Health Equity:
Eradicating Health Inequalities for Future Generations

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Grand Challenges for Social Work Initiative

The Grand Challenges for Social Work are designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work expertise and leadership can be brought to bear on bold new ideas, scientific exploration and surprising innovations.

We invite you to review the following challenges with the goal of providing greater clarity, utility and meaning to this roadmap for lifting up the lives of individuals, families and communities struggling with the most fundamental requirements for social justice and human existence.

The Grand Challenges for Social Work include the following:

- Ensure healthy development of all youth
- Close the health gap
- Stop family violence
- Eradicate social isolation
- End homelessness
- Promote smart decarceration
- Reduce extreme economic inequality

- Build financial capability for all
- Harness technology for social good
- Create social responses to a changing environment
- Achieve equal opportunity and justice
- Advance long and productive lives

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Dramatic health inequalities in the United States exist by race, ethnicity, gender, age, disability status, geography, sexual and gender identity, and socioeconomic status. Despite increased attention, our health system has made insufficient progress in reducing these disparities and creating greater health equity. Too little attention has focused on the social determinants of health—economic, social, and environmental factors—whereby health disparities take root, inequalities grow, and inequities reproduce. The American Academy of Social Work and Social Welfare believes that social work is well positioned to lead several multisectoral and transdisciplinary priorities for action to dramatically reduce inequities within one generation. Priorities for action include focusing on settings to improve conditions of daily life, advancing community empowerment for sustainable health, cultivating innovation in primary care, promoting full access to health care, generating innovations in research on social determinants of health inequities, fostering interprofessional workforce development, and stimulating multisectoral advocacy to promote health equity policies.

Key words: community empowerment, health inequity, interprofessional workforce, Patient Protection and Affordable Care Act of 2010, primary care, social determinants of health, social work

Tāne, the deity of the forest, lived with his siblings in darkness within the eternal embrace of his parents, Ranginui (sky father) and Papatūānuku (earth mother). Becoming increasingly frustrated at living in the darkness, Tāne successfully pushed the pair apart by planting his head in the earth and using his feet to lift the sky—to expose Te Ao Mārama—the world of light.

—Māori creation story[2]

Among the Māori, the indigenous people of Aotearoa/New Zealand, Tāne serves as a model for action in the world: His roots are in earth, and his head is in the heavens. Tāne is able to bear the

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[1]Authors Allen through Zebrack are listed in alphabetical order. Author contributions: K. L. Walters was the lead author for the group and was responsible for conceptualizing the paper, synthesizing authors' comments, and writing the final publication with M. Spencer. M. Spencer contributed to the conceptualization of the paper and provided leadership in co-writing the final draft with K. Walters. M. Smukler contributed to the literature review, wrote drafts of the paper, and provided final edits. All other authors are presented in alphabetical order, equally participating in various component parts of the paper's development and product. H. Allen, C. Andrews, P. Maramaldi, and D. P. Wheeler contributed to the conceptualization and the refinement of the priorities as well as edits to the final paper. T. Browne and B. Zebrack contributed to the content of the paper and provided edits on the final paper. E. Uehara contributed to the conceptualization of the paper and provided guidance throughout.

[2]Story adapted here from http://www.teara.govt.nz/en/te-waonui-a-tane-forest-mythology/page-1

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weight of action to procure necessary change. Similar to Tāne, social work must assert itself, bring new light, and bear the weight of action—in collaboration with allied health professions—to achieve health equity within the next generation. Social work has already had a significant impact on health interventions in the United States—from the health-policy reform efforts of the Progressive Era to the development of innovative community-based prevention interventions in modern times. Social work's perspective is in line with approaches that go beyond population surveillance, prompting action to address health inequities and social determinants of health. Specifically, social work has an unyielding focus on lifting the health of a nation by lifting the health of the most indigent and marginalized populations. Also, its historical social-reform efforts have sought to procure health by addressing the conditions in which people live, work, play, learn, and age. These perspectives match the calls by the World Health Organization (WHO, 2014), U.S. Centers for Disease Control and Prevention (Brennan Ramirez, Baker, & Metzler, 2008), and the Healthy People 2020 national strategy (U.S. Department of Health and Human Services, n.d.) to focus contemporary research and intervention efforts on the social conditions that produce health and health inequities. Additionally, the reassertion of social work into the national strategy and debate is timely given the recent passage of the Patient Protection and Affordable Care Act (ACA; 2010) and the bourgeoning national effort to create culturally, linguistically, and communally grounded interventions that affect the upstream determinants of the nation's poor health.

Although the United States is among the wealthiest nations in the world and spends far more per person on health care than any other industrialized nation, its health is rapidly deteriorating. Over the past three decades, the U.S. population has been dying at younger ages than those of the populations in peer nations and has endured a pervasive pattern of poorer health throughout the life course, from birth to old age (Institute of Medicine, 2013). The United States now ranks 27th out of 34 industrialized nations in terms of life expectancy. Moreover, population health diminishes along a social gradient: Populations that experience high rates of social, racial, and economic exclusion bear the greatest burden of poor health and premature mortality. These experiences lead to the current high rates of racial and ethnic health disparities within the United States.[3] Although poor health follows a social gradient, deteriorating U.S. health cannot be fully explained by the health disparities that exist among people who are uninsured or poor; in fact, even the health of relatively elite Americans—those who are White, insured, and college educated, as well as those with high income—is worse than that of their peers in other industrialized countries (Avendano, Glymour, Banks, & Mackenbach, 2009; Institute of Medicine, 2013).

