Transcript of the Socially Determined Podcast

"Political Power and Public Health in California"
with Anthony Iton, Senior Vice President, California Endowment
2019

ANNOUNCER:
Welcome to Socially Determined, a podcast about the social determinants of health. This podcast is hosted by Dr. Gabriel Kaplan, Board President of the National Association of Chronic Disease Directors. Dr. Kaplan speaks with Dr. Anthony Iton, Senior Vice President at the California Endowment, about how political power, or lack of it, impacts the health of the public. Thank you for joining us. Enjoy the program.

DR. GABRIEL KAPLAN:
So Dr. Iton, thank you so much for joining us today. We're thrilled to have the opportunity to have this conversation.

DR. ANTHONY ITON:
Thanks for having me.

DR. GABRIEL KAPLAN:
So I wondered if you could tell our audience about how you and the California Endowment have sought to position public health organizations to address the social determinants of health.

DR. ANTHONY ITON:
Yeah. It's a real pleasure to work at a foundation like the California Endowment, having worked most of my career in public health organizations, in government public health organizations. And so I come to the work at the California Endowment which I often liken to a private public health agency because we have a mission to improve the health status of all Californians. I come to this work with a governmental public health sensibility, which is sort of accountability for trying to get to the root of a broad spectrum of health problems. And so, we've been supporting our public health agencies across the state, particularly the local public health agencies, but also the state public health agency to form coalitions across health departments. There's one in the bay area called the Bay Area Regional Health Inequities Initiative. We have one in Southern California and one in the central part of the state as well, to actually work together to develop new public health practices to target the social determinants of health.

And quite honestly, targeting the social determinants of health is not sufficient. Many organizations have sort of begun to think about the social determinants of health as sort of almost discreet factors that we have to target at the individual level to help individuals find housing, to help individuals navigate healthy food, to help individuals find safe places to recreate. All of which is important, but we think that taking an individual focus on these issues is just basically taking the medical model and applying to the social determinant. What we've tried to encourage organizations to do instead is to essentially develop an analysis which takes us to the root of why we see inequities in some many different domains of American human

existence, from education to employment to land use to criminal justice to health. And if you can craft an analysis that gets you to the root of that then you can start designing strategies that help tackle the root causes.

DR. GABRIEL KAPLAN:
That's excellent. We had a conference several months ago, our annual Chronic Disease Academy, where staff from across the country come and share ideas and hear from thought leaders and do some specific developmental work in particular chronic disease program areas. And Dr. Jill Mullin spoke to us, and she expressed alarm during a plenary session about what she called the medicalization of the social determinants of health problem. And exactly as you characterized, it is thinking that if we can simply connect doctor offices as human service hubs to meet the immediate needs of families with medical concerns then that's sort of a sufficient way of addressing the problem. And I think what you point out is that a population health approach is really what public health is best at, and what we're best at advising and sharing with folks and helping advance. And that's really what you're calling on the partners of the Endowment to do.

One of the things that I noted when I wrote out my president's challenge is that the fundamental challenge for public health to do that is we're arriving very often at tables where we haven't been before. And so we have to approach those tables with some degree of humility, we can't show up at an education roundtable and say, "Well, you've been doing education wrong for the last hundred years." Or at a housing department and saying, "Let us fix the way you run your housing programs." But we do want to achieve a public health perspective on a lot of these problems. So how do you counsel the partners of the Endowment to do that and how do you get public health at the table?

DR. ANTHONY ITON:
Yeah. That's a fantastic question. So let me give you a couple of principles that we try to embed in our support for public health. One is that there's this notion of what we call ‘inside out and outside in.’ So ‘inside out’ is working with people who operate within systems like an education system or land use system, or criminal justice system to find champions within those systems that are looking to engage in what we refer to as transformative change. Change that doesn't take the status quo as a given and questions what the core purpose of that institution is, is really supposed to be about. And then ‘outside in’ is engaging the people who are most impacted by the inequity being generated by that system or not being essentially appropriately responded to by that system. And so this notion of an inside out, and outside in a balanced strategy is about sort of shifting the decider, who decides what the agenda should be. To our view, too often that is the system decides.

