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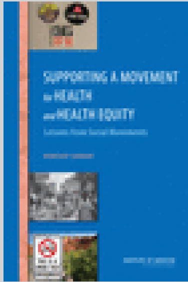

Supporting a Movement for Health and Health Equity: Lessons from Social Movements: Workshop Summary

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Alison Mack, Alina Baciu, and Nirupa Goel, Rapporteurs; Roundtable on Population Health Improvement; Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; Board on Population Health and Public Health Practice; Institute of Medicine

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SUPPORTING A MOVEMENT *for* HEALTH *and* HEALTH EQUITY

Lessons from Social Movements

WORKSHOP SUMMARY

Alison Mack, Alina Baciu, and Nirupa Goel, *Rapporteurs*

Roundtable on Population Health Improvement

Roundtable on the Promotion of Health Equity and the
Elimination of Health Disparities

Board on Population Health and Public Health Practice

INSTITUTE OF MEDICINE
OF THE NATIONAL ACADEMIES

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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The serpent adopted as a logotype by the Institute of Medicine is a relief carving from ancient Greece, now held by the Staatliche Museen in Berlin.

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"Knowing is not enough; we must apply.
Willing is not enough; we must do."
—Goethe

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Reviewers

This workshop summary has been reviewed in draft form by individuals chosen for their diverse perspectives and technical expertise, in accordance with procedures approved by the National Research Council's Report Review Committee. The purpose of this independent review is to provide candid and critical comments that will assist the institution in making its published workshop summary as sound as possible and to ensure that the workshop summary meets institutional standards for objectivity, evidence, and responsiveness to the study charge. The review comments and draft manuscript remain confidential to protect the integrity of the process. We wish to thank the following individuals for their review of this workshop summary:

Dawn Alley, Office of the Surgeon General, U.S. Department of Health and Human Services
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Frances Lu, University of California, Davis
Connie Mitchell, California Department of Public Health

Although the reviewers listed above have provided many constructive comments and suggestions, they did not see the final draft of the workshop summary before its release. The review of this workshop summary was overseen by **Susan J. Curry**, University of Iowa. Appointed by the Institute of Medicine, she was responsible for making certain

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that an independent examination of this workshop summary was carried out in accordance with institutional procedures and that all review comments were carefully considered. Responsibility for the final content of this workshop summary rests entirely with the rapporteurs and the institution.

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Acronyms

ACA	Patient Protection and Affordable Care Act
ACT UP	AIDS Coalition to Unleash Power
EPA	U.S. Environmental Protection Agency
EU	European Union
IOM	Institute of Medicine
MEDA	Mission Economic Development Association
MPN	Mission Promise Neighborhood
NAACP	National Association for the Advancement of Colored People
NRC	National Research Council
OSHA	Occupational Safety and Health Administration
PICO	People Improving Communities through Organizing
PSR–LA	Physicians for Social Responsibility–Los Angeles
RWJF	Robert Wood Johnson Foundation

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1

Introduction[1]

The Institute of Medicine (IOM) Roundtable on Population Health Improvement brings together individuals and organizations that represent different stakeholders (e.g., from the public and private sectors and from health and health care) in a dialogue about what is needed to improve population health. The roundtable engages members and outside experts, practitioners, and organizations on three core issues: exploring community action in transforming the conditions that influence the public's health, supporting fruitful interaction between clinical care and public health, and strengthening governmental public health.

The IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities was created to enable dialogue and the discussion of issues related to (1) the visibility of racial and ethnic disparities in health and health care as a national problem, (2) the development of programs and strategies to reduce disparities, and (3) the emergence of new leadership.

On December 5, 2013, the two roundtables co-sponsored a workshop, Accelerating a Movement to Improve Health and Promote Health Equity, to explore the lessons that may be gleaned from social movements, both those that are health-related and those that are not primarily focused on

[1] The planning committee's role was limited to planning the workshop. Statements, recommendations, and opinions expressed are those of individual presenters and participants, and are not necessarily endorsed or verified by the IOM, and they should not be construed as reflecting any group consensus.

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health. The workshop was organized by an independent planning committee in accordance with the procedures of the National Academy of Sciences. The planning committee was co-chaired by David Kindig and Mildred Thompson and was composed of Terry Allan, Marthe Gold, George Isham, Sanne Magnan, and Mary Pittman. The task of the committee was to plan and conduct a public workshop featuring presentations about and discussions of such topics as (1) elements identified from the history and sociology of social change movements and (2) optimizing how such elements can be applied to present-day efforts nationally and across communities to improve the chances for long, healthy lives for all (i.e., with health equity) (see Box 1-1). Unlike a consensus committee report, a workshop summary may not contain conclusions and recommendations, except as expressed by and attributed to individual presenters and participants. Therefore, this summary has been prepared by the workshop rapporteurs as a factual summary of what occurred at the workshop.

Roundtable members became interested in learning about movement building as they became increasingly aware of the signs of movements occurring across the country, focused on organizing communities around issues important to them and linked with health. The roundtable members believed it was important to learn and engage in dialogue about scholarship and practical experiences with movement building both in the realm of health and in other areas of society.

The idea of movements and movement building is inextricably linked with the history of public health (see, for example, Hoffman, 2003; Morley, 2007; and Appendix C). Historically, most movements—including, for example, those for safer working conditions, for clean water, and for safe

BOX 1-1
Statement of Task

An ad hoc committee will plan and hold a public workshop that will feature presentations on and discussion of topics such as (1) elements identified from the history and sociology of social change movements and (2) optimizing how such elements are applied to present-day efforts nationally and across communities to improve the chances for long, healthy lives for all (i.e., with health equity). The committee will develop the agenda and identify specific meeting objectives, select and invite speakers and other participants, and moderate the discussions. An individually authored summary of the presentations and discussions at the workshop will be prepared by a designated rapporteur in accordance with institutional guidelines. An individually-authored brief workshop summary will also be prepared by a designated rapporteur in accordance with institutional guidelines

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food—have emerged from the sustained efforts of many different groups of individuals, which were often organized in order to protest and advocate for changes in the name of such values as fairness and human rights.

Movements are complex phenomena in the social life of nations and communities; their causes, evolution, tools, objectives, and achievements are varied, contested, and sometimes controversial. Social scientists, advertising executives, and other experts may disagree greatly about what constitutes a movement. The purpose of the workshop was not to focus on definitions and theoretical purity, but instead simply to have a conversation about how to support the fragments of health movements that roundtable members believed they could see occurring in society and in the health field. Recent reports from the National Academies have highlighted evidence that the United States gets poor value on its extraordinary investments in health—in particular, on its investments in health care—as American life expectancy lags behind that of other wealthy nations (IOM, 2012; NRC and IOM, 2013). As a result, many individuals and organizations, including the U.S. Department of Health and Human Services Healthy People 2020 initiative, have called for putting the nation on the track for better health and longer lives for all; hence the interest of the two roundtables in learning about movement building. As Kindig and Thompson explained in their opening remarks, exploring the essential ingredients of social movements, as described by scholars and practitioners, is important information for accelerating a population health and health equity movement. The equity component relates to a recognition that socially unfair circumstances, sometimes created by longstanding policies, force some individuals and groups to live, work, study, and play in environments that make the healthy choice the harder choice. Many examples provided by speakers illustrate how the disempowered can become empowered to make their voices heard, and ultimately, to join with others in actions that change their neighborhoods and communities.

The workshop was moderated by roundtable leaders Thompson, Isham, and Kindig, and it featured invited speakers providing three standalone presentations and taking part in two topical panels. Chapter 2 of the workshop summary offers a synopsis of the morning's keynote presentations, which provided insights from sociology and the history of social movements. Chapters 3 through 5 focus on specific topics and include overviews of one or more speaker presentations; in each chapter the overview is followed by a section that synthesizes a group discussion that was led by moderators and included roundtable members and audience members. Chapter 3 summarizes the first panel's presentations on lessons from practitioners in health-related movements, Chapter 4 describes the perspective of a philanthropic organization that supports communities

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in their movement building efforts, and Chapter 5 summarizes presentations featuring social movement practitioners from non-health-related domains. Chapter 6 concludes the workshop summary with a general discussion of the day's proceedings.