Despite these downward trends, health research in the United States lags behind international research efforts to focus on upstream social and economic determinants of health. Instead, the U.S. health professions have become increasingly myopic, focusing on individualized health care rather than on health. By prioritizing interventions that target individual behavioral change, research tends to neglect upstream opportunities to intervene upon the settings and environments in which health is produced and maintained. Likewise, although the emerging field of genomics

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[3]For purposes of this document, the term *ethnic* is inclusive of groups that affiliate in terms of gender expression, sexuality, nationality, and religion.

and "precision medicine" may offer unprecedented prospects for saving individual lives, they will likely yield little impact on population health. Attention to health care and behavioral interventions are important but simply not sufficient to eradicate health inequities (Hood, Gennuso, Swain, & Catlin, 2015). To secure true, sustainable, population-based health changes, the health professions must unite and develop transdisciplinary approaches to examining the multilayered contributions of political, economic, and social determinants of population health inequities. Indeed, the nation's health depends on the development of this next wave of interprofessional and transdisciplinary collaboration (McGovern, Miller, & Hughes-Cromwick, 2014). Although health researchers have rallied to address this need, questions remain and research is needed to link policy and practice to proximal, intermediate, and distal social determinants (Syme, 2008). Thus, if we are to truly turn the tide, health disciplines, particularly social work, must train professionals in how to invest in the social determinants of good health. We must also train professionals to develop the practice and research tools, community partnerships, and localized programs necessary to combat social and economic inequities (Hood et al., 2015; Uehara et al., 2013). The social work profession has a unique opportunity to identify and mobilize its resources. Coordinated, collective practice and research will build interprofessional efforts to address the health equity challenge. Moreover, the profession is uniquely poised to address health disparities in the United States because of social work's history and values. This paper will first provide a brief overview of social work contributions to health and health care. It will then focus on the recent empirical developments in social determinants research. We conclude by outlining some of social work's priorities for future research and action, and we highlight opportunities for collaboration with allied health professions.

SOCIAL WORK'S HISTORICAL HEALTH-LEADERSHIP LEGACY

Social work is uniquely positioned for a leadership role in addressing health inequities because, as indicated in Jane Addams' speech at the 1930 National Conference of Social Work, "social work's special genius is its closeness to the people it serves" (Johnson, 2004, p. 319). Social work's historical social-justice mission as well as its commitment to serve the most disenfranchised and health-burdened populations affirms the profession's ability to provide leadership in association with allied health professions. The attributes also speak to the profession's ability to design and develop community-based approaches to eradicate health inequities. Social work faces an opportunity to leverage its history as calls to address health inequities emphasize the need for community-based innovation. Indeed, social workers have been involved in public health and the health care field for well over a century (National Association of Social Workers, 2005). Historically, social work's health-focused efforts have centered on making health care services available to the indigent while improving social conditions related to poor health and mortality (Popple & Leighninger, 2005). One of the most impressive examples of social work's success in public health can be seen in the campaign to reduce infant mortality. That campaign was engineered by social workers at the U.S. Children's Bureau and operated from 1912 to 1930:

A dual program of applied research and maternal education: To pursue new knowledge about the extent and causes of infant mortality and engage in prevention and health promotion activities that build on knowledge already gained through the public health work of settlement houses such as Henry Street and Hull House. (Almgren, Kemp, & Eisinger, 2000, p. 9)

The Children's Bureau was led in this ambitious effort by Julia Lathrop, a Progressive Era social worker and former Hull House reformer. Because of this pioneering effort, infant mortality dropped by half and life expectancy improved significantly throughout the 20th century (Almgren et al., 2000).

Public-health social workers have effortlessly incorporated an understanding of social determinants of health in their intervention efforts. They have viewed entire communities, neighborhoods, and regions as target populations across the prevention spectrum (Ruth & Sisco, 2008). In their efforts to directly address social conditions that produce poor health, public-health social work has a strong legacy of interprofessional collaboration with organizers and researchers working in the areas of community development, housing, civil rights, antiracism, and poverty. It also has had important collaborations with organized labor. This legacy provides an ideal foundation from which to launch contemporary health-reform efforts. Additionally, public health threats (e.g., from HIV/AIDS, substance abuse, homelessness, and terrorism) have grown as government funding has been cut over the past 20 years, and social work has developed increasingly involved partnerships with allied health fields, particularly public health (Ruth & Sisco, 2008). Examples of recent social work–public health partnerships can be found in areas such as, "urban health, oral health, tobacco control, and toxic waste activism" (Ruth & Sisco, 2008, p. 487). Now more than ever, public health-oriented social work is needed to address health inequities.

SOCIAL WORK'S ROLES IN LEADING A HEALTH EQUITY GRAND CHALLENGE

The medical model is failing patients: Increased use of health care does not translate to improved health, and for entire populations, disproportionately sicker lives come to disproportionately younger ends. The health care system is in a unique phase of transition, and there are unprecedented opportunities for transformation. Several factors demonstrate why social work should lead a grand challenge to achieve health equity.

First, social workers understand the complex pathways from disadvantage to health risks and outcomes. Those pathways run through the vulnerable communities in which social workers routinely operate. Additionally, health risks and outcomes among disadvantaged populations are correlated with structural and sociodemographic disadvantages (e.g., poverty, low levels of education, substandard housing, and poor access to services) as well as with high rates of co-occurring physical health problems (e.g., diabetes and cardiovascular disease). Also, trauma and violence exposure (including intergenerational and historical trauma exposures) are associated with co-occurring psychopathology (e.g., post–traumatic stress disorder and depression; Brand et al., 2010; Matthews & Phillips, 2010; Nagata, Trierweiler, & Talbot, 1999; Walters et al., 2011;

Yehuda et al., 2005). Addressing these associations will require multitasking across multiple levels of intervention, and such a broad deployment of effort is a hallmark of social work practice. Put simply, health is not created in a clinic, and we cannot rely on traditional health services alone to heal the wrongs of history and persistent inequality.

Second, social work's leadership is needed to elucidate problems and test solutions. Despite the glaring health disparities, there is a paucity of culturally relevant research on some of the most vulnerable populations. Because of this, the health fields have little data on important risk factors, coping behaviors, and health outcomes. Without a larger body of evidence, it will be difficult to identify the strategies and develop the programs necessary to reduce health inequalities and improve health equity within the United States. Many social work researchers are already at the forefront of research on health disparities and prevention needs among vulnerable populations, particularly among racial and ethnic minorities as well as lesbian, gay, bisexual, and transgender populations (e.g., Evans-Campbell, Lincoln, K., & Takeuchi, 2007; Fredriksen-Goldsen et al., 2014; Marsiglia, Kulis, Yabiku, Nieri, & Coleman, 2011; Wheeler, 2003). Moreover, social work researchers have advanced innovative, community-based, participatory-research approaches as well as conceptual models that include multilevel influences on health (e.g., Gehlert & Coleman, 2010; Gehlert, Sohmer, et al., 2008; Spencer et al., 2011; Walters & Simoni, 2002; Walters et al., 2012).