We have the systems that essentially, and this is natural human behavior, it's not malicious or anything like that, but the systems, including public health systems, try to organize the world in ways that benefit that system so that problems are defined according to the solutions that that system has to provide. And what we'd like to help public health actors understand is that our role is to essentially put the resident, the community resident at the center of the decision-making process. That to us is about equity. And so in order to do that, you have to create mechanisms to empower community residents to participate in these decision-making processes outside of health. So when we're working with criminal justice, it's about formerly incarcerated people. How do we bring them to the table in a way that they can appropriately

interact to help set the priorities of that system? Similarly with education or land use or employment, what have you. So there's an idea behind this, which is that—and it's root democracy is good for your health. Optimizing meaningful participation in decision-making is good for people's health.

DR. GABRIEL KAPLAN:
That's great. I had sort of saved this question for later, but I think I want to ask it now because of where you've just left us. When I first heard you speak on this issue back in 2008 you stated that where you wanted to take this work, and I think you were still in the bay area at Alameda County at the time, was to look at community engagement, civic health and political empowerment and that that was where you felt the conversation needed to begin because anything else that proceeded from that wouldn't be sufficiently responsive to the fundamental issues that were creating the current social determinants of health. And so I wondered if you could talk to us about the experiences you've had in trying to address this issue and how successful you've been in using public health to activate community engagement and civic participation and community voice, and what are some of the techniques that you've employed to be successful with that?

DR. ANTHONY ITON:
Yeah. Wow, thanks for that question. Let me step back just a little bit because I want your listeners to understand that the way that I and others came to the conclusions that we've come to around optimizing democracy as a public health strategy starts with epidemiology. It starts with calculating life expectancy across jurisdictions at the census track level, and seeing dramatic differences across a political jurisdiction, a city, a county of 20 to 25, and some cases 30 years difference in life expectancy between different neighborhoods in the same place. And when you look at that, it's incumbent upon the public health community to explain what's producing those differences. And one of the first conclusions you have to reach is that these are places that live in the same political regime. In other words, they're served by the same health department, they're served by the same parks and recreation department, they're served, generally, by the same educational district.

So how is it that you have radically different outcomes across a jurisdiction that is served by the same sort of policy regime? And the only conclusion you can come to, at least to my mind—I mean, once you look at things like access to health care, you find that that doesn't correlate with these differences. Behaviors, they correlate somewhat, but not nearly enough to explain the differences. But the only conclusion you can come to is that people living in different places and under the same political regime have different levels of political power. Different levels of access to meaningful opportunity to make change in their communities. And I have example after example, story after story, about how the same agency performs different levels of service in different parts of the community depending in essence on how much power that community has relative to other communities in that same jurisdiction.

So looking at these maps in Alameda County, across California, in 30 cities across the US, we saw the same pattern replicating itself over and over and over again. And so at some level we started to ask ourselves, "Well, if this is the root cause—I mean, if differential power, differential levels of opportunity and the ability to essentially hold systems accountable even in the same jurisdiction, are shaping people's health outcomes, how do we get to the root of that?" And sort of plain and simple, we concluded that we needed to build social, political, and economic power

in a critical mass of people in the communities that were most impacted by the inequitable results, the ones with the shortest life expectancy, so that they could hold systems more accountable to essentially provide equitable outcomes. And that sounds like a fancy political speak or something like that, but the political outcomes we're talking about here are things like a park or a grocery store in your neighborhood. Those kinds of decisions are made at political decision-making tables. And those communities that lack sufficient power are much less likely to get an equitable allocation of those health protective resources like, again, a park. So that's how we came to that conclusion. I want people to understand that this was through an analysis of epidemiologic data primarily looking at life expectancy and differential outcomes across relatively small geographic areas that were profound.