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2

Lessons from Social Movements

The workshop opened with presentations from two scholars of social movements: Francesca Polletta, professor of sociology at the University of California, Irvine, and Marshall Ganz, senior lecturer at Harvard University. Polletta shared insights from her work and from the sociology literature on the formation and dynamics of social movements, and she described circumstances, structures, and strategies that are associated with effective social movements (Polletta, 2008).

Ganz, who studies and teaches leadership, organization, and strategy in social movements and politics and who has worked as a community organizer, described lessons learned from his long experience in building successful social movements and in training change leaders (Ganz, 2010).

INSIGHTS FROM THE SOCIOLOGY OF SOCIAL MOVEMENTS

Concerning the need to establish goals for a movement for health improvement and equity, Polletta noted that the history of social movements indicates that movements are well served by pursuing multiple goals. Even "vague and capacious" goals can be advantageous, she said, because they may have broad appeal and therefore widen recruitment of participants and supporters. Also, a group that undertakes several goals is more likely to find success in at least some of them (e.g., litigation and consciousness raising, which have been shown to be mutually reinforcing).

Polletta then reviewed what sociologists have learned about how

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participants in successful social movements become mobilized to support a cause. "There is debate over every single one of the points I am going to make today," she said, and welcomed workshop participants to challenge her conclusions. Sociologists define a social movement as "an organized effort to change laws, policies, or practices by people who do not have the power to effect change through conventional channels," Polletta said. She emphasized that while movements often target the government and seek legislative change, they also challenge institutional policies and practices outside the government, as well as popular beliefs and common behaviors.

"The single most important insight of social movement research over the past 40 years is that movements don't come out of nowhere," Polletta said. Rosa Parks, for example, was not simply a woman too tired to stand up on the bus one day; rather, she was a longtime civil rights activist and secretary of the Alabama chapter of the National Association for the Advancement of Colored People (NAACP). Since most social movements arise from the efforts of stalwarts for a cause, it is important to understand how such activists are able to gain the necessary leverage to mobilize more broadly. Poletta described three "essential ingredients" that contribute to mobilization: political opportunities, mobilizing structures, and resonant frames (i.e., effective messaging).

Political Opportunities

"Political opportunities are typically defined as changes in the political environment that make the government newly open to challengers' claims," Polletta explained, adding that it is important to remember that movements target more than the government alone. Political opportunities include electoral instability, cleavages within a ruling elite or regime, new legislation, or even rhetoric (e.g., the president's statement on inequality)—that signal the government's openness to challengers' claims. Similarly, opportunities may be created by the presence of allies within or around the government who can petition for the movement's cause; and the appearance of threats that support the movement's claims (e.g., as the Three Mile Island disaster provided support for the anti-nuclear power movement).

The recent passage of the Affordable Care Act (ACA) presents several political opportunities for a movement seeking an enlarged notion of public health, Polletta said, despite the fact that the ACA itself has little to say about public health.[1] The extraordinary media coverage of the

[1] Polletta used "public health" to refer to "the public's health" or population health and not to the governmental public health agencies.

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ACA's implementation means that groups promoting public health could make arguments in the press that the act does not sufficiently support cost-effective preventive health care or that other factors than access to health care determine the state of the nation's health. Such efforts would be worthwhile, she said, because mainstream news media continue to set the terms of public debate, and policy makers pay attention to the media, including newspapers.

Bureaucrats implementing the ACA may also further the cause of health improvement and health equity, Polletta said, much as support was garnered for the elderly following the passage of the Social Security Act in 1935. State health insurance exchanges have some flexibility in their interpretation of the act, which could be shaped by officials sympathetic to an enlarged notion of public health, she pointed out. Polletta suggested that a public health movement could also find allies among organizations that supported the passage of the ACA (e.g., the AARP and several unions) and which now potentially could be convinced to adopt the cause of health improvement and equity. These organizations may prove instrumental in leading change beyond the purview of government—an arena that social movement scholars now recognize as important to achieving movement goals overall, she added.

Reforming the practices of the health care industry or of medical schools and other institutions may effectively further the cause of health improvement, Polletta said, and in the current climate of increasingly consumer- or patient-oriented health care this is a real possibility. She noted that the movement for alternative medicine made little headway until insurance companies recognized the value of that approach and that corporations, sensitive to issues that affect their reputations, supported equal treatment of gay and lesbian employees before governments did.

Mobilizing Structures

How does one get people mobilized to participate in a social movement? "People rarely join movements on their own," Polletta said. "Even if you believe in a cause, it doesn't make rational sense to participate," she explained. "It makes more sense to be a free rider. If the movement wins, you're still going to enjoy the benefits." People who join movements generally feel compelled to do so as a result of messages they receive from pre-existing structures (e.g., churches in the southern United States that buoyed the civil rights movement or breast cancer support groups that encourage advocacy) or from friends or others whom they respect.

The Internet makes it easy to support a social movement, Polletta noted. "If participation means signing a petition, and all you have to do is click a button, you have solved the free rider problem," she said. Thus,

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it is possible that Web-based organizing may make pre-existing mobilizing structures less important to the growth of new social movements, but this will be true only if Internet-based protest actually foments change. "I think it can," Polletta said.

Research suggests that many effective social movements combine grassroots participation with support from elites. "Outsiders" who bring time, energy, and commitment to a cause can ally with "insiders," such as political officials and executives who have political and economic capital and connections. "We need to think much more about ways in which elites and grassroots participation can work together effectively," Polletta said. Another characteristic of successful social movements is the presence of coalitions, which are strategically beneficial, but are effective only when personal relationships and comfort among people of the separate groups are forged.

Deploying Effective Messages

"To mobilize participants, garner media coverage, enlist support, delegitimize antagonists, and persuade policy makers, movement groups must generate a persuasive message," Polletta said; that is, they must "frame," or communicate, their issue in a way that resonates with the general public. Effective framings explain the problem, offer a solution, and motivate participation, and they do so in the context of dominant values, such as equality, cost effectiveness, and personal responsibility, Polletta said. Equality is an especially persuasive theme, she said, and it usually trumps the theme of personal freedom; according to findings by the Pew Research Center. Polletta noted, that according to the Pew findings, 90 percent of Americans believe that "the government should do everything it can to ensure equality of opportunity" (Pew, 2009).

Polletta's work has led her to the observation—one that not all movement researchers agree with—that social movements are most effective when they rely on multiple framings. As an example, she spoke of using possibly contradictory arguments against the death penalty in order to appeal to different audiences: first, that capital punishment violates the sanctity of life, and, second, that it is not an effective deterrent to murder and therefore not a cost-effective means of crime control. How important is "staying on message" in mobilizing support for a social cause? Although some pundits may disagree, Polletta said, "in fact you maintain more in the way of support and coverage by having multiple messages that speak to different groups."

Research also suggests that effective framing demands an antagonist, Polletta said. "It is hard to mobilize without an enemy," she explained, although she noted that some successful social movements, such as

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Mothers Against Drunk Driving and anti-littering campaigns have done that. Movements without antagonists, sometimes called "consensus movements" can be effective, but are often limited in scope and momentum. She offered as an example the movement to address climate change, which has been compromised, according to environmental activist Bill McKibben, because it has become a "lifestyle" movement of individual recyclers and Prius drivers rather than a broadly driven campaign to compel developed nations to decrease their greenhouse gas emissions.[2]

Those who wish to mobilize a movement to promote health equity and raise awareness of the social determinants of health face a similar dilemma, Polletta said. "[I]f you don't have an antagonist, then does the movement risk being styled a lifestyle movement?" she asked. Although convincing individuals to take responsibility for their health through such means as weight control and exercise is undeniably important to the health of individuals, "you don't want that to be the sum total of the movement," Polletta said, and she challenged those who are seeking to create such a movement to define without alienating potential allies who or what they are fighting against as they strive for health improvement.

