INTRODUCTION
David Satcher, former Surgeon General of the United States, recently stated that “Although critical to eliminating disparities, access [to health care] only accounts for 15% to 20% of the variation in morbidity and mortality that we see in different populations in this country.” To change the factors that account for the other 80% to 85%, we will need to look far beyond the health and medical sectors of society and focus on the root causes of poor health.

This report aims to identify health inequities in Alameda County, explore their underlying causes and propose possible actions to eliminate inequities. Specific economic and social policies are suggested to achieve greater health equity in our county. The importance of, and our commitment to, working collaboratively across sectors and with various stakeholders—neighborhood residents, community-based organizations, advocacy groups, local planners, and government agencies—to influence policy change is underscored.

Following this Introduction, Part One (Health Inequities) describes the nature and magnitude of health inequities in Alameda County as they specifically relate to place, income, and race. Part Two (Social Inequities) examines inequities in key economic, social, physical, and service environments that contribute to the health inequities described in Part One, including 1) segregation; 2) income and employment; 3) education; 4) housing; 5) transportation; 6) air quality; 7) food access and liquor stores; 8) physical activity and neighborhood conditions; 9) criminal justice; 10) access to health care; and 11) social relationships and community capacity. For each of these eleven areas, the connections to health are explained, relevant county-level data are provided, and policy goals and implications for action are proposed.

How and Why Is Alameda County Public Health Department Involved?

It is the role of the Alameda County Public Health Department (ACPHD) to inform the public and public officials of what research and local data reveal about health inequities in Alameda County. While acknowledging that the political will for implementing some of the suggested policies is limited, it is important that the ACPHD offer our professional judgment about how to bring equal resources and opportunities to all communities. We are committed to working with stakeholders and decision makers across sectors to identify, prioritize, and advocate for policy solutions based on analysis of potential health and social equity impacts.

In order to move forward to address the root causes of health inequities and improve the health of all people in the county, ACPHD undertook a participatory process of strategic planning in 2007. We conducted internal discussions on racism, gender discrimination, and class exploitation; held seven community forums including one for Spanish-speaking residents; had dialogues with the Public Health Commission, ACPHD staff, and Alameda County youth about their vision for a healthy Alameda County; interviewed the Board of Supervisors and other key stakeholders; created an on-line survey to get input from all ACPHD staff; and held two planning retreats to finalize the plan. Our efforts to address health inequities are guided and supported by our strategic plan (summarized on page 4).

ACPHD is using the Bay Area Regional Health Inequities Initiative’s (BARHII) Framework for Health Equity (Figure 1 on page 4) to understand and address the multiple pathways that lead to stark differences in health outcomes. Traditionally, public health departments work on the right side of the chart—providing immunizations, diabetes education, smoking cessation, and other services to individuals in need. Health
education and access to health care can influence, but only partially explain, different health outcomes. These public health strategies are essential because they affect risk behaviors and access to health care services, which we know influence health outcomes. However, one can see by moving “upstream,” that health inequities do not merely arise from individual variation in genes, health knowledge, and risk behaviors. The economic, social, and physical environment, as well as available services in neighborhoods all shape behavioral choices and disease risks. The policies and practices of powerful institutions strongly influence the environments where people live, work, and play. Finally, broad social inequalities create and structure differential access to power, resources, life chances, and opportunities—all of which determine the distribution of health and disease within the population.

To address the root causes of health inequities, ACPHD is bridging downstream and upstream public health activities highlighted in the BARHII framework.

Figure 1: Framework for Health Equity

<table>
<thead>
<tr>
<th>Socio-Ecological Model</th>
<th>Medical Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Upstream</strong></td>
<td></td>
</tr>
<tr>
<td>Discriminatory Beliefs (ISMS)</td>
<td>Institutional Power</td>
</tr>
<tr>
<td>Race</td>
<td>Corporations</td>
</tr>
<tr>
<td>Class</td>
<td>Businesses</td>
</tr>
<tr>
<td>Gender</td>
<td>Government agencies</td>
</tr>
<tr>
<td>Immigration status</td>
<td>Schools</td>
</tr>
<tr>
<td>National origin</td>
<td></td>
</tr>
<tr>
<td>Sexual orientation</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social Factors</th>
<th>Health Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapted from the Bay Area Regional Health Inequities Initiative</td>
<td>Access to Health Care</td>
</tr>
</tbody>
</table>