Now how do we operationalize this? I want to just return a little bit to the answer I gave you before which is about this whole notion of an inside-out strategy. The inside-out is working with institutions and systems and the leaders and champions within those systems that are trying to transform those systems, but also an outside-in strategy which is essentially organizing a critical mass of people in a community to hold those systems like the school system or the criminal justice system or the land use system accountable for serving communities that have essentially the greatest degree of threat from inadequate services from those particular institutions. But let me stop — I do not want to go on too long with that, but let me stop there and see if that helps. I will point out, however, that when I say critical mass, and this seems kind of amazing to people, we're talking about half a percent or one percent of the population in question, we're not talking about masses of people. Our political system sways on the efforts of about .5 percent of the population.

DR. GABRIEL KAPLAN:
So it sounds like because of the important role of geography that local communities are just going to be essential to be the vehicles for doing this work. How would you counsel a state chronic disease program because they're very rarely sort of operating at that community level unless they are under a directive from the federal government to distribute some of this money to communities? And they tend to think more state-wide than systemwide. How can they sort of get involved in this game, and what kinds of roles and contributions can they play in that key role of activating a community? And as you said, it's not a large percentage of the community, but that really critical .5 percent of the local population that ends up being the influential factor that can steer a local debate towards the provision of important resources?

DR. ANTHONY ITON:
Yeah, that's a fantastic question. And so we grapple with this every day. There is a natural symbiosis that you're trying to generate in doing this work because we're a state-wide foundation. And so our community is the State of California, 40 million people. And what we recognize is that there is — you have to start locally, but you don't stop locally. You have to network and bridge the work that's happening across different places in the state and create these regional and ultimately state-like networks of effort that add up, in many cases, to advocacy for state level policy change. But in terms of who decides that agenda, that has to come from the people closest to the pain, the people that are experiencing the inequity in their day-to-day lives because we know what needs to be fixed. That's not what matters. It's whose priorities control how that agenda gets set. That's really the fundamental question. If it's in a domain of systems leaders like myself, a public health director who's saying that the issue is obesity, or the issue is poor diet, then that's where the resources will go.

But if it's in a domain of communities to make that decision, and they have the opportunity to sort of prioritize, the answer's going to be something very different. It's going to be about community safety. It's going to be about access to jobs. It's going to be about how policing is managed in their communities. And all these things, whether you believe it or not, the evidence is there. If we can improve those things, we can improve health outcomes because health is fundamentally about opportunity. It's not about just behavior. And these are the opportunity obstacles that communities are defining as the most salient in their lives. So bottom line, you start local but you don't stay local. You've got to build out from local and create the kind of networks and symbiosis as necessary across places to ultimately impact the entire state.

DR. GABRIEL KAPLAN:
It also sounds like if you're an obesity program manager at a state health department, that one of the first things you need to do before you begin approaching community is go around your department and talk to the other folks and say that you want to do this. Because there's no guarantee if you're bringing in federal obesity dollars that the community that you reach out to, maybe you picked it out because the obesity prevalence in that community is really high, or you identified that there is a food desert there and you want to do some work.

But there's no guarantee if we follow this model that that community's going to say, "Well, the first thing we want to work on is the thing that you came to us with interest in." Then they may say, "Yes, that's all interesting to us, but what we really want to talk about is the lighting on the streets." And they may be money that you can use—that may be a problem you can use your money towards addressing, but it may not be. And so if you have your drug control and your population health approach is the behavioral health team with you, you can connect to them as well. If the community wants to speak to those people, you're sort of serving partly as a broker and a navigator of the full broader public health system to sort of patch them through the resources that they really want to tap into.

DR. ANTHONY ITON:
Yeah. I think that you've crystallized the challenge. When I say what matters is who decides, that's what you just described. So if you're an obesity program manager at the state level, you've already decided that that's the issue that's of import in your work. And so you're inclined to try to impose that agenda on communities. Again, not maliciously, you're trying to help, but you're saying your problem is obesity. And that already is hubristic at a minimum, but it's not even close to reality. When people are being locked up or deported or being made homeless, and you're telling them that the problem is obesity, you're on a different planet than their reality.

So what's your responsibility to essentially frame your ability to help in a way that's actually relevant to the lives of the people that you're trying to help. What is your responsibility? And I think you've described one approach which is to work across your agency to find ways to braid and link resources that facilitate you being able to do two things. One is allow communities to set their own agendas and priorities, and B, to essentially invest resources towards the root of many problems. The root of tobacco use and obesity and various other different types of public health programs are often very similar. And so what it is it that you can do with your combined, your pooled resources that tackles that root cause?

