out of high school – I am 18'… now for some reason…these opportunities are not for them."

To improve health and quality of life, the community is taking actions such as:

- Neighborhood block clubs, discussing these issues block by block: NE Minneapolis.
- Outreach to new communities by bilingual workers who receive training and reimbursement (although not true for mental health services): Mankato.
- Youth leadership institute with culturally appropriate curricula: SE Minnesota.
- Hmong health education videos: Dr. Poua Xiong, St. Paul. "When the communities can really or really do have their own community services - that is a real good indicator of the health of the community."

Strengths to build on include:

- Readily available resources: faith communities (youth groups, services, etc.), minority media, sporting/cultural events, word of mouth, key individuals, schools.
- Community-based organizations already doing "the work."

Factors that keep the community-based organizations from doing what needs to be done include:

- Community organizations need more resources AND technical assistance to secure funding: "[With our organizations] it's always a day late and a dollar short."
- Lack of disaggregated data for the Asian community.

Some of the most important things we can do to improve health and quality of life include:

- Train, recruit, retain more health professionals of color and those from disadvantaged backgrounds.
- Make services culturally responsive on all levels: interpretation, diverse workforce, community involvement "It is very difficult for me as a nurse to encourage a family to put a demented elderly Hmong woman at an adult day care center that is specifically all English speaking - all Western food, - am I doing her more harm or am I doing her good?"
- Increase access to affordable housing.

- Provide technical assistance/funding to organizations working in communities.

MEETING #3, OCTOBER 24, 2000, 8-10 AM

Preliminary Issues:

- Need representatives from the meetings to help synthesize.
- Let people know what messages are being passed on as this information moves up the ladder.
- Keep information coming in—that's the key to effecting change.

Important characteristics of a healthy community include:

- Absence of fear related to safety, INS. "The community loses out…on the valuable resources of the individuals who don't participate because they are afraid of immigration officials or that. And also they lose out health-wise because I know a lot of people who don't go to doctors because they are afraid."
- "Community care system" – sharing responsibilities to care for one another.
- Community connectedness.
- Diverse, representative staff in decision-making positions. "…very, very few positions are opening up for people [of color] to be in places where decisions are being made or opinions are being shared about what is health care."
- Healthy kids, youth (drug-free, violence-free, mentally healthy).
- Healthy elders (both ends of age spectrum).
- Living wage jobs.
- Respect for diverse perspectives and commonality.

Issues that must be addressed to improve health and quality of life include:

- Fear of deportation, INS: some staff taking on "gatekeeping" duties that are not part of their job description.
- Concentrated poverty in a few neighborhoods.
- Racism, racial profiling and related stress. "I think the whole issue of racism is a huge thing and I think that we would lose sight of health if we didn't tackle the whole issue of racism and discrimination… all the isms because I think that that has a significant impact on health and health outcome and health status."
- An exclusive (how many did you keep out) rather than inclusive (how many did you serve) system of services. "You're treated like a criminal just trying to get health care."
- Hard issues like chemical dependency, violence in many communities. "See we've got a problem with drugs in our community; we've got a problem with violence in our community; we've got a problem with racism in our community. And I don't care what the health care system does, the health care system can't solve those problems because the health care system is not directed toward dealing with them problems."

Factors that keep the community from doing what needs to be done to improve health and quality of life include:

- Lack of affordable health insurance and challenging admissions processes. "It takes an average of 6 – 14 hours to get a family signed up for health care…and those are the ones we know are eligible."
- Kids in poverty are not diagnosed for disabilities or special needs before it's too late.
- Lack of interpreting services, especially for mental health.
- Stress related to racism, discrimination, leading to burnout.
- Culture of western medicine is the only valid one in the system.
- Communities themselves not taking responsibility for their own health. "So we are looking at how does the community take care of itself? How does the community think about its own health? It's really clear to us that the system is not responsible for us. It's not. I mean, we have lots of evidence. The system is not responsible, as it can't be, and we shouldn't let it be."
- American health care system is a last resort for many communities, so it gets the sickest patients.