Social work's longstanding commitment to a diverse workforce with full representation of all stakeholders is a third reason for the profession to lead the health equity grand challenge. The ACA and recent national reports, including one from the National Institutes of Health, call for more inclusion of underrepresented ethnic and racial minorities among funded investigators and community-based researchers (Shavers et al., 2005; Sopher et al., 2015). Despite these calls, a very limited number of underrepresented ethnic and racial minorities have served as principal investigators for awards by the National Institutes of Health. Moreover, racial and ethnic minorities remain significantly underrepresented in higher education. In the United States, they account for only 12% of all people with doctorates and less than 3% of medical school professors (Sopher et al., 2015). A broad and dense network of highly trained and productive health-science scholars, a network that includes underrepresented ethnic and racial minorities and is dedicated to culturally grounded research, is needed to ameliorate health disparities.

Finally, as we have suggested above, the legacy of social work and the roles historically played by social workers should spur the profession to lead the grand challenge of health equity. Throughout history, social workers have played pivotal roles in efforts to increase critical consciousness within competing systems, linked key health-system stakeholders, and led in efforts to incorporate social and ecological realities into assessment and treatment. This distinctive legacy enables social work to provide leadership at a time when the ACA is driving promotion of community involvement. The legacy also provides paradigms for creative solutions to problems that extend across systems.

COMING TO TERMS: SOCIAL DETERMINANTS AND HEALTH EQUITY

In assessing population health, research has typically considered such indicators as mortality, life expectancy, morbidity, health status (physical and mental), functional limitations, disability, and quality of life (Hood et al., 2015; McGovern et al., 2014). *Health determinants*, also known as *social determinants of health*, refer to the economic and "social conditions into which people are born, grow, live, work, play, and age"—the conditions that "influence health" (Newman, Baum, Javanparast, O'Rourke, & Carlon, 2015, p. ii127). In the United States, these conditions are shaped by the specific social structures that differentiate access to and distribution of money, wealth, power, knowledge, prestige, resources, and social connectedness (Link & Phelan, 1995; McGovern et al., 2014). *Health inequalities* are the persistent, systematic differences in the health of social groups within a nation—differences resulting from unequal exposure to and distributions of the social determinants of health (Farrer, Marinetti, Cavaco, & Costongs, 2015). Quite often, impoverished conditions attend populations that have endured significant legacies of discrimination based on their racial, ethnic, class, or gender identity, or on their sexuality. Such conditions include unequal distribution of resources—such as quality education, culturally relevant medical care, and housing—that are typically tied to good health (Mitchell, 2015). Racial and ethnic minorities bear the greatest burden from conditions that give rise to poor health and premature mortality. Those conditions have structural components as well as social ones: race- and class-based segregation of neighborhoods and schools; low-wage employment without collective bargaining rights or realistic opportunities for advancement; political disempowerment in the form of abrogated voting rights and lack of political representation; and institutionalized discrimination in education, employment, and health care (Agency for Healthcare Research and Quality, 2013; Mitchell, 2015; Smedley, Stith, & Nelson, 2003). *Social determinants of health inequities* are conditions of social stratification. These conditions "create … differences in health status between population groups that are socially produced, systematic in their distribution across the population and avoidable and unfair" (Dahlgren & Whitehead, 1992, as cited in Newman et al., 2015, p. ii127). Social determinants give rise to a common soil in which health disparities grow, health inequalities take root, and inequities become reproduced at distal, intermediate, and proximal levels.

Health equity refers to a state characterized by the "absence of systematic inequalities in health" (Farrer et al., 2015, p. 394). As they are elsewhere, health inequities in the United States are tied to social and economic factors (e.g., race, ethnicity, sex, age, disability status, geography, sexual and gender identity, and socioeconomic status). A large body of research has established the strong links between socioeconomic disadvantage and poor health outcomes across the life span (Braveman & Gottlieb, 2014; Commission on Social Determinants for Health, 2008; Kaplan, Shema, & Leite, 2008; Marmot & Bell, 2012). The disparities are manifest in screening, incidence, treatment, survivorship, and mortality. For example, the Framingham Heart Study found that 35% of women suffered a second heart attack but that only 18% of men had a second attack. This disparity in incidence has been linked to a disparity in treatment: Although cardiac rehabilitation is known to lower the risk of a second heart attack, women are 55% less likely than men to receive it after the first attack (Centers for Disease Control and Prevention, 2011; Mosca et al., 2005).

Although lack of access to health insurance and health services contributes to poor health outcomes, disparities in access to coverage and services also stem from significant social, economic, and environmental deprivation (i.e., social disadvantage) grounded in race- and culture-based discrimination. Those disparities often produce cumulative, intergenerational disadvantage that profoundly affects health (Braveman & Gottlieb, 2014). Such disadvantage is positively correlated with levels of debilitating chronic disease (Gordon-Larsen, Nelson, Page, & Popkin, 2006) and rates of premature mortality (Commission on Social Determinants of Health, 2008). Specifically, populations tend to be stratified by their socioeconomic resources along a social gradient. Environmental disadvantage, a manifestation of this stratification and the underlying determinants, is a condition tied to residing in communities with concentrated poverty, food deserts, and high rates of trauma and violence. Exposure to these social determinants of health often accompanies such stratification (Braveman, 2014).