PRACTICAL LESSONS IN MOVEMENT BUILDING

Ganz began his presentation by emphasizing the importance of social movements over the course of U.S. history. That social movements have served as the main engine of political change in this country is not an accident, he said; rather, it is a direct result of the "particularly sclerotic set of electoral and formal political institutions" established by the founding fathers, who intentionally created a system with multiple barriers to innovation, including "many veto points, [at the] legislative, judicial, state level, and such deep principles of unequal representation, whether the Three-Fifths rule[3] as applied to voting or institutions like the Senate that allocated representation regardless of the electorate." Models for change instead emerged from the religious movements known as the Great Awakenings, which were followed by the temperance movement, the abolition movement, the suffrage movement, the populist movement, the early labor movement, the civil rights movement, the women's movement, the environmental movement, and the conservative movement,

[2] Speaker Martha Arguello of Physicians for Social Responsibility–Los Angeles later challenged Polletta's characterization of McKibben as "the father of the climate change movement." The environmental justice movement has had a long interest in climate change, Arguello said, and it is crucial to recognize their broad, committed leadership on this issue, particularly as that recognition influences funding decisions.

[3] Refers to the so-called Three-Fifths Compromise of 1787, which determined how slaves would be counted for electoral purposes.

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among others. When the United States is not under the influence of war or depression, political change happens primarily through the influence of social movements on electoral politics, Ganz concluded.

According to Ganz, "social movements emerge from the efforts of purposeful actors, individuals or organizations, to respond to changes, to conditions experienced as unjust—not just inconvenient, but unjust—so as to assert new public values, form new relationships, and mobilize political, economic, and cultural power to translate those values into action." He also defined social movements by what they are not: fashions, styles, or fads, none of which are collective, strategic, or organized. However, he added, to say that a social movement is organized "doesn't always mean that everybody is getting along," because social movements often incorporate competing groups. The aim of such movements is not simply to reallocate goods, or "win the game," but instead to change the game's rules. Furthermore, he said, social movements are not the same as marketing, which is transactional in nature (e.g., "Buy my idea, give me your vote"), leaves people unchanged, and does not attempt to build capacity. At best, marketing can mobilize people to support a movement over the short term, but it cannot sustain participants' commitment.

Relationships Build Movements

Movement building is about building relationships among people that change the people involved and that also build capacity, Ganz stated. It involves both mobilizing people and organizing people, which are two distinct processes. To understand the distinction, he said, consider what happened in the aftermath of the Sandy Hook Elementary School shooting, which was followed by "enormous mobilization around gun violence, [that] came up, and went away. What [the groups reacting to the Sandy Hook shooting were] confronted with was 13,000 local gun clubs of the NRA [National Rifle Association]. That is organization, which is very different than momentary mobilization," Ganz said.

Successful social movements go beyond mobilizing to actually organizing, Ganz said, which enables them to create the capacity to support ongoing and sustained change. Such efforts must be structured strategically so as to combine local action with regional and national purpose and also to benefit from timing, e.g., by taking advantage of events that shift public opinion in favor of a cause. "E. E. Schattschneider, the political scientist, pointed out that elites always try to localize conflict because they are likely to have an advantage in that setting," Ganz said; by contrast, "insurgents are always trying to create turfs that are translocal, because it creates more opportunity to create a playing field in which you can find leverage" (Schattschneider, 1960). For example, Ganz added, the battle for

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civil rights was carried out by linking cities across the South and mobilizing support in the North.

"Since participation rests on moral suasion more than economic or political coercion," Ganz said, "the outputs of movements depend on voluntary, motivated, and sustained effort" as well as on leaders who can motivate that commitment rather than merely assert control, which might work in a conventional organization, but does not in a movement. The less authoritative structure of movements tends to produce campaigns that incrementally alter the status quo. "Rarely do you start a campaign with all of the resources you need to win it," Ganz said. "You are developing the capacity and the resources you need to win it in the course of doing it."

Leadership resides at the heart of social movement activity, Ganz continued (Ganz, 2010). Leaders are those "who step up, who accept responsibility, who care deeply enough to commit, who begin to do the work of enabling others to join them to achieve purpose under highly uncertain conditions." Rather than focus on the question of "What is my issue?" successful leaders first ask "Who are my people?" because movements are built by the people whose cause is being undertaken—a cause that they themselves must define, Ganz asserted. The leader's purpose is to determine what it will take for the (powerless) people to create the power they need to solve their problem, not how the resources of the powerful can be mobilized to solve it.

Because movements are about giving voice to underrepresented people and groups, they are inherently insurgent undertakings, Ganz said. In order to do that, they must tap new sources of power, new sources of capacity, and often new leadership—something that requires not only great commitment, but also immense creativity.

Marshall Ganz's Core Practices of Movement Building

According to Ganz, five "core practices" are required to build and organize successful social movements. They are:

1. Relationship Building

"Movements are built by the formation of new relationships among people," Ganz said. People move people, and people are moved by examples of people moving people. The "skilled, intentional, purposeful forming of relationships" on which social networks can be built is essential to the success of social movements—especially insurgent ones, Ganz said. He described how in the course of his life's work, house meetings provided a way to accomplish these relationship-building goals when institu-

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tional conduits were inaccessible, both in the context of community organizing with the United Farm Workers, and later, when advising the first Obama presidential campaign. Through such house meetings, he said, movement participants established common ground for a commitment to work together, thereby creating a solid foundation for ongoing efforts.

2. *Developing a Narrative*

Ganz, as did Polletta, emphasized that successful social movements tell a story. The purpose of the story, he said, is to "articulate the challenge that is to be faced and bring alive the values to be drawn upon in order to find the moral or emotional resources to confront that challenge." Such a narrative prepares movement participants—whether as individuals, communities, or movements as a whole—to face daunting challenges by countering fear with hope, empathy, and a sense of self-worth. People gain a sense of agency through identifying with the story's protagonist as well as with a set of values, which should be understood not as abstractions, but as reflecting emotional relationships to experiences, objects, and people. Thus, he concluded, the narratives of successful movements inspire urgency and protect participants from fear, isolation, and self-doubt.

"When we work with people on this," Ganz said, "we construct it as a three-part narrative: a story of *self*, which is an articulation through narrative of why you have been called to what you have been called to; a story of *us*, which is a way of bringing alive the values shared by the community being mobilized; and, a story of *now*, which is a way of making real the challenge to those values that demands urgent action." A complete narrative, he said, answers the questions, "Why are we doing this?" "What is at stake?" and "Why do we care?" but the narrative does not explain *how* the problem should be addressed. To do that requires the next practice: strategizing.

3. *Strategizing*

Although narrative does the emotional work of movement building, strategizing is its cognitive partner, Ganz said. At its most basic level, strategizing is figuring out how to turn what people have—that is, resources—into what they need—power—in order to get what they want, he explained. "Effective movements strategize at multiple levels and equip people with the resources and the capacity to be strategists."

People are hard-wired for both storytelling and strategy, Ganz said. "We go through life telling stories and strategizing, but often we do so implicitly." In his own work, Ganz attempts to bring intentionality and purpose to these actions and direct it toward the community's goal.

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And because social movements are, in his words, "always David, never Goliath," they must compensate in resourcefulness what they lack in conventional resources. "People become the fundamental source of power of a social movement," Ganz concluded, whether they choose to walk to work instead of taking a bus in Montgomery, Alabama, to defy British rule by making their own salt in India, or to boycott California grapes. How to aggregate resources that are broadly distributed into a purposeful focused effort—and, thereby, transform the important into the urgent—is the key strategic challenge in most social movements, he concluded.

4. Action

"Unless strategy and story and the relational foundation turn into effective, clear, measurable, recognizable action, nothing much is happening," Ganz said, adding that action is occurring only if there is something to count: votes, for example, or people coming to rallies and showing up at meetings and signing petitions. "I was trained in organizing and in movement building that if you couldn't count it, it didn't happen, because you then have no way of measuring your effort—and that means you have no way of learning," he said.