To improve health and quality of life, the community is taking actions such as:

- Mille Lacs Band of Ojibwe's Circle of Health: removing financial, logistic barriers to help people get in the door and into the programs they need. "We pay the premiums for [band members]; we pay their co-pays; we pay their deductibles. Whatever it takes to get them to get to the doctor…We do mailings; we've done phone calling saying, 'Come on in. You can get insurance. We'll help you. We do whatever we can to help Band members and their families get medical and dental coverage.'"
- African American Family Services: community-based programs.
- Powderhorn Philips Cultural Wellness Center: promoting community connectedness.

Strengths to build on include:

- Health professionals trained in other countries.
- Other cultures' view of health, medicine.
- Bilingual, bicultural staff.
- Constituency-run agencies, organizations. "The thing that works at Head Start for us and this is a federal mandate which I don't know why they don't why they don't do with other funds, is that HeadStart dollars nationwide are run by the parents. We have in Hennepin County over 300 staff over half of which were HeadStart parents and that's from the top down. Most of our administration as well has been HeadStart parents."

Factors that keep the community-based organizations from doing what needs to be done include:

- Lack of and restricted funding for innovative projects, community-based programs.
- Agencies/communities not using the same determinants of health.
- Inability to attract and RETAIN health professionals of color in the community. "In the past four years, we've been working with Hennepin County residency program…The minute that the doctor or nurse of color graduates, they leave the community. Being in the community is a huge burden for them. And so we're say-

ing to them let us look at how can we reduce the burden of staying in the community and beginning to take care of people of your own cultural ethnic group."

Some of the most important things we can do to improve health and quality of life include:

- Promote community connectedness and support at a community level.
- Empower newcomers, help them navigate the health care and wider systems. "…as our community changes in Minneapolis, our staff changes, we don't hire interpreters; we hire staff that speaks all the languages of our community."
- Judge the system on inclusivity, not exclusivity. "I keep thinking of it as in terms of education. Not that we have an ideal education system, but everybody is in it. There's not a question as to whether or not you go to school …access is not an issue on education. Health care is a continual discussion of access and eligibility so you're in and you're out, you move, you change clinics. It's the most complex system we can make."
- Do not put numbers (top 2, 2-3 most important) on the issues to be dealt with: most people have more than a few in their lives.
- Educational institutions that receive public funding (like the University) should be mandated to provide the community with professionals that reflect the make-up of the population.

Additional strategies from invitees who were unable to attend the meetings:

- Create incentives for current health care professionals to better understand racial, ethnic, and linguistic minorities, such as higher compensation to health care professionals that acquire a foreign language that is present in the community.
- Establish a certification process for medical interpreters. It is our belief that in areas where a persons rights and/or livelihood are at stake, certified interpreters should be used whenever possible.
- In an effort to reduce the number of uninsured and underinsured in Minnesota, the State of Minnesota should partner with the business sector to try to assure that all employed Minnesotans and their families have adequate health coverage. Examples include:
  - –Incentives for businesses to offer health coverage all of its employees.
  - –State/business collaborations to better inform citizens on how to supplement business provided health care coverage with state provided coverage.

APPENDIX E

The Guide to Community Preventive Services: Sociocultural Environment Chapter

The Task Force on Community Preventive Services was formed in 1996 under the auspices of the U.S. Public Health Services with the charge of summarizing what is known about the effectiveness of community-based interventions to improve population health. The *Guide to Community Preventive Services: Systematic Reviews and Evidence-Based Recommendations (Guide)* will evaluate the effectiveness of health promotion and disease prevention interventions applied in community-based settings in 15 public health areas, including the Sociocultural Environment. The Sociocultural Environment Chapter of the Guide will include evaluations and recommendations on interventions to reduce health inequalities through modifying the social environment.