In this paper, we treat health disparities and health equity as intertwined concepts: Health equity implies "social justice in health"; "disparities are the metric we use to measure progress toward achieving health equity" and eradicating inequities (Braveman, 2014, p. 7). Although a reduction in health disparities would indicate that we are inching toward health equity, an exclusive focus on disparities is not sufficient. Reducing gaps while maintaining substandard population health does nothing to enhance equity for all. Nor does it contribute to a healthy and robust society. Rather, it is critical to level the social gradient in health because, if all groups among the targeted community benefitted equally from a particular health intervention, then inequities would actually worsen. These are also known as intervention-generated inequities (since people in higher positions will likely benefit more; Newman et al., 2015).

Meeting the grand challenge of health equity and eliminating health inequities require dealing with "root causes"; focusing on what can be seen as upstream interventions and primary prevention; and addressing "unequal distribution of power, income, goods and services" (WHO, 2014, p. 2; see also, Gehlert, Mininger, Sohmer, & Berg, 2008). This challenge entails an explicit commitment to eliminating health disparities at individual *and* population levels. Meeting the challenge also involves eliminating social determinants that function as precursors to adverse health conditions and outcomes. Social work's pursuit of health equity as a grand challenge means that the profession strives to ensure the highest possible standard of health and wellness for all people while prioritizing upstream interventions and primary prevention efforts among those who are at greatest risk for poor health—those who, because of social and economic disadvantage, experience the extremes of health inequalities. This prevention approach is critical in that it provides the social and ethical framework for action. It also provides opportunities for policies to eliminate the conditions that produce and reproduce health inequalities. Finally, a health equity approach draws upon insights from the field of human rights. Current human rights law obligates countries to protect, promote, and fulfill the whole population's right to human rights, including the right to health (Annas, 1998; Leary, 1994). Implicit in this obligation is the responsibility to pay particular attention to the most disenfranchised—the segments of a nation that experience the greatest barriers to healthy living conditions. To be healthy, people require access to quality, culturally resonant care as well as to socioeconomic conditions that promote well-being in community, family, school, workplace, recreation, and environmental systems.

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ADDRESSING SOCIAL DETERMINANTS AND HEALTH INEQUITIES: CONTEXTUALIZING MODELS

In developing a model for contextualizing health disparities, Warnecke et al. (2008) suggested that social determinants can be categorized across three primary levels: distal, intermediate, and proximal. In this model, distal determinants include public policies and such social conditions as racism and poverty. Intermediate-level determinants "include the immediate social and physical contexts … in which the distal effects are experienced" (2008, p. 1610). Settings, places, social relationships, and institutions are examples of such contexts, which provide "opportunities for social interaction [in contrast to social isolation] to redress the effect of the distal factors" (p. 1610). Proximal determinants include individual-level factors like health behavior, demographic characteristics, and biological and genetic pathways. Gehlert (2014) expanded the model of health disparities to include changes that occur across the developmental life cycle. The primary implication of this expanded model is that multiple levels of influence, from the microbiological to the societal, interact in complex ways to produce health disparities that vary across the life cycle as well as by race and ethnicity. All three levels must be addressed to produce population health change. However, producing sustainable population health changes remains a major struggle.

Krieger addresses sustainability in her health-equity embodiment model (N. Krieger, personal communication, August 16, 2014). Consistent with the United Nations Millennium Declaration (2000) on sustainable development, Krieger posits that three interrelated components shape population-level embodiment of health equity: political economy, political ecology, and sustainability. The political economy component refers to the influence of public policy on the economic and social welfare of a political unit, which has the power to create and maintain the social/health gradient, particularly as it relates to poverty and wealth. The political ecology component connects politics and economy to problems of environmental control and ecological change (Robbins, 2012). Political ecology refers to social and physical contexts that influence health. Such factors include environmental degradation, climate change, and issues of environmental justice or the unequal distribution of toxins and hazards in low-income communities and communities of color. According to the U.S. Environmental Protection Agency (National Research Council, 2011), to pursue sustainability is to create and maintain the conditions under which humans and nature can exist in productive harmony to support present and future generations. This definition may be extended to health equity: Social sustainability is achieved when a society and the related institutional arrangements of political economy and political ecology satisfy an extended set of human needs over time and the normative claims of social justice, human dignity, and participation are fulfilled (Littig & Griessler, 2005). Just as the body illuminates the stories of past generations and present political economies and ecologies (body politics and bodily truths), the goal within Krieger's model is embodiment of equity: social justice through population health (Krieger, personal communication, August 16, 2014). In many ways, the goal of social work is social justice and the embodiment of equity through social, political, economic, and environmental processes—all interrelated components of health. By addressing interventions at the intersection of these processes, we will produce sustainable population health changes.

An example comes to us from obesity research. Obesity, which is strongly associated with cardiovascular disease, diabetes, and cancer, is subject to many influences at the levels of social and physical contexts. In neighborhoods where safety and crime are pressing issues, there may be few opportunities for the sort of physical activity that prevents obesity or reduces its rates. Likewise, fresh fruits, vegetables, and other foods known to help maintain healthy weight are less likely to be sold in low-income, rural, and racial/tribal communities (Beaulac, Kristjansson, & Cummins, 2009; Cummins & Macintyre, 2002; O'Connell, Buchwald, & Duncan, 2011). Such settings-based deprivation exacerbates individual disadvantage in a process known as "deprivation amplification" (Beaulac et al., 2009, p. 1). That no racial or ethnic group met the Healthy People 2010 goal for obesity in the U.S. population—no more than 15% of adults with a body mass index of 30 or more—speaks to how distal-level factors embody inequality (National Center for Health Statistics, 2012). Models that focus only on one level will likely yield some change to address health inequities, but these changes will be unstable and unsustainable unless all three layers of influence are addressed. Social work is well positioned to take a strong role across all three levels, particularly in addressing intermediate- and proximal-level determinants and working closely with allied fields to address distal factors such as racism and poverty.