5. Structures

Many participants in movements have operated under the belief that structure meant one person telling everybody else what to do, Ganz said; in reaction, his own generation came to believe that structure was evil. In the early 1970s Jo Freeman, a feminist sociologist, wrote an influential article called "The Tyranny of Structurelessness," in which she pointed out that groups naturally create some sort of structure for themselves (Freeman, 1972). If that structure is informal, she argued, decision making tends to be opaque, personalistic, and factionalized rather than explicit, accountable, and transparent. Thus, appropriate structures allow movements to coordinate, make decisions, and strategize effectively. Ganz's recent work—including for the first Obama presidential campaign—has focused on the development of such structures in the form of interdependent leadership teams and cascaded leadership teams.

Ultimately, building effective movements requires both the identification and recruitment of leaders and also their development, either with formal or informal training, Ganz said. Effective social movements carry out this identification, recruitment, and development at multiple organizational levels throughout the movement, he added. As an example of such an effective social movement, he described the Grange, a 19th-century movement supporting agricultural communities, which had

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450,000 members in 450 chapters—a structure whose operation required 77,775 volunteer leaders, of which 99 percent were local. Today, the NRA is organized along similar lines, he said. It is investment in local and intermediate levels of leadership that allows these movements to be able to build and sustain constituencies over time, Ganz said. The people in these movements are organized, not merely mobilized, as is the case with the millions of people who "click and forget" their support of a cause.

The Prophetic Imagination

In closing, Ganz shared an idea he credited to Protestant theologian Walter Brueggemann. In his book *The Prophetic Imagination* (1978), Ganz argued that transformational vision occurs at the intersection of two factors: criticality, which is perception of the world's pain, and hope, a sense of the world's possibilities and of its promise. "One without the other doesn't yield the energy for change," Ganz concluded.

DISCUSSION

Pros and Cons of Antagonism

The concept of antagonism as a tool for mobilization—when it can be used, its possible drawbacks, and its applicability to a public health movement—led to an extended discussion. It was initiated by a question from Terry Allan, president of the National Association of County and City Health Officials, and health commissioner of the Cuyahoga (Ohio) County Board of Health, who asked how a movement for population health improvement and health equity might define its opposition and avoid alienating key allies. Polletta replied, "We don't want to antagonize anyone, but we know that having an antagonist is mobilizing. We know that the media covers stories of conflict. If you present your story, then they are going to want to have the opposing side."

It is more important to be clear about what you are fighting *for* than what you are fighting *against*, Ganz said. Demonization is not very effective and can be turned against those who use it—which is not to say that healthy conflict is not good for a movement. "I wouldn't get too hung up on the enemy," he said; if the goal is clear, anyone who gets in the way is by definition an antagonist.

Mary Pittman, president and chief executive officer of the Public Health Institute, noted that demonizing an antagonist *was* an effective tool for the anti-tobacco movement, but that such obvious, single targets are not always available. When they are, she said, she worries about sce-

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narios in which antagonists learn to use the language of the movement to disguise their own intent and thereby steal power.

"That has been a criticism often leveled at groups like BP [British Petroleum] and other oil companies that have now glossy advertisements where they talk about local movement building," Polletta observed. She noted that both she and Ganz had defined social movements as representing people who are relatively powerless, so the danger of the movements being co-opted by the powerful is always there. That is why it is important for movements to be organized rather than being run by "a bunch of entrepreneurs," she added. Organizers will understand such strategic trade-offs and eschew marketing (e.g., of the sort conducted by BP) in lieu of real commitment to change. Moreover, Polletta added, "if a company is attempting to co-opt, then that provides an opportunity for a movement to say, 'These are your so-called values, but your actual practices diverge wildly.'" Revealing such co-optation as hypocritical gives the movement power, she noted. Ganz agreed and noted that Saul Alinksy, a famous community organizer, once said that organizers have to be "well-integrated schizoids" who can "polarize to mobilize and depolarize to settle" (Alinsky, 1971). Alinksy (1971) also advised that if enough pressure is applied to the opposition, it will make mistakes of which a movement can take advantage.

Nevertheless, Ganz added that he objects to the use of demonization because it gives opponents too much power. Instead, he offered the example from Shakespeare of Henry V's speech to his men before the Battle of Agincourt, in which they were vastly outnumbered by the French. Henry, Ganz noted, never mentions the enemy, but instead he focuses solely on enhancing his men's sense of worth and value. "The opposition has to be named, has to be called out, has to be recognized as opposition," he acknowledged, "but I also think we need to avoid giving it too much power."

Catherine Baase, chief health officer for The Dow Chemical Company, asked the speakers if they felt that the antagonist needs to be identified as an individual entity, such as an industry, or whether it could be something as broad as the status quo. Although it is certainly easier to stand in opposition to a clear adversary, such as the tobacco industry, it is also possible to mobilize against something more abstract, Polletta said. "We can't always put faces and names to the antagonists," she said. "We have to think about ways in which you can make the challenge to overcome structures, beliefs, practices, institutions."

By way of answering Baase's question, Ganz distinguished between "power over" problems, such as those posed by a polluting industry, and "power with" problems, which stem from a lack of cooperation or collaboration. An example of the latter was the need for cheap credit,

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which was solved by the organization of credit unions. But even in these circumstances, adversaries can emerge, he observed—in this case, predatory lenders, who lost business to credit unions. "Even when we think we are just being collaborative, power dynamics being what they are, we often wind up in a situation in which conflict comes our way," he said. "We want to change things. That is going to cost somebody something."

Therefore, Ganz continued, "the question is, under what conditions will they accept that cost?" Answering that question is a key point of strategic focus for a movement, he said. In the civil rights movement, for example, the decision was made to take on the bus company in Montgomery, Alabama—before schools, housing, or another deserving target—in order to build capacity, and then move on to other goals.

Strategic Alliances

Returning to the concern that creating an enemy might alienate potential supporters of a movement, Polletta emphasized that movements need to be open to alliances with novel and unlikely partners—for example, corporations that instituted benefits for partners of gay and lesbian employees before legislation required them to be provided.

Michelle Larkin of the Robert Wood Johnson Foundation asked both speakers to expand on this point with a specific focus on its implications for public health. "Business, for example, can at one time be an ally and in the next breath be an antagonist for us," she observed. "How do you maintain those relationships and keep those networks well connected and trusting so you can come together [and] work on the common areas . . . [but] when you have to, separate and be comfortable in . . . critiquing each other and really pushing each other to change and move forward for a better outcome?"

Longtime combatants can develop a relationship of respect, Ganz said, and such a relationship should be possible between business and public health community and its partners. The challenge in such relationships stems from power imbalances, he explained; thus, the public health community needs to organize itself to achieve the status of equal partner to industry so that it can exercise agency and truly collaborate. Otherwise, power gets in the way.

To illustrate this point, Ganz described a project in which he is involved that involves a collaboration between public health officials in New Zealand and the Pacific Islander youth community. Diabetes rates are especially high among these youth, Ganz explained, and the public health group wished to engage that community rather than try to impose its own agenda. Thus, the members of the public health group took an organizing approach, which allowed them to learn that the young

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people were much more concerned about suicide among their peers than about diabetes and that they had been organizing themselves around that issue. Public health is now supporting that suicide-prevention effort, Ganz reported, and he and colleagues have collected data that show that the young people involved in leadership teams are functioning well and that positive health outcomes are resulting from this collaboration—confirming not only the importance of true collaboration but also the notion that "agency is good for you," he concluded.

Ganz also reported that in the past 3 years he has noticed a sharp increase in interest in organizing among medical and public health students at Harvard University, where he teaches in the Kennedy School of Government. Until 3 years ago it was extremely rare for him to have such a student in one of his classes, whereas in the past year, he said, he had 20 students from the School of Public Health, half of them doctors. "I think there is something starting to happen out there that you probably sense better than I do," he said.