The conceptual framework shown in Figure 1. was used to develop the chapter. This framework portrays health as a product of social institutions and processes, not merely the result of individual risk factors for disease. The conceptual framework provides a means to characterize health-related dimensions of the social context by identifying six interacting, observable, community-level conditions: (1) neighborhood living conditions; (2) community development and employment opportunities; (3) civic engagement and collective efficacy; (4) community norms and customs; (5) education and developing human capacity; and (6) health promotion, prevention, and care. These conditions are quantifiable, and thus, offer a means to account for why communities with few social resources experience poorer health outcomes. Rather than focusing on high-risk individuals, this perspective points to high-risk social conditions which are amenable to community-level intervention.

A priority-setting process among national experts yielded the following interventions for systematic review:

(1) early childhood development programs;

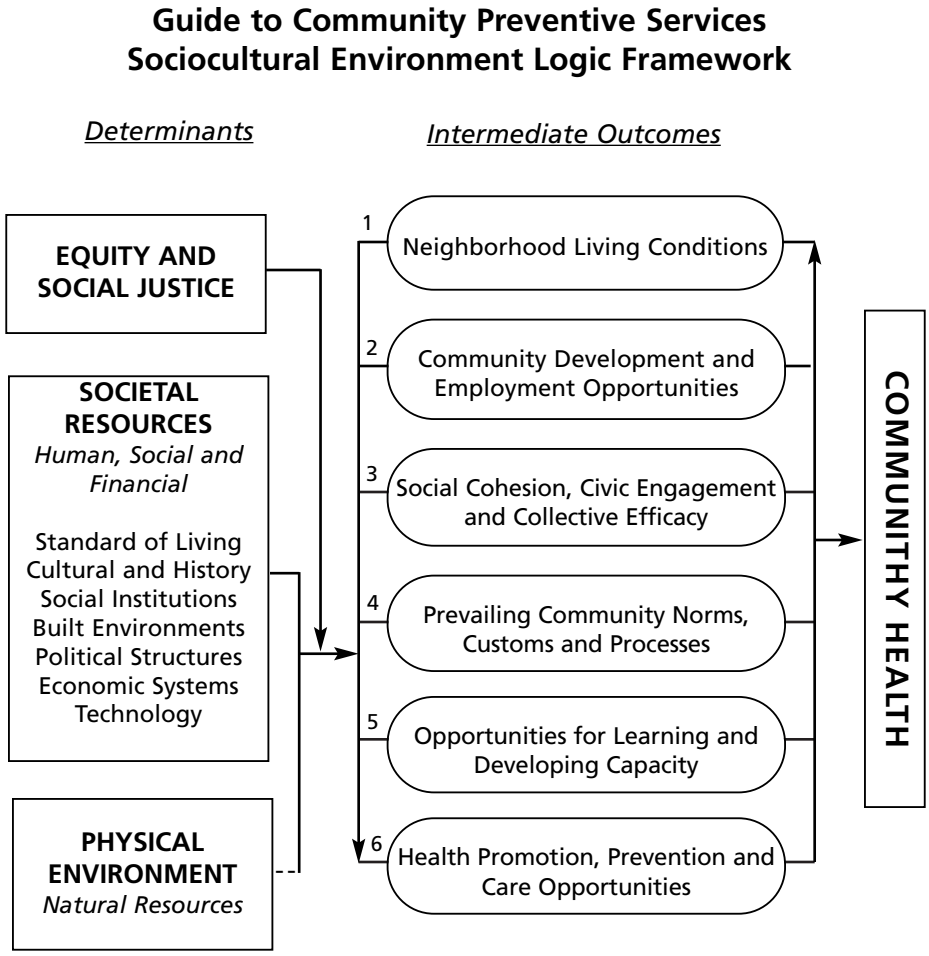
(2) adequate public investment in education;

(3) minimum wages to move working families above poverty;

(4) mixed-income housing; and

(5) access to quality health care: cultural competency of health care systems.