The *VicHealth framework for health equity* is a particularly helpful model for social work in that it identifies potential entry points for preventive and interventive action across the following layers: the socioeconomic, political, and cultural context; daily living conditions; and individual health-related factors (Newman et al., 2015). These layers, and the process of social stratification that interacts with them, are posited to create health inequities (Dahlgren & Whitehead, 1992). Proponents of the VicHealth framework note that addressing inequity requires not just focusing on specific disadvantaged groups but also leveling the *social gradient in health*, so that middle groups experience health that is closer to the top and the bottom groups. The researchers assert that two questions should be asked simultaneously when designing any interventions for any layer: "Does it work to improve health?" *and*, "Does it work to reduce health inequities?" (Newman et al., 2015, p. ii127)

ACHIEVING POPULATION HEALTH: MOVING BEYOND THE INDIVIDUAL/CLINICAL TO THE SOCIAL/ENVIRONMENTAL

Although there is abundant evidence that intermediate- and distal-level factors exert strong influence on population health, it is worrisome that most health research continues to focus primarily on changing proximal-level factors such as individual health behavior. In fact, social and economic factors may actually exert stronger influence on health outcomes than do individual risk behaviors or clinical care (Hood et al., 2015). Health-service interventions account for only a small proportion of the factors that promote health in the U.S. population (McGinnis, Williams-Russo, & Knickman, 2002). Although health behaviors in some studies account for the largest proportion (30%–40%), the effects of such behaviors are substantially mediated by social circumstances (15%) and genetic disposition (30%; Gehlert, Mininger, et al., 2008). In turn, the effect of genetic disposition is mediated by the stress of social environments. A recent study focusing on modifiable (nongenetic) determinants of health demonstrated that

approximately 40% of such determinants are due to social and economic factors (e.g., community safety), 30% are due to health behaviors (e.g., diet or exercise), 20% are due to clinical care (e.g., access and quality of care), and 10% due to physical environmental factors (e.g., housing and air or water quality; Hood et al., 2015). As a result, recent health-equity research strategies have pursued sustainable improvements in population health by promoting attention to prevention research and interventions on social determinants of health while *simultaneously* focusing on downstream behavioral determinants as well as improvements in clinical care (McGovern et al., 2014). It makes sense, then, that social work health-research efforts will have the most impact if they are directed at making a community's environment *and* behavioral patterns more health positive—that is, if they mediate the adverse effects of the distal social circumstances and environmental exposure.

Simultaneously, to promote sustainability of these innovations, settings-based interventions (e.g., in schools, parks, and computerized virtual worlds) should also be considered. Such community-based, settings-focused, and intermediate-level interventions naturally build on social work's strengths. A model of intervention offered by the Centers for Disease Control and Prevention (Frieden, 2010, p. 591, Figure 1) suggests the large potential impact that change in the community and social groups can have on population health. Such change efforts typically demand significant collective effort but less from the individual. Clinical interventions, in contrast, contribute relatively little to health in the community and place the burden of change on the individual patient. Social work interventions developed in response to identified social determinants can fall on a continuum that extends from preventive care or treatment (e.g., inoculation) through secondary and tertiary intervention all the way upstream to community-based health preventions, which can be a way to achieve universal, primary prevention (Koh et al., 2010).

ACHIEVING HEALTH EQUITY BY 2050: SOCIAL WORK HEALTH RESEARCH AND ACTION PRIORITIES

We are at a critical juncture in U.S. history. With the enactment of the ACA and the launch of Healthy People 2020, there is national momentum to address health inequities. Although the ACA's primary focus falls on expanding insurance coverage, it also invites innovations that fall within particular domains of social work expertise: the creation of equitable health care systems by expanding health care into and in collaboration with the communities where people live and work, increasing health workforce diversity, improving cultural competency throughout health-care delivery systems, fostering community-based approaches to prevention, and creating community health centers in medically underserved areas. All of these efforts are hallmarks of social work practice and history. Consistent with social work's approach and values, Healthy People 2020 advocates for an ecological, multilevel approach to examining health determinants. It focuses on building healthful social and physical environments that will promote health and well-being (U.S. Department of Health and Human Services, n.d.) through place-based approaches. These approaches consist of "five key social determinants of health [areas]: economic stability, education, social and community context[s], health and health care, and the

neighborhood and built environment (for example, buildings, bike lanes, and roads)" (Mitchell, 2015, p. e71). Although the ACA and Healthy People 2020 provide the impetus for addressing health inequities, neither offers "definitive strategies for communities and health professionals" (Mitchell, 2015, p. e71). Also, Mitchell (2015) notes, there remains limited evidence-based research on the fundamental determinants of health and limited evidence of settings-based interventions that affect population health.

In order to maximize the opportunities afforded by the ACA and stem the tide of health inequalities in the United States, it is imperative that emphasis be placed on the social determinants of health inequities, particularly on factors that operate at the distal and intermediate levels of influence and that require expertise from multiple sectors. The WHO (2014, p. 5) notes:

> Effectively addressing social determinants requires multistakeholder and multisectoral action across government and society. This includes strengthening capacity to govern for better health across sectors and implementing multistakeholder policies, services and systems. These actions need to engage citizens, service providers, civil society, the media, planners, policymakers and politicians.

The environment of innovation fostered by the ACA offers a unique opportunity to create a more equitable, high-quality health-care system focused on community empowerment, prevention, cross-sector collaboration, workforce development, workforce enhancement, and improvements in the social determinants of health. The act also provides a chance to strengthen the health-care delivery system serving socially disadvantaged and vulnerable populations. The social work profession is positioned to facilitate interdisciplinary efforts among applied social and behavioral scientists, educators, and practitioners. As members of interprofessional teams, social workers already contribute in the movement toward patient-centered care. They also are engaged in the implementation of integrated care models to better address physical, mental, and behavioral health issues (e.g., substance abuse). The next decade offers an opportunity to develop a strategy for leveraging the momentum of health-care reform efforts to create a social-determinants-focused agenda for research, practice, and action. Such a strategy would enable social workers to set measureable targets and timeframes for alleviating the deep and persistent health inequities in the United States.

Our proposal seeks to close these inequities through a "geography of science" approach that draws upon diverse disciplines, community leaders, and theoretical and community-centered perspectives (Logie, Dimaras, Fortin, & Ramón-García, 2014, p. 2). Making health reform work toward improving health equity for disadvantaged communities will require a persistent long-term view toward strategy that builds momentum over years. In that frame, social work and the health professions can activate seven linked priority areas within an overarching health equity grand challenge initiative to overcome health inequities within the next generation. The following priority areas are proposed here as the first steps in initiating community and scientific conversations and launching broad, multisectoral, and interprofessional collaboration.