Polletta said that public health is an issue that crosses many institutional boundaries and disciplinary boundaries and, as such, lends itself to broad alliances. For example, she said, urban planners could take up the issue of population health improvement and health equity, developing their own movement to create cities that can be more responsive to public health concerns.

"I think there are all kinds of alliances that could be made," Polletta said. "I don't want to imagine a kind of central group directing these efforts. I think what is important is that these different groups, like medical students or urban planners, come to feel that this is their issue, that they own it, and that they want to mobilize around it."

Lessons from Occupy Wall Street

Replying to Anthony Iton of The California Endowment, who asked both speakers to "diagnose Occupy Wall Street," Ganz described this phenomenon as "a tactic in search of a strategy." It was a great tactic, he added, because it succeeded in shifting the discourse and made taxes an issue in the 2012 campaign, but it did not build the power that was needed because it was not embedded in a structure capable of strategizing. "It is as if there was one sit-in, and that was the only tactic the civil rights movement ever used," he observed. "There has to be an organizational venue in which the strategizing goes on. If it doesn't exist, then it is not happening."

Polletta largely agreed. "A lot of people say the problem with Occupy was that they couldn't agree on a goal," she observed. "I don't think there was any possibility of that." On the contrary, she argued, Occupy would

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have had greater impact if its participants had been free to organize around a broader range of issues. "If there were people within Occupy who wanted to work with progressive congressional candidates, they should have gone off and done that. If there were people who wanted to go off and squat in foreclosed homes, they should have gone and done that." She observed that the tremendous media coverage, interest, and support from surprising allies could have been utilized to push for change in many directions.

Measuring the Impacts of Organizing

Martha Argüello of Physicians for Social Responsibility–Los Angeles noted that the difference between mobilizing and organizing often confuses funders and sometimes even movement practitioners, who associate large numbers of people at rallies or demonstrations with success.

Polletta agreed. "That is the problem: How do you measure the impacts of organizing?" Because the relationships that are built by organizing are not readily quantifiable, the benefits of organizing can be difficult to ascertain. On the other hand, she said, creativity in tactics can help produce a movement that has been built without actual organizing. To illustrate this point, she told the story of Harvard University School of Public Health professor Jay Winsten, who in 1988 worked with Hollywood writers and producers to embed the concept of the "designated driver" in prime-time television shows—an apparent factor in a subsequent substantial decline in alcohol-related traffic fatalities.[4] Although Winsten's actions did not substitute for organizing in the anti-drunk-driving movement, Polletta observed, Winsten was able to take advantage of an opportunity and benefit the movement.

A movement can measure its progress in various ways, Ganz said, by counting its members, by counting its leaders, or by measuring the extent to which it has developed infrastructure. He noted that before the 2008 election, the Obama campaign measured its progress by counting votes based on voter identification—until organizers argued that a better indicator of progress would be the level of capacity that was being built, such as the number of volunteers recruited or the number of leadership teams formed. Funders, he observed, "want razzle dazzle, quick action." To maintain their freedom from such demands, movements must operate without a lot of funding, or else receive funds from several competing sources. Grant-driven organizing "is not going to produce a whole lot of change," he contended.

[4] See http://news.harvard.edu/gazette/story/2009/12/designated-driver-turns-21 (accessed June 13, 2014).

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Making What's Important Urgent

Marthe Gold of the City University of New York initiated a conversation about how movements develop a sense of urgency among different constituencies. Associating population health with cost-effectiveness and equal opportunity would seem to appeal to two broad strands of American values, but neither message seems to have "caught fire," she observed. What could be done to change that?

"I am struck by how much media attention there is right now to the inefficiencies of health care provision," Polletta replied. "There seems to be real interest in the kind of arbitrariness as well as wastefulness of health care spending." That provides an opportunity to publicize the cost-effectiveness message, she said.

The equality message is more difficult to sell because to some people it means equality of opportunity, while to others it means equality of result, Polletta continued. Health tends to be viewed as a personal, individual problem that requires self-care. If a baby born into poverty has a shorter life expectancy than one born into the middle class, she asked, "how do you get people to see it as equality of opportunity rather than equality of result?"

"Urgency is created through action," Ganz said. To illustrate this point, he described the planning behind an act of civil disobedience at Harvard to support higher pay for its janitors. "Nothing was happening until one day 28 students went in to visit the president and just decided to stay in his office until something was done," he recalled. This was a strategic action, he explained. The students had spent several years building a base of support in the university and city. "They were very smart about how they chose to do their civil disobedience," he said, because it took a general concern and "ratcheted it up to the top of the urgent list." The occupation lasted 20 days and was eventually successful. Although not all actions are so successful, they do raise urgency, Ganz concluded. One does not win all the time when one summons the moral courage to take the risks that action requires, he added; good timing helps.

One of the risks one takes in acting is offending, which might undermine one's cause, Gold observed. For example, she imagined that, to make a point about health care inequality, people might hold a protest at the funeral of a very elderly affluent person with the message that the average poor person's life is many years shorter. "That would give you a lot of publicity, but that would perhaps not be seen as sensitive," she said. But how can you both be sensitive and grab attention?

"That is where the creativity comes in," Ganz said. Ghandi used the issue of salt regulation to mobilize his countrymen to confront the British colonizers, much as American revolutionaries had done with tea, he noted. Non-violent tactics such as sit-ins and fasting are elegantly

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simple—and effective. "I think you are right about the cemetery. I don't think that would be too cool," he advised. Instead, it would be better to pursue "a rhetoric of action that is consistent with what you are seeking." "There is no easy answer to this," Ganz said. However, he added, the moral authority of the public health field is "enormous" in the United States, and that authority can be leveraged to effect change. "I really do think that there is something stirring in this whole world of healing," he said. "The dissonance between being called to healing and the commodification and bureaucratization that is faced in trying to do it is growing not just because the system is becoming more problematic, but because I think the expectations of the people who are called to this calling are raised," he said. "I think that is a good thing. I am hoping that can be a source of change for us."

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Lessons from Health-Related Movements

Building on the theoretical foundation laid by Polletta and Ganz, a diverse panel of speakers experienced in organizing and participating in health-related social movements next provided a range of strategic perspectives and thoughtful interpretation of the meaning of "health improvement" and "health equity." Moderator Mary Pittman of the Roundtable on Population Health Improvement introduced the session by stating its objectives: to highlight lessons that could be adapted to a broader movement for health and health equity and to discuss challenges and potential solutions.

Pittman also noted that the European Union (EU) has made significant strides toward health and health equity by identifying social conditions linked to the existence of avoidable social inequalities in health, documenting health disparities, and using this information to drive health strategy. Thus, the EU could serve as an example and a source of lessons learned as we attempt to encourage similar thinking in the United States, she observed.

SUPPORTING HEALTH EQUITY

Mildred Thompson, director of the PolicyLink Center for Health Equity and Place and co-chair of the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, described PolicyLink's role in supporting health equity as part of its mission to foster social and economic equity. Within the context of health, PolicyLink

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has focused on promoting health food access; she described the organization's work with the Pennsylvania Fresh Food Financing Initiative as a model of such efforts.

From Models to Movements

The Fresh Food Financing Initiative is a public–private partnership that supports economic development by supporting new grocery stores offering healthful food choices to Philadelphia inner-city neighborhoods that have become "food deserts." Because this initiative offered multiple benefits—including health—to underserved neighborhoods, it was an attractive investment for PolicyLink, Thompson said. To present this model to the Obama administration in hopes of scaling it up, PolicyLink worked in partnership with the Food Trust and The Reinvestment Fund; together they assisted in creating a federally funded National Healthy Food Financing Initiative that supports new grocery stores, converting neighborhood stores to offer healthier products, and promoting farmers markets that offer access to healthy food. This process exemplifies how PolicyLink supports valuable ideas through networking, outreach, and engagement at many levels, she said.