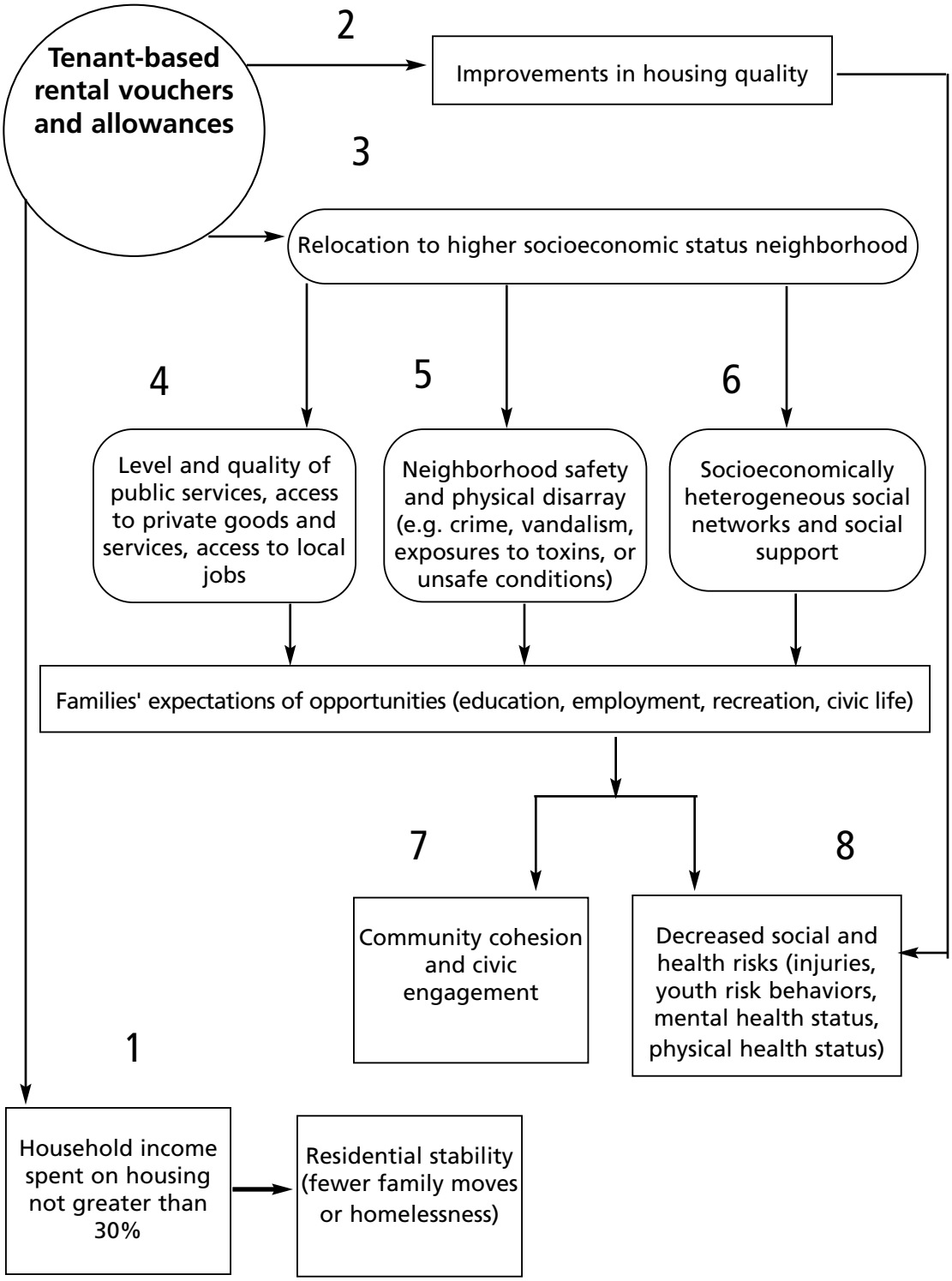
Figure 1. Logic Framework for the Sociocultural Environment Chapter