**Alameda County Public Health Department Strategic Plan 2008-2013**

1. Transform our organizational culture and align our daily work to achieve health equity.
2. Enhance public health communications internally and externally.
3. Ensure organizational accountability through measurable outcomes and community involvement.
4. Support the development of a productive, creative, and accountable workforce.
5. Advocate for policies that address social conditions impacting health.
6. Cultivate and expand partnerships that are community-driven and innovative.
Introduction

(Figure 1). Public health work continues to address the downstream factors—“Individual Health Knowledge” and “Risk Behaviors” and “Health Care Access.” Moving more to the upstream side, the City-County Neighborhood Initiative is designed to change “Social Inequities”; institutional change work is intended to lessen “Social Inequities” as well as to influence institutional decision-making (“Institutional Power”); and policy change activities are designed to address all three upstream levels— “Discriminatory Beliefs,” “Social Inequities,” and in particular “Institutional Power.”

The City-County Neighborhood Initiative (CCNI) builds the capacity of neighborhood residents to assess and address violence and other health inequities. Founded in 2004, the CCNI is a place-based partnership between the ACPHD, City of Oakland, community-based organizations, and neighborhood resident groups. The CCNI community capacity-building approach builds upon existing neighborhood assets. City and county staff work closely with residents to increase their leadership skills and build their social, political and economic power. Residents can leverage this power to create healthier neighborhoods. For example, residents have advocated successfully for cleaning up local parks and reining in nuisance liquor stores. More details about this initiative appear in the Social Relationships and Community Capacity section.

Institutional change within ACPHD is a crucial component of our work. As staff members are called upon to address increasingly complex health equity issues, mechanisms must be in place to build internal capacity. Staff continue to work with national, state, and local partners, universities, and others to increase our understanding of and ability to address these issues. In addition, we have created a five-module Public Health 101 training series for all staff that covers 1) the history of public health; 2) cultural competency and cultural humility; 3) undoing racism; 4) health inequities; and 5) community capacity building. Trainings on policy are offered to staff who are engaging in more focused policy work. Staff members have offered recommendations that will be incorporated into future trainings.

Policy change to affect health inequities is a central focus of our work. Place Matters is a national initiative of the Joint Center for Political and Economic Studies, Health Policy Institute, designed to improve the health of participating communities by addressing social conditions that lead to poor health. Addressing these root causes of health through action and policy development and using data to look at changes in the social conditions that affect health are at the heart of the Place Matters work. As a partner in the Place Matters initiative, the role of ACPHD is to develop a local policy agenda. This report, Life and Death from Unnatural Causes: Health and Social Inequity in Alameda County, informs that agenda and reflects our commitment to inspire and inform necessary policy changes. For more information about the health equity work of the ACPHD, go to http://www.acphd.org/healthequity/index.htm.

Unnatural Causes: Is Inequality Making Us Sick? is a recently released documentary film series that has informed and inspired this report. Produced by California Newsreel, the oldest non-profit, social issue, documentary film center in the country, Unnatural Causes: Is Inequality Making Us Sick? is intended as a tool to help communities discuss health inequities and their root causes. In partnership with the National Association of County and City Health Officials (NACCHO), our local partners and over 100 health departments and other organizations across the country, ACPHD uses this tool to promote discussion of root causes of poor health in Alameda County.

The documentary as well as a recent report by the MacArthur Foundation Research Network compare societies to ladders, explaining that “the rungs of the ladder represent the resources that determine whether people can live a good life—prosperous, healthy, and secure—or a life plagued by difficulties—insufficient income, poor health, and vulnerability.” People stand-
ing on the top rungs have the most access to the economic, social, physical, and service resources to help them maintain good health, while people on the bottom rungs lack access to many or all of these material benefits and power. The report also notes that while people in the middle may fare better than those on the bottom, they still have worse health than those at the top. Policy decisions can impact how long and steep the ladder is, or how much inequity there is between those on the top and the bottom. The report states that “of all the outcomes determined by your position on the ladder, none is more fundamental than this: it predicts how long you will live and how healthy you are during your lifetime.”

What Makes Communities Healthy?

During the 2007 strategic planning process, the Alameda County Public Health Department asked this question of community residents and partners, local politicians, and ACPHD staff. Answers came back with remarkable consistency. Participants identified priorities in four arenas: first, the economic environment, including access to good jobs, diverse businesses that support the neighborhood, as well as policies that facilitate home ownership. Second, crucial elements of the social environment, such as safety, trust, good relationships with police, policies that address structural racism, and social support for everyone, especially those most in need, such as youth. Third, they told us about aspects of the physical environment that help make communities healthy, such as clean air and water, safe places to walk and play, access to healthy foods, and quality affordable housing. Finally, they mentioned the service environment that is needed to have a healthy community, including not only access to health care and information about health, but also other services that can affect health, like access to quality education and reliable transportation. This framework for organizing the factors essential for community health is consistent with that developed by PolicyLink, a national research and action institute. PolicyLink suggests that the four aspects of neighborhood environments provide a helpful framework for shaping healthier communities.