DR. GABRIEL KAPLAN:

So one of the things that I like to say is that if you're going to be an employee of the government, to be effective you better be a master of bureaucracy. And that it's important to understand all of the rules. Whether those rules are procurement, hiring, what can be done with money, and what can't be done with money, in order to know best how to use the tools are at your disposal and how to use that information to advance your objectives. And so just sort not necessarily—but simply not to simply stand down in the face of bureaucratic obstacles but to be able to use them to advance your objectives. One of the things that strikes me in all of this is how do we begin to make the connection to tie back to outcomes and results and how do we connect the work that public health ends up supporting that comes out of these communities. And how do we cap the resources that we typically have? Because it's very rare that we have the kind of flexibility that an endowment might have.

Where there's a pot of money and there are social purposes which are articulated in the mission statement of that endowment and as long as the grants that that endowment issues are in support of that mission statement, then there are really no objections and concerns. I'm looking at some of my tobacco tax dollars and they come with a specific focus either on tobacco prevention or the mitigation of cancer that results from the use of tobacco. And so what are some examples perhaps that you can point to of places around the country or maybe in California where folks have taken money where it looks like it has a lot of strings and rules attached to it and been able to use it creatively in ways that allow them to give the money over to the community, have the community direct it to the thing that's of major priority to them with the understanding that there are going to be all these potential benefits that grow out of the disbursement of those funds that are in line with the objectives of those funding sources.

DR. ANTHONY ITON:
Yeah. That's a great question, right? It's translating sort of government-speak and restrictions into meaningful resources for communities. That's the artistry of public health practice in a nutshell. I'm going to give you two examples. One I was personally involved with. When I was the Alameda County Public Health Director, and this was, I think, in 2004, when bioterrorism was still a big sort of source of funding for local public health departments and we were all stepping up our bioterrorism prevention plans and we'd been through SARS and various other different—anthrax, and various other things. I happen to have been in Connecticut during the anthrax episode when a 97-year-old lady in Connecticut died of anthrax through cross-contamination in her mail and I got caught up in the whirlwind of having to design a protocol to test a postal distribution center for anthrax residue. So in 2004 I was in California and bioterrorism money was coming down and people were trying to develop these plans. And one of the things that was very clear to me and we'd seen examples of it.

There was a heat wave in the Chicago area in the mid-90s and many elderly people died. Many low-income people died for lack of air conditioning and safe places to seek respite from the heat. And a study was done that showed that poverty wasn't the best predictor of who died because similarly poor places had very different mortality rates, despite similar exposure to heat. And what they found was social networks and social connectedness was critical to essentially protect people from death, from prolonged heat wave. And so this whole notion of social isolation and people being disconnected started to present itself as an important variable in community health. So when the bioterrorism money came down, we designed a plan in Alameda County, which would essentially help communities organize themselves to be able to manage in the face of an acute disaster by building by their [inaudible] social networks within those communities. The idea was if we could strengthen, essentially, social cohesion and bring

people together in a time when there was no crisis, that when there was a crisis, they could lean on those networks to essentially protect themselves—and particularly the most vulnerable—because we knew government couldn't be everywhere. And government certainly in the first 48 to 72 hours was not going to be there for people. So we took bioterrorism money and we went door to door in two of our communities that we saw as being the most vulnerable, East Oakland and West Oakland, and we gave people emergency preparation kits. But the goal was really to essentially invite them to participate in community planning for emergencies and to create stronger social networks by facilitating ongoing opportunities for people to come together in their neighborhoods and communities.

When we presented this plan to our funders at the state, the state said, "No, you can't do that. That's not bioterrorism. It's not bioterrorism prevention." And we said, "Well, we have very good evidence that it is." And they said, "No. You shouldn't do that." In fact, somebody threatened that if I did it we'd go to jail for misappropriating money. But we did it. And it ended up being essentially the core funding that led to subsequent efforts to organize those communities and build more resilient communities for not just acute disasters, but for what we call kind of the constant hurricane in the lives of low-income people in Alameda County, that they were facing kind of disaster-level threats on a day in, day out basis. We just didn't describe them as such. So that was the root of some of the work that I've done subsequently with organizing as a strategy to enhance community health. It's this notion of building community resilience both at the individual level, at the family level, and then at the community level.