SOCIETAL RESOURCES refers to the presence of basic resources which may support health, while EQUITY and SOCIAL JUSTICE refers to the distribution of these resources within the population

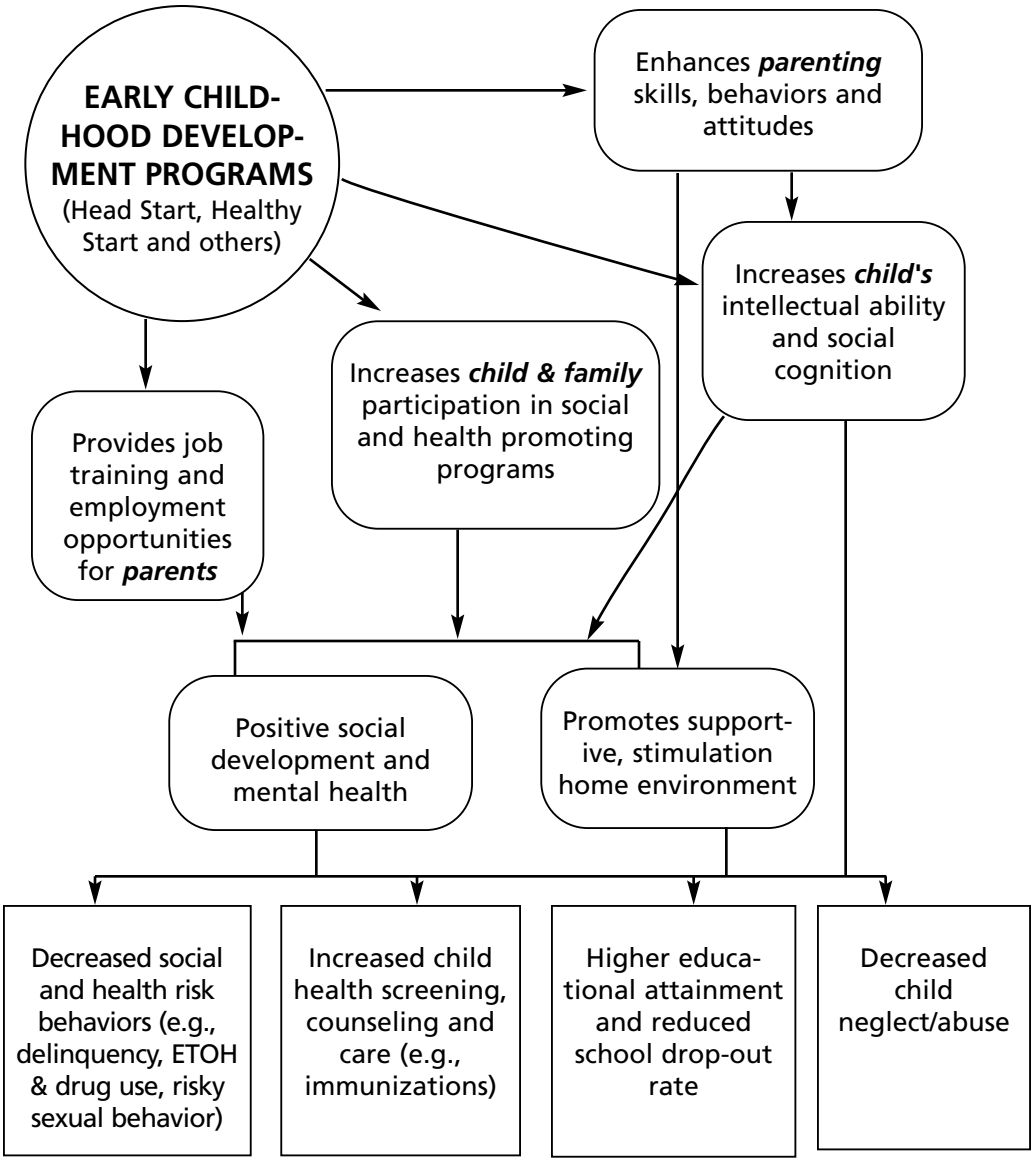
---- A pathway that will not be examined
Links 1-6 indicate strategic points for intervention