Why Are Some Communities Healthier Than Others?

When one or more of the four environments—economic, social, physical, and service—are weak, the health of the community suffers. Many of the people we heard from during the strategic planning process observed that the broader determinants of health are not equally distributed throughout the population. Some communities are rich in resources and as a result, have created and sustained health, whereas other communities struggle to be healthy because of inadequate resources. They also recognized that policy decisions determine the resources available to communities and that a more equitable balance of power in decision-making is critical for eliminating health inequities.

Research is amassing nationwide which establishes that health outcomes are linked to place (where people live) and the level of resources and opportunities for health available to them based on race, income and

---

**A Framework for Healthy Communities**

1. Economic environment
2. Social environment
3. Physical environment
4. Service environment

---

a. The Aspen Institute states the term structural racism is “used to describe the ways in which history, ideology, public policies, institutional practices, and culture interact to maintain a racial hierarchy that allows the privilege associated with whiteness and the disadvantages associated with color to endure and adapt over time.” See page 27 for a full explanation.
education. Low-income people and people of color are more likely to be burdened by poor environments, which often include substandard housing, poor schools, and pollution. These are some of the disparate community conditions that have direct and profound consequences on residents' health.

Overall, the health of most groups in Alameda County is improving—people are living longer, healthier lives—but there are still large, persistent, and in some cases growing health inequities. For example, some groups living in the Oakland flats can expect to die, on average, more than a decade before other groups living in the Oakland hills and this gap in life expectancy appears to be increasing. This is clearly not a random statistic and reflects inequities in opportunities and exposures in these two areas. The residents of the Oakland flats, predominately low-income African Americans and Latinos, deserve the same opportunity to live in a healthy environment as the residents of the Oakland hills.

County-level data reveal large and persistent disparities in the economic and social factors that underlie these health inequities we see in Oakland. The gaps between Alameda County's haves and have-nots actually increased during the 1990s. In other words, the county experienced greater concentration of wealth in the hands of a few, decreased housing affordability, increased school segregation, and a loss of decent-paying jobs.

Current research can inform our understanding of broad health determinants and guide our attempts to advocate for policies that provide more equal opportunities and resources in all Alameda County communities. The following list, “10 Things to Know about Health,” taken from California Newsreel's documentary, Unnatural Causes: Is Inequality Making Us Sick?, summarize current research findings and should guide our collective work.

1. **Health is more than health care.** Doctors treat us when we’re ill, but what makes us healthy or sick in the first place? Research shows that social conditions—the jobs we do, the money we’re paid, the schools we attend, the neighborhoods we live in—are as important to our health as our genes, our behaviors and even our medical care.

2. **Poor health in populations is more than specific diseases.** People at lower levels of income not only have more illnesses, but they also have more comorbidity... Because morbidity clusters in particular vulnerable subgroups rather than being randomly distributed, overall improvements in equity in health are likely to require generic interventions rather than ones directed at specific manifestations of ill health (such as diseases).

   —Barbara Starfield

3. **Racism imposes an added health burden.** Past and present discrimination in housing, jobs, and education means that today people of color are more likely to be lower on the class ladder. But even at the same rung, African Americans typically have worse health and die sooner than their White counterparts. In many cases, so do other popula-
tions of color. Segregation, social exclusion, encounters with prejudice, one’s degree of hope and optimism, differential access, and treatment by the health care system—all of these can affect health.

4. *The choices we make are shaped by the choices we have.* Individual behaviors—smoking, diet, drinking, and exercise—matter for health. But making healthy choices isn’t just about self-discipline. Some neighborhoods have easy access to fresh, affordable produce; others have only fast food joints, liquor and convenience stores. Some have nice homes, clean parks, safe places to walk, jog, bike or play, and well-financed schools offering gym, art, music and after-school programs, and some don’t. What government and corporate practices can better ensure healthy spaces and places for everyone?

