A community-driven social marketing approach to policy development

by craig lefebvre on Apr 26, 2013

This presentation at the World Social Marketing Conference presents a rationale for expanding the scope of social marketing to change markets through policy change to improve health. The original community-based prevention model has been re-imagined as a process to guide community coalitions in the selection and marketing of policy options. The presentation highlights the basics of this approach, and describes its implementation in Lousiville, KY by a coalition tackling childhood obesity. What began as an idea to focus on schools became a much larger environmental and policy initiative as the coalition used the revised CBPM process to arrive at innovative approaches for addressing food deserts and dual use of school facilities.

http://www.slideshare.net/rcraiglefebve/toronto-social-marketing-and-obesity-policylefebvre?utm_source=buffer&utm_medium=twitter&utm_campaign=Buffer:%2BSocialBtrfly%2Bon%2Btwitter&buffer_share=e4698

Policy Guide

- **UNNATURAL CAUSES Policy Guide (2.6MB)**
  Advocating for Better Policies
  Planning for Media Advocacy
  http://www.unnaturalcauses.org/assets/uploads/file/UC_PolicyGuide.pdf
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http://www.unnaturalcauses.org/media_and_documents_about_the_issues.php

What Is Health Equity? Excerpted from the UNNATURAL CAUSES Action Toolkit

Health equity is a new idea for most people. It's not hard to grasp, but it does require us to reframe the way in which health differences are usually presented and perceived.

When the Robert Wood Johnson Foundation showed focus group participants evidence of glaring socio-economic and racial disparities in health, many felt that these were "unfortunate but not necessarily unfair." People tended to attribute health differences to behaviors, genes or nature, and inevitability: "That's just the way things are." And it is true that some outcomes are random or result from accidents of nature or individual pathology.

However, health equity concerns those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair.

Most of us can readily see how air pollution and toxic waste might harm health. But social structures can also get under the skin and disrupt our biology. Epidemiologist Sir

Michael Marmot put it this way: "Real people have problems with their lives as well as with their organs. Those social problems affect their organs. In order to improve public health, we need to improve society."

Tackling health inequities requires widening our lens to bring into view the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health. When societal resources are distributed unequally by class and by race, population health will be distributed unequally along those lines as well. One way to understand what Marmot calls the "causes of the causes" is to ask new questions:

Conventional question: How can we promote healthy behavior?
Health equity question: How can we target dangerous conditions and reorganize land use and transportation policies to ensure healthy spaces and places?

Conventional: How can we reduce disparities in the distribution of disease and illness?
Health equity: How can we eliminate inequities in the distribution of resources and power that shape health outcomes?

Conventional: What social programs and services are needed to address health disparities?
Health equity: What types of institutional and social changes are necessary to tackle health inequities?

Conventional: How can individuals protect themselves against health disparities?
Health equity: What kinds of community organizing and alliance building are necessary to protect communities?

Just as the roots of illness and wellbeing encompass more than individual factors, so too do the solutions. Historians attribute much of the 30-year increase in U.S. life expectancy over the 20th century not just to the invention of drugs or new medical technology but to social reforms. The eight-hour workday, a minimum wage, universal schooling, prohibitions on child labor, business regulation, social security and progressive tax policies all helped ensure that improvements in productivity would be shared, at least in part, by all Americans. The passage of civil rights laws in the 1960s extended these benefits to African Americans, whose health also improved in both absolute and relative terms.

For the past 30 years, however, the U.S. has been moving in the opposite direction. The top one percent of the population now holds as much wealth as the bottom 90 percent. Approximately 22 percent of our children live in poverty. The United States has by far the greatest inequality of the industrialized countries—and the worst health.

The good news is that the conditions that drive health inequities are neither natural nor inevitable but are the consequence of public policies. We've changed them in the past and can do so now. A good start is recognizing how other campaigns for social justice

represent opportunities to improve our health and wellbeing. Struggles over jobs and wages, employment security and working conditions, housing, food security, social supports and transportation are as much health-promoting initiatives as anti- smoking campaigns, emergency preparedness and increasing access to health care. Forging alliances with groups working on these issues can increase everyone's power and effectiveness, leading to a more equitable society and better health.