Analytic Framework: Tenant-Based Rental Voucher



A work in progress for the Guide to Community Preventive Services Sociocultural Environment Chapter. For more information see www.thecommunityguide.org

Early Childhood Development Programs: Analytic Framework



--- topic will not be included in evidence review

A work in progress for the Guide to Community Preventive Services Sociocultural Environment Chapter. For more information see www.thecommunityguide.org

Chapter Development Team:
Laurie M. Anderson, PhD, MPH, Centers for Disease Control and Prevention
Mindy Fullilove, MD, Columbia University
Susan C. Scrimshaw, PhD, University of Illinois, Chicago
Jonathan Fielding, MD, MPH, County of Los Angles Department of Health Services
Jacques Normand, PhD, National Institutes of Health
Ruth Sanchez-Way, PhD Substance Abuse and Mental Health Services Administration

Contact: Laurie M. Anderson, CDC-EPO-Community Guide
Phone: (360) 236-4274 Fax: (360) 236-2445 Email : LAA1@cdc.gov

APPENDIX F

COMMUNICATIONS PLAN

Introduction

In the past five years, several hundred studies have been published on various aspects of the relationship between social conditions and health. Social conditions include things like socioeconomic status, housing, transportation, education, isolation, poverty, spirituality, and pollution. Some researchers argue that economic inequality is now the most powerful predictor of ill health. Consequently, the National Institute of Health declared in 1998 that the relationship between social status, race, and health is now one of its top priorities.

Those concerns are also reflected in the priorities set by the Minnesota Department of Health and published in the *Healthy Minnesotans 2004.* Goal 18 of that report specifically states that the Social Conditions and Health Action Team will develop strategies and tools that public, private, and nonprofit organizations can use to:

- Deepen their understanding of the social conditions that affect the health of Minnesotans, and
- Identify action steps that Minnesota Health Improvement Partnership member organizations and the Minnesota Department of Health can take to address these issues.

In the course of its work, the Action Team (which considered social conditions as distinct from health behaviors and recognized that health disparities across race/ethnicities are often the product of structural and institutional arrangements) identified six distinct audiences to target as we work to foster an understanding of the social conditions that affect health. The audiences (i.e., the general audience, public health leaders and workers, leaders of groups affected by health disparities, government and policy makers, business, and media) are detailed in the Communications Plan below.

We will be particularly challenged in our efforts to communicate with the general public for two primary reasons. First, we need to explore and build consensus around the health improvement actions to be taken. Second, limited financial and human resources will affect the scope of communication with such a large, diverse audience. Yet, because the health of all members of society is linked, we want to communicate with all Minnesotans to raise awareness, understanding, and dialogue about the social conditions that affect health. We want to build support for collective action to reduce health disparities, especially as the public influences expenditure of public funds and public policy.

Goals and Strategies

Communicating the outcome of our work and disseminating the Action Team's final report are integral to the Team's work, and the expressed priorities of its members. The Action Team's communication goals include:

- Raising awareness and understanding of the social conditions that affect health and the health disparities that have been documented in Minnesota.
- Promoting understanding of the collective and individual role that Minnesotans play in creating, perpetuating, reducing, and eliminating the social conditions that affect health.
- Encouraging dialogue within and between audience segments.
- Building support for collective action to reduce the socioeconomic disparities that lead to health disparities.

The strategies for reaching our audiences include:

- Assessing communications options.
  - Leveraging the knowledge and networks of Action Team and Minnesota Health Improvement Partnership (MHIP) members to identify communications vehicles for this audience.
  - Leveraging the knowledge and networks of Action Team and Minnesota Health Improvement Partnership (MHIP) members to identify key decision-makers, supporters, and detractors for this audience.
- Summarizing research findings in easy-to-understand language:
  - Disseminating research findings and existing data.
- Creating forums for discussion and the exchange of ideas.
  - Designing forums to facilitate cross-audience dialogue and understanding.
  - Designing forums to permit disagreement.
  - Designing forums to build consensus and recruit supporters.
  - Designing forums to include Minnesotans from different socioeconomic, cultural, and geographic groups;
- Developing a method that people can use to rate performance of agencies and policy makers on these issues. Periodically publishing these "report cards" to raise awareness and encourage collective action.