The other example I would give is essentially some work that happened in Fresno, California, around what they call their Parks for All campaign, which was really kind of taking an obesity prevention agenda and turning it upside down and saying, "Look, you say the issue is obesity. We say the issue is there aren't meaningful and safe spaces to recreate in Fresno." And so they took resources, some from us and some from others, to develop this Parks for All campaign, and delved into the city's land-use planning documents and found a five to one differential between parks per capita in the southern part of the city compared to the northern, wealthier part of the city. In other words, the wealthier part had five times more parks per capita than the low-income part of the city. And so they used the city's own data. They took the report and they blew it up and they put it on bus shelters. They put it on billboards. They put it in the newspaper. They wrote op-eds. And they drove the city to essentially reprioritize its park spending plan to essentially bring park resources to the southern part of Fresno and applied for some state grants and won some $10 million to essentially invest in parks and a parks master plan for the city of Fresno. So that's an example of a community taking an obesity prevention agenda and turning it into substantial resources for a recreational space that is equitable across the City of Fresno.

DR. GABRIEL KAPLAN:
That's fascinating. In another life, I was a political science student. And I wrote a paper for a master's class in political science on the Model Cities project from the 1960s. And it was part of Lyndon Johnson's Great Society initiative. And there is a common perception in policy circles, certainly in Washington, that the Great Society was a huge failure. And very often, people will point to program like the Model Cities Program that were deployed and shut down within two, three years' time. My own research showed that the driving force of— sort of ended the model cities program was the reaction of Democratic machines and urban areas that felt threatened by a lot of the initiatives to cede community voice and activate community empowerment. And so I

wonder you mentioned the threat that you might be jailed for making use of the obesity money in the way that you've made of it to do work that challenges systems leads systems to push back. And what kind of pushback can public health expect and what can they do in response to that? How do they — what you described is an act of remarkable courage.

I don't know that I, if threatened with jail, would be able to say, "Well, I'm going to do it anyway." But not necessarily, assuming a case is quite as dramatic as that. What can public health do to continue to speak truth to power, which is an incredibly important role despite the fact that, for most of us listening to this podcast, we are employees of government. And we have to be careful about that. What advice can you give the audience about balancing that role within the context of a public administration function?

DR. ANTHONY ITON:
Yeah. That's just a fantastic question. Really, really, well put and particularly at the state level. I think it's less of an issue at the local or county level. It's still an issue, but it's much more an issue at the state level where things are just so highly politicized and there's so much political scrutiny on actions. I'll say two things. One, when I was threatened with jail, I figured that that was an idle threat anyways, but—and the thing that saved me was that Katrina happened a few months later. All everybody was talking about community resiliency. So I was never in any serious jeopardy [laughter] of actually going to jail. But the question that you're asking me is one that I've faced so many times and I've seen so many of my colleagues face, and some come out on the good end.

A handful come out on a short end of that, even in places like San Francisco where the politics are pretty liberal. There's a lesson I learned in this work early on from a mayor that I worked with in Connecticut who ultimately became the governor of Connecticut. And he told me, he said, "Tony, it's not that I recognized you're the health director, and you've got an obligation to do what you think, and your best judgment will improve the health or protect the health of the citizens of this community. All I want you to do is give me a heads up about the positions that you're going to be taking. If I don't want to be out there and get ambushed by somebody saying that your health director is doing X, Y, and Z, I don't want you to seek my permission. I want you to just give me a heads up that something is coming up because you're essentially taking a political position, or aa health position that could be translated into a political position. And I was like, a-ha. So that's what it is.