> **Priorities for Social Work's Grand Challenge to Achieve Health Equity**
>
> 1. Focus on settings to improve the conditions of daily life.
>
> 2. Advance community empowerment for sustainable health.
>
> 3. Cultivate innovation in primary care.
>
> 4. Promote full access to health care.
>
> 5. Generate research on social determinants of health inequities.
>
> 6. Foster development of an interprofessional health workforce.
>
> 7. Stimulate multisectoral advocacy to promote health equity policies.

Priority 1: Focus on Settings to Improve the Conditions of Daily Life

Combating the distal-level influence of socioeconomic inequity and racism on health and the intermediate-level consequences in a community's institutions (e.g., inadequate schools, unsafe streets, food deserts, families with an incarcerated member) requires a sphere of intervention centered on changing the community environment to elevate the health prospects of a local population. Although large-scale social and economic (distal-level) policy changes may be the ultimate instrument for resolving the nation's health crisis, an accessible starting place for social work is to build the community-enhanced evidence base for change from the bottom up (Institute of Medicine, 2013). This is achievable. Social work has a strong history of harnessing community research and practice efforts to improve conditions in the lived environments of marginalized populations.

Highly promising components of community-based research and practice for addressing social determinants of health inequities are found in the "places" and "social contexts where people engage in daily activities, in which environmental, organizational and personal factors interact to affect health and well-being, and where people actively use and shape the environment, thus creating or solving health problems" (Newman et al., 2015, p. ii127; WHO, 1998). Such settings include but are not limited to geographical places (e.g., cities), physical spaces where people congregate (e.g., religious centers), workplaces, green spaces (e.g., community gardens or playgrounds), and virtual worlds (i.e., social websites; Newman et al., 2015). It is critical for

social work to be particularly present in settings that target and include young people—from birth to young adulthood—to address the cycle of intergenerational disadvantage.

The importance of addressing the social determinants of health inequities within settings has been highlighted by the Commission on Social Determinants of Health (2008) as well as by social determinant researchers (Marmot, 2005 Marmot & Bell, 2012). The WHO (1998) recommended that settings-based approaches change structures yet found that most such approaches are still based on behavioral interventions within a noted setting and do not change the setting itself. Newman and colleagues (2015, p. ii135) note that, in addressing the social determinants of health within settings, there is room to "integrate individual behavior approaches with approaches at structural" or distal levels. Moreover, they note that settings approaches require cross-sectorial collaboration, committed leadership, genuine involvement of stakeholders, and strong research. Social work has a legacy of system change efforts and can work across sectors to address root political, social, economic, and environmental threats to health.

Priority 2: Advance Community Empowerment for Sustainable Health

A community organized for health improvement may work on either or both of two goals: representation in governance of the health-care delivery system and interventions that create sustainable community changes. Representation in the governance of disadvantaged communities is critical for (a) efforts to ensure the enrollment in health care of as many community residents as possible and (b) active participation in evaluating services and resolving deficiencies to the community's benefit. Maximizing health-care enrollment, especially among children and youth, ensures that they are counted in the assessment of efforts to improve the health of a vulnerable community. Representation in the governance of the health system may be accomplished through community organizing that strives to improve health equity. The particular task of securing representation over the long term calls for continued commitment to face-to-face, community-level education on the issues (Horton & Freire, 1990). It also calls for engagement with all of the organic social/cultural threads and groups in the community (e.g., religious and spiritual institutions; Stout, 2010). Community health coalitions and local learning communities can also play critical roles in developing local capacity for representation, monitoring progress, training volunteers, and demonstrating local options if reform implementations break down. By focusing on the community as the center of efforts to advance health—efforts that will complement those of the health-service sector—activists build community-based interventions that are not only culturally grounded but sustainable.

Community-promoted interventions with sustained impact are characterized by a cycle of community development (Butterfoss & Kegler, 2012; Institute for Alternative Futures, 2012; Wandersman, 2003; Wandersman & Florin, 2003). The steps are analogous to many change cycles, including health-care quality improvement (W. Edwards Deming Institute, n.d.). There are six general steps in the cycle: Organize effective community and other shareholder representation, make an assessment of the problems using the best data available, plan an intervention from among evidence-based (including culturally promising) options, act to make

the change, evaluate the effectiveness, and apply those findings as information for the beginning of the next cycle. In this way, social work can support the accelerated development of community-owned effective innovations through rapid innovation science. Social work can also collaborate with community coalitions to develop community-oriented research networks across the country. In parallel to practice-based research networks, community-oriented research networks can be developed to identify common measures and themes as well as lead in the design and development of culturally grounded health promotion interventions. Finally, social work can also partner with existing organizations, such as the National Community Building Network, the U.S. Department of Housing and Urban Development's Office of University Partnerships, and the Alliance for Children and Families, to identify common interests and strategies for community-engaged research and action (Johnson, 2004).

Priority 3: Cultivate Innovation in Primary Care

Improving the health of those suffering lifelong and even intergenerational disadvantage, especially those previously without regular primary health care, will require innovation in primary and other care. Such innovation must reach disadvantaged populations through social interventions aimed at meeting families' nonclinical needs (i.e., material, social, and emotional needs) when and where needs are greatest. Social intervention will also be required to challenge the social determinants in vulnerable communities. The premise for introducing social-service interventions to meet the basic, nonclinical needs of primary-care patients is that such innovations achieve more than improvements in patient outcomes. As shown by desired results from the familiar measures, social interventions can improve the functioning of the health system: positive outcomes, lower cost, and supportive experiences. These improvements lead to health equity. The potential for innovation extends across a continuum: At one end are interventions that employ new modes in helping individuals effectively cope with their current circumstances; at the other are efforts to organize for change in the community, including change in its physical, social, and economic environment.