Similarly, PolicyLink supports the Harlem Children's Zone in its efforts to provide a path for inner-city children focused on a "cradle to careers" framework. "These are just two examples of how you can take an idea to scale and it begins to be a part of a movement," Thompson said. An idea is not a movement, she said, but if it can be connected to relevant issues and nurtured through shared interest, an idea can fuel a movement. PolicyLink also serves as partner and advisor to The California Endowment, helping it to invest strategically in healthy community initiatives, she said, and, in so doing, it coordinates with grassroots, community-based, and government organizations to change school meals, neighborhood environments, and health care institutions—and, ultimately, to shift mindsets.

Anticipating the Demographic Shift

By 2040 people of color will no longer be "minorities" in America, Thompson noted. "We don't even use that term anymore because we are not minorities in California," she said. "There are four states which are a majority of color: California, New Mexico, Texas, and Hawaii. Right now, 48 percent of all children under the age of 18 are children of color."[1] Pre-

[1] U.S. Census Bureau, 2012 National Population Projections. www.census.gov/population/projections/data/national/2012/downloadablefiles.html (accessed October 6, 2014).

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paring the nation for this important demographic shift is an overarching goal for PolicyLink, she said. It aims to raise awareness of this phenomenon and to mobilize people to make changes in policies, practices, and research in order to build an equitable economy.

This challenge is the subject of the recent book *All-In Nation: An America That Works for All* (Cárdenas and Treuhaft, 2013), a joint project of PolicyLink and the Center for American Progress. In addition to presenting the case for economic justice in an appealing, attention-getting format, the two organizations were interested in knowing how Americans were responding to the demographic shift, Thompson explained. Although most people seem to welcome the changes to come, according to a survey conducted as part of the project, some respondents expressed some reasonable concerns. For example, they expressed concerns about job security, government responsibility for the needy, and their identity as Americans in this changing context. "As long as we have conversations about those things, as long as we talk about them openly, it continues to build the sense that we are all in this together," she said, and the best way to build a movement for equity will be to include as many people as possible through such opportunities.

This project reflects PolicyLink's approach to advancing economic and social equity. "It always involves partnerships," she said. "It is about building capacity. It's about looking for opportunities for growth because inequality is not good for our economic growth." "There is urgency in this work," she continued. "It does require a movement, and we must each figure out what our role is in shaping this new tomorrow."

THE ROLE OF PHILANTHROPIES IN SOCIAL MOVEMENTS

The Robert Wood Johnson Foundation's (RWJF's) vision for the future is of a nation striving "to create a culture of health enabling all in our diverse society to lead healthy lives, now and for generations to come," and in which "health is the outcome," said speaker Michelle Larkin, the assistant vice president of the health group at RWJF. This is not a vision that the foundation can achieve on its own, she emphasized; rather, the role of foundations such as RWJF is to help shape public dialogue and thereby build demand for change, to invest directly in the people and projects that propel social movements, and to advocate for policy changes that support movement objectives.

Building Demand for Change

Shaping public dialogue begins with getting people engaged with an issue, Larkin said. In the case of health, this can take the form of

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supporting existing organizations and networks whose mission encompasses health; as an example of such an organization, Larkin pointed to MomsRising (http://www.momsrising.org), which engages mothers to advocate for all aspects of family well-being. Research—including marketing research and big data—is needed to inform the framing and communication of critical issues, she continued. "We need to provide clear, accurate, and usable information [and to] truly understand what individuals want and need and what excites them and what motivates them to take action." This is especially important given the nation's growing diversity, she added. "If we really want to empower people, and we want them to take part in creating this society that we hope for, we have to help them see where they fit, and we have to listen to them and understand how we can create demand for change."

Several ingredients are essential to building this demand, Larkin said. Organizations, people, leaders, elites, and, most importantly, communities can be brought together around an issue through networks such as parent–teacher associations, professional organizations, and communities of faith. Demand for a healthier and more health-promoting nation can be grown through highlighting success in innovation and engaging and influencing the actions of others. She encouraged health professionals to reach beyond their circle of peers to engage and influence other sectors, such as education, transportation, housing, and business, which truly represent communities and workforces.

Examples of Movement Building

Larkin offered three examples to illustrate the development of health movements. Nearly 50 years ago, the first Surgeon General's report on tobacco use shaped national dialogue by presenting scientific evidence on the harmful effects of tobacco products, sparking a demand for change which continues to shape legislation at all levels of government. Similar momentum has gathered around the issue of childhood obesity over the past decade, a cause in which RWJF has been involved. The foundation has gathered evidence on effective strategies for reducing childhood obesity through both individual choice and policy initiatives, and it is beginning to see signs that the issue is gaining attention in diverse communities and populations throughout the United States, she said.

RWJF is also involved in research to support efforts toward health improvement and equity by raising awareness of the social determinants of health. For the past 5 years, in partnership with the University of Wisconsin Population Health Institute, RWJF has compiled an annual ranking of almost every county in each of the 50 states, ranking health outcomes and predictors of health, including healthful behaviors (i.e.,

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tobacco use, obesity), access to and quality of clinical care, socioeconomic factors (i.e., education, employment, housing and environmental factors). Rankings are helping people understand the social determinants of health, highlighting successes, and showing where improvements are needed. "Those are powerful strategies that get people excited," Larkin observed.

RWJF considers the County Health Rankings and Roadmaps initiative to be a platform for the culture of health that it hopes to cultivate, Larkin said. Much as a shopping mall gathers diverse shops and shoppers under one roof to the advantage of all, she said, the County Health Rankings unite civic leaders with concerns about health determinants. "Schools, business, law enforcement, community developers, and funding agencies (e.g., United Way) that care about the communities they are part of . . . don't often work together or see their issues as having shared or common opportunities. The Rankings [and Roadmaps Initiative] provide[s] that opportunity and stimulus for our conversation and—we are happy to say—more action."

Influencing the Actions of Others

A key aspect of RWJF's work in building demand for change involves influencing others' actions, Larkin said. She described five elements of this process: (1) building relationships with sectors outside of health; (2) becoming an influential contributor to the goals of those sectors; (3) bringing ideas and innovations into the movement; (4) sharing credit (without being co-opted or co-opting); and (5) raising the visibility of solutions. To engage other sectors in a movement toward health improvement and equity, she said, "we need to be asking ourselves how we can become an influential contributor to their goals and the strategies that they are pursuing and where are opportunities for us to work together"—and also how to bring their ideas and innovations into our own movement. In order to avoid the problem of co-optation, it is necessary to cooperate on shared solutions, acknowledge contributions, and together publicize the results, she explained.

The notion of a "culture of health" is both inspiring and daunting, Larkin said, much as were the ideas that launched the civil rights and marriage equity movements as well as specific health initiatives such as seatbelt use and efforts to counteract childhood obesity. To establish a culture of health, she said, it will be necessary to connect the vision of a culture of health with the dreams and aspirations of individuals, to build engagement and partnership across broad sectors of society, and to set concrete, meaningful targets to gauge progress. "It will take time to get there," she acknowledged. "I hope that we will be more and more

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creative about how we find, solicit, engage, and influence allies because this is a heavy lift. It matters to us and me and my family, and I hope it matters to you."

LESSONS FROM THE HEALTHY CITIES AND COMMUNITIES MOVEMENT

Joan Twiss, executive director of the Center for Civic Partnerships within the Public Health Institute, offered the following four points of advice based on the center's 25 years of supporting initiatives to improve health in more than 100 cities and communities in California and in other parts of the United States:

1. Leadership and community participation that are diverse, broad, and deep
2. Geopolitical context and history matter
3. Home-grown and locally driven networks
4. A regional "fishbowl" that provides incentives

Leadership and Community Participation: Diverse, Broad, and Deep

To be effective, movement leadership should be diverse in every way, Twiss said: It should be representative of a community's full lifespan spectrum, its racial makeup, and gender and sexual orientation—and also should be diverse in terms of the functions its leaders perform. "We need people who want to plan and implement, and who want to be the spokespersons," she said. "We need to cross-fertilize across [disciplines] and cultivate stakeholders from all walks of life be they planners, engineers, civic organizations, faith-based groups. These are the model coalitions that we see and support in our work."