Audiences and Key Messages
The Action Team has identified six distinct audiences to target as we work to foster an understanding of the social conditions that affect health: the general audience, public health leaders and workers, leaders of groups affected by health disparities, government and policy makers, business, and media.

Audience: *General*
The general audience represents all people in Minnesota; it includes the general public, as well as core communications with the other audience segments we've identified. The general audience is an integral part of specific social conditions, such as neighborhood cohesion, spiritual health, and racial and socioeconomic tolerance; they are the "social" in social conditions. In addition, this group influences public policy and the expenditure of public funds through public opinion.

Key messages for this audience include:

- Health is about more than health care.
- Health is about more than public health programs and policies.
- Health is also about social housing, taxes, income, education, community connectedness, and equal opportunity.
- We cannot eliminate health disparities without addressing the social and economic environment.
- A healthful social environment benefits the whole community.

Audience: Public Health Leaders and Workers
Governmental public health agencies are responsible for activities intended to protect and promote the health of the population. They prevent epidemics and the spread of communicable diseases, protect us from environmental hazards in our water and soil, prevent injury and violence, encourage healthful behaviors that reduce other health costs, respond to disasters, and provide essential services to at-risk populations not served by the medical care system. In Minnesota these public health activities are carried out through a unique partnership between state and local government. However, no single economic sector—government or otherwise—can successfully address all the social, economic, and behavioral issues affecting health. Instead, health must be achieved through a collaborative effort, one that

harnesses the resources of the public, private, and nonprofit sectors, as well as those of individuals, in a common enterprise. Public health leaders and workers contribute to this common enterprise by providing coordination and leadership in health promotion, disease prevention, and early detection.

Key messages for this group include:

- Same messages as for all audiences and the general public.
- Minnesota is consistently regarded as one of the healthiest states, yet we have some of the biggest health disparities in the nation. Populations of color, children with special health needs, and foreign-born populations, among others, do not enjoy the same level of health as other Minnesotans.
- Eliminating disparities will require systems and social change, which will require stronger partnerships across the community. You are working with a collaborative of other stakeholders, agencies, and individuals.
- There are some immediate actions you and your agency can take, and there are other, longer-term actions you can work toward.
- It's okay to advance these goals incrementally.

Audience: ***Leaders of Groups Affected by Health Disparities***
Minnesota ranks very high in health status nationally; yet populations of color, low-income groups, and foreign-born populations, among others, do not enjoy the same level of health as other Minnesotans. Barriers to improved health often go beyond problems with access, and may include poverty, language, and culture, and other socioeconomic factors. Community groups serving those populations most affected by health disparities, those bearing the greatest burden of poor health, can work to alleviate the effects of these barriers. Their leaders can facilitate dialogues that stress the strengths and successes of these groups, as well as the challenges they face in terms of health disparities.

In general, state and local government agencies and other health and social service systems have much to learn from members and leaders of these disadvantaged groups. Indeed, there is little more this communication plan could aim to tell them about the social and economic forces that shape health, that they haven't already experienced in their day-to-day lives.

The focus of communications activity with members and leaders of these groups should therefore include:

Listening

Providing data (tables, graphs, and narrative interpretation) on health status and health disparities so that affected groups can use this information in advocacy and grant-writing activities.

Key messages include:

- Same messages as for all audiences and the general public.
- Populations of color and low-income groups generally have worse health than the overall population.
- These health disparities are big, consistent for many health indicators, and (in some cases) growing.
- Many community members and researchers agree that eliminating these disparities will require even more than access to culturally competent health care and healthy personal behaviors.
- In order to eliminate these disparities, all people in Minnesota need equal access to resources such as a quality education, economic opportunity, opportunities to participate fully in the cultural and civic life of community, and opportunities to develop their full potential.