There are a number of promising steps that can be taken to develop a comprehensive continuum and to construct social interventions that facilitate positive outcomes whereby social work is poised to make a significant contribution. Such steps include: (a) incorporating health care services within community-based recreational or cultural centers (e.g., Peckham Experiment; Hall, 2001); (b) promoting community health and prevention for children and youth; and (c) expanding, through community-enhanced research, the evidence-based set of culturally grounded preventive interventions for physical, mental-health, neurological, and substance-use disorders. As members of practice-based research networks, social workers now cooperate with other groups in identifying successful social innovations for medical, hospital, community, and mental-health settings. Social workers also examine health care processes and care of patients, designing and developing culturally grounded health interventions. Finally, social workers provide an organizational structure for surveillance and research.

Priority 4: Promote Full Access to Health Care

To achieve health equity, the profession must embrace and advance community-based, culturally grounded interventions to facilitate health care access. Such interventions must focus on financial and bureaucratic barriers that have plagued access to the health care system for decades. The ACA provides unparalleled opportunities to expand access and reduce difficulties in navigating complex health care systems. First, the ACA has dramatically expanded health insurance coverage in the United States through a major expansion of Medicaid and the creation of health insurance marketplaces. Since these expansions went into full effect in 2014, more than 23 million U.S. residents have gained health insurance (Carman, Eibner, & Paddock, 2015). Second, the ACA establishes patient navigation funding to assist people in getting insurance and accessing health care (Andrews, Darnell, McBride, & Gehlert, 2013). Third, the ACA has established new incentives to promote innovative models for coordinating and integrating health care. Such incentives are designed to encourage changes that make it easier for patients to find and receive the services they need. Prominent examples of these incentive programs include the Medicaid health home model and Medicare's accountable care organizations (ACA, 2010).

In pursuing universal access to health care, social work should take action in several areas. First, we must promote maximum enrollment in health insurance, particularly among disadvantaged populations that are likely to experience difficulties during the enrollment process. Social work involvement is needed in enrollment and patient navigation. The ACA continues to provide funding to support community-based enrollment navigation services, including "activities to raise awareness about qualified health plans; distributing fair and impartial information about plan enrollment and the options for premium assistance and cost-sharing reductions; assisting consumers in selecting plans; providing referrals to consumer assistance programs; and providing information that is culturally and linguistically accessible" (Andrews et al., 2013, p. 68). We must also advocate on behalf of vulnerable populations *not* included in the ACA's protections—most notably, the nation's undocumented immigrants. In addition, social work should engage in advocacy efforts to educate voters about the benefits of the optional Medicaid expansion in states that have not yet done so and to raise awareness of racial disparities exacerbated by uneven expansion of Medicaid. African Americans and American Indians and Alaska Natives are more likely to reside in states that have not expanded Medicaid. Consequently, the uneven expansion of Medicaid has exacerbated racial disparities in health insurance coverage (Andrews, 2014; Andrews, Guerrero, Wooten, & Legnick-Hall, 2015). Finally, social work can play an important role in advocacy and research to advance coordination and integration of health care services that improve service access, particularly for vulnerable populations. Social workers also can promote community-engaged and culturally sensitive models of provider engagement.

Priority 5: Generate Research on Social Determinants of Health Inequities

The WHO (2014) specifically calls for development of locally and culturally based strategies to eliminate trauma, stress, and violence. Implemented at the levels of family, community, and state, such strategies would focus on disadvantaged populations. Research on social determinants

of health is essential for analyzing how environmental and traumatic stressors, racism (and other isms) harm health and how these determinants become embodied over time, generations, and political-historical contexts (Krieger 2012, p. 939). There are many social and cultural pathways by which discrimination harms health, including "economic and social deprivation; excess exposure to toxins, hazards, and pathogens; social trauma; health-harming responses to discrimination; targeted marketing of harmful commodities; and ecosystem degradation" (2012, p. 937). In particular, stress in response to these determinants may be an underdeveloped mechanism influencing how people respond to upstream and downstream determinants (McGovern et al., 2014). In the past 20 years, social work research has focused its efforts on addressing the role of stress, particularly discriminatory stress in health outcomes. The profession is well positioned to leverage this work in designing and developing research and corresponding interventions for multilevel health determinants. In partnership with communities, social work can identify culturally appropriate, modifiable stress risk factors across the life course. In partnership with public health, the profession can focus research efforts on mechanisms related to how multilevel discriminatory practices and other stressors harm health, particularly for the marginalized. Additionally, social work's partnerships with epigenetic researchers, neurobiological researchers, and researchers in other allied disciplines can identify how these experiences become embodied in populations over time and across generations.

Finally, many emerging models of social determinants of health equity need testing. Among these are the VicHealth model noted earlier, as well as population-specific approaches such as the Health Equity Promotion Model for lesbian, gay, bisexual, and transgender populations (Fredriksen-Goldsen et al., 2014). Moreover, there is quite often a gap between what is known through health equity research and what is actually taken up within communities. Davison, Ndumbe-Eyoh, and Clement (2015) identified six health-equity models that bridge research and practice but require further testing: the Knowledge Brokering Framework (Oldham & McLean, 1997), the Framework for Research Transfer (Nieva et al., 2005), the Joint Venture Model of Knowledge Utilization (Edgar et al., 2006), the Translational Research Framework to Address Health Disparities (Fleming et al., 2008), the Model of Knowledge Translation and Exchange with Northern Aboriginal Communities (Jardine & Furgal, 2010), and the Ecohealth Model applied to knowledge translation (Arredondo & Orozco, 2012). The models have many strengths. They value the direct participation of community stakeholders; prioritize multisectoral engagement; recognize the importance of environmental and contextual determinants; have a proactive, collaborative, problem-solving approach; and support an inclusive conceptualization of knowledge (community and traditional, culture-based knowledge, as well as qualitative and quantitative forms). Social work, which has its feet firmly planted in research, clinics, communities, organizations, and public policy, is well positioned to test these models and, in partnership with communities, to develop new ones.