My political bosses don't want to be ambushed. It's not that they want me to sort of fall into lust with their particular world perspective because they recognize that health is special. There's no anti-health constituency. And there are things that we can do from a health perspective that a lot of other people can't do. For instance, our land use partners frequently really welcome us to the table because they may be pushing a smart growth agenda or some sort of urban design agenda that sounds to developers as sort of a political agenda. If they can justify that agenda, density or what have you, around a health outcome, obesity prevention, reducing social isolation, reducing vehicle miles traveled and its impact on climate change and health benefits of that, they feel that they can move much further faster behind a health argument than they can behind it's just strictly planning argument.

So health has this sort of credibility and kind of, somewhat, less controversial kind of mantle that it can actually use to leverage policy strategies. The best example I have of this is when I was in Alameda County, and we decided to take on the Port of Oakland, which is the fourth biggest

container port in the United States. And it was producing significant diesel particulate emission in the West Oakland community, a low-income traditionally African-American community through port trucking, through port diesel trains, through burning so-called bunker fuel that many of the cargo ships used. And so the diesel particulate emissions in West Oakland and the consequent hospitalizations for asthma, chronic obstructive pulmonary disease, and congestive heart failure and various other forms of cardiovascular disease were, essentially, off the charts. And we decided we have to go after the poor to take steps to essentially reduce its toxic footprint. And before we did that, we went to our county supervisors who some of whom had served or did serve on the port commission and said, "Look, we're doing this. We're just giving you a heads up that we're taking on the poor. We're going to take them on publicly. We're going to write op-eds. We're going to stand with environmental justice actors in West Oakland that are fighting this particular issue. And you should know that we're doing this. And we're not telling you to seek your permission. We're telling you that this is our obligation as a health agency." And we got incredible support from our supervisors who appreciated the fact that we didn't let them get ambushed. And they said to me, they said, "Look, we may come out against you publicly, but we respect your right to take that position. In fact, that is your obligation as a health officer for this county. So we appreciate that." And that's in fact what happened. One of them came out against me politically saying, "You know, I disagree. We have to balance the economic interest against the health interest." Blah, blah, blah. But they didn't come after me to get me fired because I'd given them a heads up that we were going to do this, and I wasn't seeking permission. I was just trying to protect them from being ambushed.

DR. GABRIEL KAPLAN:
Well, that's a great, positive, inspirational note to end on. I'm afraid we're out of time. I could continue talking to you for several hours more because this is so fascinating and engaging. But I really want to thank you for your time. You've been really generous with us. And I have learned so much in this conversation. And I am pretty confident I'll be following with some additional questions from my own state in writing with you. So thank you very much Dr. Iton.

DR. ANTHONY ITON:
Well, thanks for having me. I really appreciate the thoughtfulness of your questions. And this was very enjoyable. There are a couple of places that your audience can go to, to learn more about the work of the California endowment and some of these ideas. One is www.buildinghealthycommunities.org. That's all one word. The second is www.calendow.org. And the third is for one of our regional partners, www.barhii, B-A-R-H-I-I, dot org. And that's a regional consolidation of somewhere between 12 or 13 local county health departments in the San Francisco Bay Area that have come together out of frustration, quite frankly, at the limitation of public health tools, given the significant public health challenges that we're facing, particularly around health equity in California.

DR. GABRIEL KAPLAN:
Great. Well, thank you so much. And again, thank you very much from the whole chronic disease community for your time.

DR. ANTHONY ITON:
Yeah. Let me just thank you, in particular, Dr. Kaplan. I think that your perspective and you talked about once a long time ago being a political scientist. I think that's clearly informed your

approach to chronic disease prevention. And we need that. We desperately need people who understand, sort of, the political context of this work. And when I say political, I'm not talking about partisan politics. I'm talking about a definition of politics, which is the struggle over the allocation of scarce and precious social goods. And health is a precious social good and the resources that we're talking about are distributed politically. So having an understanding of that and not running under the table every time you hear the word politics, is really critical, I think, to doing this work in a way that actually can have the kind of lasting impact that's necessary.

DR. GABRIEL KAPLAN:
Great. Thank you. I appreciate that.

ANNOUNCER:
Thank you for listening to socially determined. A podcast brought to you by The National Association of Chronic Disease Directors. Please visit www.chronicdisease.org to listen to more podcast like this one.

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