Twiss also stressed the importance of establishing and maintaining political support without being tied to a single administration or political party. She acknowledged, however, that policy making is critical to the work, and her organization has formed productive alliances with respected associations and organizations who have the ear of those in power and who can link them to governmental agencies involved with issues such as sustainable communities, transportation, climate change, and environmental justice.

Geopolitical Context and History Matter

"If we are trying to influence policy makers, we need to be most concerned with their concerns, which is their sphere of control," Twiss said.

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Thus, it is important to supply policy makers with information that is relevant to them, easily accessible, and ready to use. "Learn how local government is organized and appreciate the current context," including the relationship between public and private sectors, she advised. "Don't just go ahead with your agenda and hope that it will be embraced by others."

Rely on Homegrown and Locally Driven Networks

Twiss emphasized the importance of relying on homegrown and locally driven networks. "This is where the most potent strategy comes in," she said. "Networks are organic and inherently self-serving. That's a good thing. Connect them versus direct them." She noted that nationally orchestrated "top-down" movements have not, in general, been as successful as those that came up from the grassroots. "Build on what works and resist the temptation to brand it as your own," she warned. "Locals really resent that."

Professionals armed with data about the problem at hand or with likely solutions may face challenges and need to be open to various alternative scenarios, Twiss said, recalling Ganz's example of the New Zealand community that had a problem with childhood diabetes, but in which young people were most concerned about suicide. She recommended going with where the community's interests lie. Recently, she said, a community with which the Center for Civic Partnerships has worked for decades announced that it wanted to comprehensively reorganize the city from a health standpoint rather than go from initiative to initiative, without any external resources. This is a breakthrough of the sort that only comes with time, patience, and sustained involvement with a community, Twiss added.

The Regional "Fishbowl" Provides Incentive

Diffusing innovation is important, Twiss said. "Find the 10 percent that will embrace the work and embrace the initiative, and help them to advocate among their peers," and then showcase the successes that emerge. Phenomenal work in healthy communities has been achieved through the health departments of Los Angeles County and San Diego, which have been recipients of federal grants, such as Communities Putting Prevention to Work and Community Transformation. In Los Angeles, the county worked with cities that would not have been competitive in a standard competition for funds, she said. Often such successes hinge on finding one influential person, such as the smart growth developer in Southern California who in turn influenced superintendents of schools, champions of industry, and leaders of universities. "Sometimes one indi-

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vidual can be your Johnny Appleseed that can really get some things going," she said.

What a national organization such as the IOM can do to stimulate a social movement is to provide "glue" to connect activity that is already taking place, Twiss said. Twenty years ago, she recalled, 1,600 people from around the world attended an international Healthy Cities conference in San Francisco, sponsored by her organization and many others—an experience that many in attendance now say changed the way they viewed their life's work in public health. "Maybe it's time to think about something like that again," she suggested.

BUILDING PUBLIC WILL TO ACHIEVE HEALTH EQUITY

Ned Calonge, president and chief executive officer of The Colorado Trust, described four frameworks of social movements and focused on the process of building public will in support of a cause. For The Colorado Trust, that cause is health equity, an issue that the organization has embraced relatively recently and around which it is maturing. The frameworks Calonge presented have provided critical guidance in this process, he said, having allowed the Trust to organize its work and develop a strategy to move this issue forward.

Community Wealth Partners' Steps to Social Transformation

The first of four experience-derived frameworks that Calonge shared consists of the following set of 10 insights to achieve social transformation, developed by Community Wealth Partners[2]:

1. Be bold and believable
2. Discipline is key
3. Create shared leadership
4. Open your circle
5. Communications is strategy
6. Change the conversation
7. Build public support
8. Live in the market
9. Experiment, learn, and evolve
10. Build culture, intentionally

"This is a roadmap of how to be successful in social movements," Calonge said. Focusing on the third and fourth insights, which concern leadership,

[2] See http://communitywealth.com/transformation-insights (accessed June 13, 2014).

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he observed that shared leadership requires humility, as Ganz pointed out, and that by opening one's circle, the number of possible stakeholders in a cause can be increased significantly. "We need to work with everyone we can who is interested in trying to reach the goal of improved population health or health equity," he advised.

A Framework for Building Public Will

The Metropolitan Group's framework of five phases for building public will provides important guidance for this crucial process, Calonge said. The first phase, "framing the problem," requires research to build a knowledge base on the causes of a problem and its cultural context and to identify entities that can have an impact on it. These steps lead to an assessment of current work, the players involved, and gaps to be addressed. In the case of framing the problem of health inequity, he said, a body of research exists on this issue, and government agencies and foundations are already recognizing the importance of the social determinants of health. On the other hand, he added, the cultural context of a dialogue about equity may present challenges, given foundational economic values that can obscure the uneven playing field upon which health inequities operate. This makes it necessary to learn who can make a difference, build on others' successes, and invest wisely to further the cause of health equity.

The second phase of building public will, Calonge said, focuses on raising public awareness of the problem by using information to raise the sense of urgency around the issue. This requires an understanding of the audience for the message and recognizing that something that worked elsewhere may not move the current target population. Calonge illustrated this point with the example of the RWJF health equity slogan, "Your zip code is more important than your genetic code." Although it may have resonated in some parts of the country, he reported that it fell flat in rural Colorado, where people simply countered, "I can't change my zip code." Conveying the meaning of health equity to that particular population required that they understand that some people are unfairly denied access to a healthy life. "Opportunity and fairness play a little bit better than equal in rural Colorado," he said; in order to build public will there, one must recognize that attitude and connect the issue of health equity to opportunity and fairness.

People cannot change the personal values of others, Calonge said, but they can change attitudes by building and delivering tested messages through traditional communications as well as through advocacy and grassroots outreach. "You take social marketing and grassroots outreach

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and movement building and stick them together, and that is public will building," he said.

The IOM has a key role to play in the third phase of public will building, which involves the sharing of information. Through the collecting and dissemination of information on an issue, Calonge explained, such communities of experts can engage politicians, health care systems, and foundations and thereby promote policy changes.

In the fourth phase, Calonge continued, the creation of personal conviction leads to action by individuals and organizations that actively champion the issue. Furthermore, successful movements create aspirational community expectations and publicly celebrate their successes in order to encourage more widespread participation.

The fifth and final phase focuses on evaluating and reinforcing progress, including examining whether or not messages succeeded in building public will for a cause. The Colorado Trust recently discovered that one of its two key messages, "Your health care is too important to leave up to others," was successful, while the other, "You should be able to get the health care you need when and where you need it," proved ineffective with health care organizations, which constitute an important segment of the Trust's audience, Calonge reported. "We are learning from that and building new messages going forward."

A Framework for Change

Figure 3-1 depicts The Colorado Trust's equity theory of change as a flow chart, connecting strategies with intermediate and long-term outcomes, together with the group's vision of healthy and productive lives for all Coloradans. To achieve this goal, Calonge said, the Trust is investing in evidence-based policy and advocacy in order to build public will in favor of healthy communities. In particular, he noted that the Trust supports community-based participatory grant-building, a process that encourages the growth of authentic partnerships that can serve as the foundation for a movement for health equity.

Bill Moyer's Eight Stages of Social Movements

The fourth and final framework Calonge presented was created in 1987 by Bill Moyer (Moyer, 1987). It comprises eight stages through which social movements transition on their way to establishment (see Box 3-1).