Audience: *Government and Policymakers*
State and local government public health agencies are not the only entities with responsibilities related to health. Other government agencies (e.g., Department of Human Services, Minnesota Planning, Department of Children, Families and Learning, etc.) have an interest in promoting understanding of how social conditions affect health. In addition to these government employees, the government and policymakers audience includes elected officials (e.g., school board members, county commissioners, and state and local elected officials), whose actions affect both the social environment and the health of the population.

Key messages for this group include:

- Same messages as for all audiences and the general public.
- Everyone in this community should have the opportunity to maintain a reasonable standard of living and quality of life.
- The health of communities is affected not only by actions in the health sector, but also by actions in the areas of housing, transportation, recreation, taxation, etc.
- While economic development is important, it alone does not necessarily lead to improved health and quality of life. We need to provide equitable access to jobs, education, transportation, health care, and other basic services.
- There are some immediate actions you and your agency can take, and there are other, longer-term actions you can work toward.
- Immediate actions may also provide long-term benefits and costs savings (e.g., more funding for HeadStart means reduced costs of law enforcement and prisons), which should be exposed.

Audience: *Business*
This audience includes employers, business leaders, and the business community. The actions of this group have profound effects on the social conditions that affect health, including particular influence over wages, pollution, and access to health care, and, to a lesser extent, over transportation, housing, environmental, and education policy and spending. In addition, the energy and efficiency of the private sector can be harnessed with other sectors to address the social, economic, and behavioral issues affecting health

Key messages for this audience include:

- Same messages as for all audiences and the general public.
- The actions of the business community have powerful effects on the social environment, which in turn affects health.
- The quality (and equality) of the social environment has powerful effects on people, which in turn affects employers, employees, and the economy.
- Productivity, workforce preparedness, quality of life, and other business drivers are linked to health.
- Investments in reducing disparities will improve health, boost productivity, improve education, and improve the ability of Minnesota businesses to compete, and capture, new wealth.
- Not investing in reducing disparities will result in lost opportunity to advance in these areas.
- Economic development is important, but does not necessarily lead to improved health and quality of life.
- Improved access to health care alone is not sufficient to improve health. Coordinated dialogue, research, and tracking (to improve understanding of the role of employers and the business community in creating, perpetuating, reducing, and eliminating the disparities that adversely affect health) will help advance these goals.

Audience: *Media*
Media refers to the variety of formats, or pathways, by which messages reach their audiences. Media channels range from network television and national newspapers to cable access television and organizational newsletters. Public health campaigns sometimes use the media as their primary agent for changing population behaviors or awareness; more often, however, the media plays a complementary role. It works in conjunction with other interventions. Action Team members have identified a number of potential media outlets. These include public and cable television, radio, newspapers (local, community, and ethnic), magazines, and web pages.

Key messages for this group include:

- Same messages as for all audiences and the general public.
- The health of communities is affected not only by actions in the health sector, but also by actions in the areas of housing, transportation, recreation, taxation, etc.
- Minnesota is consistently regarded as one of the healthiest states, yet we have some of the biggest health disparities in the nation. Populations of color, children with special health needs, and foreign-born populations, among others, do not enjoy the same level of health as other Minnesotans.
- Eliminating disparities will require systems and social change, which will require new and stronger partnerships across the community.
- While economic development is important, it alone does not necessarily lead to improved health and quality of life. We need to provide equitable access to jobs, education, transportation, health care, and other basic services.
- Immediate actions may also provide long-term benefits and costs savings (e.g., more funding for HeadStart means reduced costs of law enforcement and prisons), which should be exposed.
- A collaborative of stakeholders, agencies, and individuals is committed to working on this issue.
- It's important to consider what will happen if we don't act now.