Priority 6: Foster Development of an Interprofessional Health Workforce

According to the Bureau of Labor Statistics (2014), the demand for a social work health-care workforce will outpace that for all other occupations: Between 2012 and 2022, employment of health-care social workers is projected to grow by 27% and employment of mental-health and

substance-abuse social workers is projected to grow by 23%. The anticipated rise in the need for social workers in these areas coincides with the increasing need for health-care services as baby boomers age. The rise also coincides with increases in the diversion of drug offenders to treatment programs (Bureau of Labor Statistics, 2014). Likewise, given the focus on community- and settings-based interventions, additional training is needed for public-health social-work. Because of these occupational trends, social work and related health-care disciplines can create integrated pathways to health careers in social intervention. The fundamental contribution from such a collaboration would be an enhanced empirical foundation for specifying the knowledge and skills that define each of the career steps from paraprofessional community-health worker to graduate professional. A unified scheme would provide students with preparation for the continuum of clinical services and community work to promote health in marginalized communities. This pathway should also incorporate sustainable models to increase the number of ethnically and culturally diverse paraprofessional and professional providers delivering culturally grounded and evidence-informed services.

Social work can lead integrated initiatives for evidence-based workforce development by reviewing practitioner preparation for transdisciplinary social interventions, defining a core curriculum for the initiatives, establishing training standards for advanced practice in specialized areas, and identifying new competence areas for the emerging health system (e.g., prevention science, place- and settings-based research, community engagement, improvement science, health-data analytics, and team methods for collaborative behavioral and physical health care). Additionally, we should develop an integrated public-health social-work curriculum across master of social work programs. That curriculum should go beyond master of social work– master of public health dual-degree programs.

Priority 7: Stimulate Multisectoral Advocacy to Promote Health Equity Policies

Social work's disciplinary competencies related to the person-in-environment perspective and applied ecological theory offer unique opportunities to forge broad alliances capable of advocating for a more comprehensive, multisectoral view of health determinants as well as for practices and policies to address the racial and economic injustices that form the bedrock for health inequities. Part of the strategy to close the gaps in health among subgroups is "'leveling up' the health of less advantaged groups" (Farrer et al., 2015, p. 394). The WHO has demonstrated the utility of multisectoral approaches to leveling up conditions for vulnerable and marginalized populations. Government, health care, public health, and university entities have been the traditional participants in efforts to eliminate health disparities, but many settings within communities could be employed in advocacy and change efforts. According to Williams and Wyatt (2015, p. 556), "Multilevel policies … in homes, schools, neighborhoods, workplaces, and religious organizations can help remove barriers to healthy living and create opportunities to usher in a new culture of health in which the healthy choice is the easy choice." Sectors far removed from health must be brought into multisectoral advocacy to ensure that the efforts include a broad range of constituencies. Social work researchers and practitioners can play a leading role in collaboration with populations that are most affected by social determinants of health inequities; they can raise public awareness and understanding of the social determinants of

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health affecting the well-being of communities, and they can provide ongoing multisectoral training in policy advocacy for health professionals (Farrer et al., 2015).

Multisectoral approaches have effectively translated research into action through networks of individuals, communities, government entities, health providers, institutions, businesses, and industries, but more innovation is needed. One historically momentous model for using innovation facilitators to bridge science and best practices in a critical sector of the national economy is the 80-year old agricultural extension service, which is based in public universities. In the modern adaptation of that institution for the purpose of community health transformation, schools of social work have an opening to create (or sometimes join) continuous university-extension relationships with distressed communities and their health services. The urgency of the need to make rapid progress in the health of poor communities and communities of color calls for national collaboration both to advance the science for breaking the cycle of intergenerational disadvantage and to translate that science into action. Practice-based research networks focused on community transformation can systematically support upward social mobility for a generation of underrepresented racial and ethnic minority populations as well as impoverished young people. At the same time, fully engaging in that commitment has the potential to fundamentally change the profession—in terms of its science and its professional education to prepare social work specialists in health services, community practice, and multisectoral policy advocacy.

CONCLUSION

Beyond the opportunities provided within the context of the ACA and Healthy People 2020, the proposed priority areas for health equity give expression to several broad themes. First, as we have emphasized above, the challenge underscores the need for research and practice efforts that incorporate a social-determinants approach. Second, the goal of health equity implies that health inequities and suffering caused by social determinants extend beyond the patient to family members and their communities. Thus, community-wide changes are critical and a settings-focused agenda is imperative. All efforts related to these health-equity priorities should emphasize the importance of incorporating community voice and vision. Third, efforts to achieve health equity should focus on culturally grounded prevention and social innovation. Fourth, the priorities noted below call attention to the fact that all prevention, care, and treatment efforts, whether simple or highly complex, should have an evidence base that provides program planners, practitioners, community leaders, and providers with effective, culturally congruent models. This evidence base should be inclusive of multiple knowledges (e.g., traditional cultural knowledge) as well as data gathering strategies (e.g., qualitative and quantitative). Finally, the challenge emphasizes the need for cross-sector collaboration in the conduct of research and prevention efforts. Collaborators will share access to data, expertise, and capacity-building opportunities. The profession has a long history of community organizing and community development. As a result, it is poised to nurture community empowerment and build community capacity to address health determinants and eradicate health inequities.

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Finally, our proposals to address this grand challenge are designed to stimulate the national conversation on the role that social work can play in promoting health equity. Social work is poised and primed to bring our research, education, policy, and practice skills together to adapt and apply what we know for use in national efforts to reduce health disparities; improve mental and physical health outcomes, particularly among society's most vulnerable and marginalized; and ultimately to promote health equity and well-being for our society as a whole. As our science and profession have matured, we have grown in readiness to tackle the "scale, complexity, and interrelatedness of societal problems—from poverty and dramatic inequality to the sustainability of health and human service infrastructures across the globe—[and to] demand problem-solving skill and collaboration at levels perhaps unprecedented in our history" (Uehara et al., 2013, p. 165). The health of future generations depends on the actions we take in our current generation. Let us be remembered not only for our science and practice but also for our resolve to harness our collective will and intelligence to transform the health of the nation.

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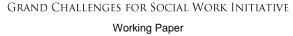
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