As Dr. David Williams of the Harvard School of Public Health says in UNNATURAL CAUSES, "Housing policy is health policy. Educational policy is health policy. Anti-violence policy is health policy. Neighborhood improvement policies are health policies. Everything that we can do to improve the quality of life of individuals in out society has an impact on their health and is a health policy."

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Promoting Health Equity: A Resource to Help Communities Address Social Determinants of Health
L Ramirez, E Baker, and M Metzle, with the Social Determinants of Health Work Group at the Centers for Disease Control and Prevention, 2008

A workbook for community-based organizations seeking to affect the social determinants of health through community-based participatory approaches and nontraditional partnerships. Along with an introduction to the concepts of health equity, the workbook presents case studies of communities working at both small and large scales. The authors then provide guidelines for developing your own initiative, from creating partnerships to identifying your approach to assessing and maintaining your progress.

Closing the Gap in a Generation

Commission on the Social Determinants of Health, World Health Organization, 2008

A project of the World Health Organization, the Commission supports countries and global health partners to address the social factors leading to ill health and inequities. It draws the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries. The determinants include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems. The Web site also contains final reports from the different knowledge networks, as well as additional background articles and resources.

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In the United States, I helped write a report called "The Economic Value of Improving the Health of Disadvantaged Americans"[5] as background for the recently launched Commission to Build a Healthier America. In that report, we translated health disparities into monetary terms using standard estimates of the value of a healthy life year. We estimate that closing education-related disparities in health and mortality would increase the level of "health capital" in this country by over one trillion dollars each year. Quantifying disparities in this manner may help the public and policymakers better understand the magnitude of disparities in comparison with other policy issues competing for attention.

[5] Dow W, Schoeni RF. Economic Value of Improving the Health of Disadvantaged Americans, Technical Report for *Overcoming Obstacles to Health*. 21 January 2008. http://www.commissiononhealth.org/Publications.aspx

Ten Things to Know about Health

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.

Health is tied to the distribution of resources. The single strongest predictor of our health is our position on the class pyramid. Whether measured by income, schooling, or occupation, those at the top have the most power and resources and on average live longer and healthier lives. Those at the bottom are most disempowered and get sicker and die younger. The rest of us fall somewhere in between. On average, people in the middle are almost twice as likely to die an early death compared to those at the top; those on the bottom, four times as likely. Even among people who smoke, poor smokers have a greater risk of dying than rich smokers.

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 populations of color. Segregation, social exclusion, encounters with prejudice, the degree of hope and optimism people have, differential access and treatment by the health care system – all of these can impact health.

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 and 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?

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 childcare, no healthcare, 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.

Chronic stress can be toxic. Exposure to fear and uncertainty triggers 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 the engine of a car, this constant state of arousal, even if low-level, wears us down over time, increasing our risk for disease.

Inequality – economic and political – is bad for our health. The United States has by far the most inequality in the industrialized world – and the worst health. The top 1% now owns as much wealth as the bottom 90%. Tax breaks for the rich, deregulation, the decline of unions, racism and segregation, outsourcing and globalization, and 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 U.S. is now greater than at any time since the 1920s.

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

Health inequalities are not natural. Health differences that arise from our racial and class inequities result from decisions we as a society have made – and can make differently. Other rich nations already have, in two important ways: they make sure inequality is less (e.g., Sweden's relative child poverty rate after transfers is 4%, compared to our 22%), and they try to ensure that everyone has access to health promoting resources regardless of their personal wealth (e.g., good schools and health care are available to everyone, not just the affluent). They live healthier, longer lives than we do.

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 the average rich country spends, and our health care system is strained to the breaking point. Yet our life expectancy is 29th in the world, infant mortality 30th, and lost productivity due to illness costs businesses more than $1 trillion a year. As a society, we face a choice: invest in the conditions that can improve health today, or pay to repair the bodies tomorrow.