5. *High demand + low control = chronic stress.* It’s not CEOs who are dying of heart attacks, it’s their subordinates. People at the top certainly face pressure, but they are more likely to have the power and resources to manage those pressures. The lower in the pecking order we are, the greater our exposure to forces that can upset our lives—insecure and low-paying jobs, uncontrolled debt, capricious supervisors, unreliable transportation, poor child-care, no health care, noisy and violent living conditions—and the less access we have to the money, power, knowledge and social connections that can help us cope and gain control over those forces.

6. *Chronic stress can be deadly.* Exposure to fear and uncertainty trigger a stress response. Our bodies go on alert: the heart beats faster, blood pressure rises, glucose floods the bloodstream—all so we can hit harder or run faster until the threat passes. But when threats are constant and unrelenting, our physiological systems don’t return to normal. Like gunning a car, this constant state of arousal, even if low level, wears down our engines over time, increasing our risk for disease.

7. *Inequality—economic and political—is bad for our health.* The United States has by far the highest inequality in the industrialized world—and the worst health. The top 1% now holds as much wealth as the bottom 90%. Tax breaks for the rich, deregulation, the decline of unions, racism and segregation, outsourcing and globalization, as well as cuts in social programs, destabilize communities and channel wealth and power—and health—to the few at the expense of the many. Economic inequality in the United States is now greater than at any time since the 1920s.

8. *Social policy is health policy.* Average life expectancy in the United States improved by 30 years during the 20th century. Researchers attribute much of that increase not to drugs or medical technologies but to social reforms—for example, improved wage and work standards, universal schooling, and civil rights laws. Social measures like living wage jobs, paid sick and family leave, guaranteed vacations, universal preschool and access to college, and guaranteed health care can extend our lives by improving our living conditions. These are as much health issues as diet, smoking, and exercise.

9. *Health inequalities are not natural.* Health disparities that arise from our racial and class inequities result from decisions we as a society have made—and can make differently. Other industrialized nations already have, in 2 important ways: they make sure absolute inequality is less (e.g., Sweden’s relative child poverty rate is 4%, compared to our 22%), and they guarantee that everyone has a chance for prosperity and good health regardless of a family’s personal resources (e.g., good schools and health care are available to everyone, not just the affluent). As a result, they live healthier, longer lives than we do.

10. *We all pay the price for poor health.* It’s not only the poor but also the middle classes whose health is suffering. We already spend $2 trillion a year to patch up our bodies, more than twice per person than what the average industrialized country spends, and our health care system is strained to
the breaking point. Yet our life expectancy is 30th in the world, infant mortality 31st, and lost productivity due to illness costs businesses more than $1 trillion a year.²

As a society, we have a choice: reduce poverty, increase incomes and job security, and improve equality today or pay to repair our bodies tomorrow.

How Can We Work Together to Create Healthy Communities?

The people participating in our community forums expressed a variety of ideas about what we could do collectively to improve the health of all Alameda County residents. An overarching principle is that in order to truly eliminate health inequities in Alameda County, we must break free of traditional “silos”, sectors, and agency divisions to address the complex and multi-dimensional root causes of health inequities. Other key considerations of forum participants included the following:

- **Historically, policy decisions shaped both the positive and negative environments in which Alameda County residents live and work; therefore, policy change and enforcement is essential to reverse these trends, address social inequities, and improve health outcomes.** Formal, legislative policies are needed as well as informal institutional policies that are not legally required, but that can improve our collective ability to address inequities.

- **Residents must be involved in this process, not just as the recipients of services, but as leaders and participants in structural-level change.** Decision-making must be transparent. Agencies, officials, and staff must carefully address the forces and policies that have prevented residents from engaging in decision-making in the past. Professionals and bureaucrats must be willing to share power with community residents.

- **Eliminating health inequities will require sustained interventions that go beyond typical public health programs.** We will need to partner with residents, politicians, elected public officials, and other professionals and activists in the sectors of housing, city and regional planning, education, transportation, criminal justice, business and others in order to create structural change. In some of these areas, the public health sector has built solid partnerships that are already helping us get to the root of the problem; in other areas, we have yet to start. In all areas, there is much more to be done.

Conclusion

Wide and persistent inequities exist in the economic, social, physical and service environments where residents of Alameda County live and these environments affect health. Collectively, Alameda County has the opportunity to address inequities and ensure that our residents do not face death from “unnatural causes.” The Alameda County Public Health Department is committed to forming multi-sector partnerships in working with community residents to identify and advocate for policies that will reduce social and health inequities. Using our data and policy analysis capacity to evaluate the potential health and social equity impacts of proposed policies, we will track progress toward achieving health for all.
References