"I think we are in the three-to-four range," Calonge observed of the movement for health equity. The conditions are right, and the movement is starting to take off, he said, but he warned against the next stage: iden-

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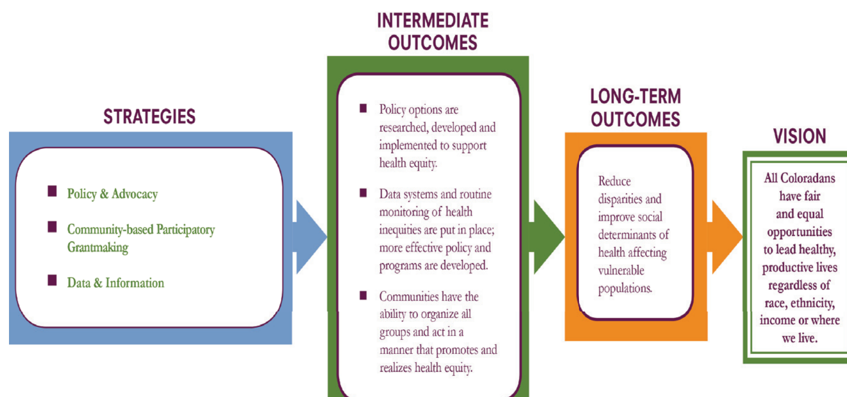

FIGURE 3-1 The Colorado Trust health equity theory of change.
SOURCE: Calogne presentation, December 5, 2013.

BOX 3-1
Stages of Social Movements

1. Normal times
2. Prove the failure of institutions
3. Ripening conditions
4. Social movement take-off
5. Identity crisis of powerlessness
6. Majority public support
7. Success
8. Continuing the struggle

SOURCE: Adapted from Moyer, 1987.

tity crises in the form of "movement fatigue." Ironically, he observed, such challenges often arise just as a movement is starting to gain traction.

LESSONS FROM THE WALKING MOVEMENT

In introducing his presentation, Raymond J. Baxter, senior vice president for community benefit, research, and health policy at Kaiser Foundation International and president of Kaiser Foundation Health Plan, invited the audience to join a social movement in development. "It is a movement that is about health and meaning and happiness, and it doesn't really have a demon," he said. "It's about walking as a way of life."

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Five Features of Successful Social Movements

Before presenting the case for walking, Baxter noted that the walking movement shares several key features with other successful social movements, including the health-related movements that shaped his career: the institutionalization of mental institutions and nursing homes, tobacco control, childhood lead poisoning, and AIDS. "Those movements drew on different core constituencies for support and succeeded with seemingly different strategies," he said. However, at their core, they had at least five things in common, and Baxter listed the following:

1. *Everyone was invited*. These movements were grounded in concepts of equity, drawing in and representing multiple interests and including unlikely allies. They organized broad-based coalitions—and coalitions of coalitions—to extend the reach of what otherwise could have been perceived as a narrow interest group.
2. They *worked on multiple fronts*. These movements launched comprehensive attacks that changed practices, behavior, policies, and cultural norms. To do this, they built on small successes to create bigger ones which ultimately reshaped societal expectations.
3. They had *clarity of purpose*. Each movement was able to articulate a clear set of values, not just goals. Those values drove activities and served as a rallying point and a magnet to bring in more supporters and participants.
4. They provided *meaningful points of entry* for individuals and for organizations, offering many ways for people to join and many levels of participation. They understood the value of action, and so provided ways to engage people either as individuals or collectively or as members of an organization, as well as ways to form and strengthen personal and organizational relationships. Those actions positively reinforced participation because they helped people see how they benefited from the movement as well as how they could contribute to it.
5. They engaged in *distributed action*. Successful social movements have always been messy. Rather than rely on a linear plan, the leaders of these movements relied on and built relationships and capacity and capabilities, embracing opportunities as they emerged. They achieved success through distributed, shared, and often unpredictable and unpredicted action—and they continue to do so because such movements are never-ending.

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The Walking Movement

Walking—which has had a powerful role in many social movements—merits one of its own, Baxter argued. The most direct benefit of walking is its ability to reduce the growing burden of chronic diseases, which currently account for 80 percent of health care costs in the United States and 65 percent of deaths worldwide. Risk for cardiovascular and lung diseases, diabetes, and cancer can be substantially modified through exercise as well as through other behavioral changes. "If you could cut your risk of cardiovascular disease or diabetes or chronic lung disease or some cancers or dementia by 40 to 60 percent, would you take that action?" Baxter asked. "Walking 30 minutes a day, 5 days a week, can cut the risk of premature death from those factors by that much."

To grow a constituency of support for walking, Baxter's group launched an awareness campaign that consisted of speeches, modeling behavior, a social media campaign, and a website[3] offering a range of resources, including publications, a free smart phone app, and a 30-minute documentary, *The Walking Revolution*. The group has also been helped by a pre-existing "backbone organization," America Walks,[4] that is a coalition of hundreds of organizations united in their support for walkable communities.

From this foundation, Every Body Walk! shifted toward movement building by hosting a summit in October 2013 in Washington, DC, that drew more than 200 advocates from about 150 national organizations, including doctors, policy makers, developers, realtors, employer groups, foundations, and elected officials. The summit participants discussed how to reshape behavior, policies, practices, and social norms to encourage both walking and walkability. Baxter concluded his presentation with a video clip that showed the summit.[5]

In the discussion session following panel presentations, Terry Allan asked what lies ahead for the walking movement. Baxter responded that in the quest for distributed leadership, Kaiser Permanente downplayed its brand, focusing instead on funding and supporting various initiatives and on building relationships and social networks. Now, in order to support the walking movement to maturity, there is a need to define the role of the national group of organizations involved in Every Body Walk! in the context of many successful local initiatives.

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[3] See http://everybodywalk.org (accessed June 13, 2014).
[4] See http://americawalks.org (accessed March 28, 2014).
[5] See http://www.youtube.com/watch?v=XfXx7rKlLIc (accessed March 28, 2014).

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PANEL DISCUSSION

A lively discussion followed the panel presentations, sparked by questions from in-person attendees and webcast participants. Although the questions, as described below, addressed a variety of topics, most threads of the discussion ended up touching on the overarching issue of the language used by movements and its potential to "open the circle," uniting a broad spectrum of constituencies in support of a cause.

From "isms" to Equity

Winston Wong, medical director of the Kaiser Permanente Community Benefit, Disparities Improvement and Quality Initiatives, noted that none of the panelists made direct mention of the "isms" (e.g., racism, sexism, ageism, homophobia, etc.). Is that framing of the issues antiquated, he wondered, or is there still a case to be made for calling out issues that have driven the major social movements?

Thompson replied that while she often specifically mentions issues of race in her presentations for PolicyLink, she rarely uses the term "racism." There is a balance to be maintained between careful use of language and confronting tough topics, she observed, and the term "equity" may help maintain that balance.

Larkin noted that in the course of conversations on the county health rankings that have taken place in communities around the country, the "isms" issues have come up as challenges to improving those rankings. These moments have provided useful opportunities for community leaders and members to openly discuss issues that might otherwise have been avoided, she said, and they have also raised awareness of the often invisible, but significant, divisions that exist within communities.

Terry Allan argued in favor of a collective, community understanding of "the narrative around issues of the 'isms.'" In Cleveland, he reported, eliminating racism as a social determinant of health emerged as a central theme of the city's health improvement plan as a result of discussion with community groups. "That term requires a lot of dialogue and discussion, a lot of emotion," he observed; thus, a developing movement for public health will need to grapple with the question of addressing racism and other "isms" directly.

It is not a question of whether to address the role of racism in health inequity, but when, Calonge said. "You are going to have to address it, and you will call it racism at some point. The issue is, where is that tipping point?" In addition to the personal journey of recognizing one's own biases, there is a need to publicly acknowledge the impact of race throughout the history of any community. When and how should that process occur?

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Thompson responded to Calonge's query with an example from her experience working with a social justice initiative in Seattle–King County, Washington. After considerable discussion, the community decided that eliminating racism would be the focus of their efforts. At the time, she said, she wondered how the group would approach this daunting goal and how they would measure their efforts. But out of this resolve, she reported, they were able to create a public health department initiative on racial equity after shifting their frame from eliminating racism to social justice. In so doing, she said, "they were able to get the entire department to buy into the idea," having made the terms of change inclusive, while not compromising their primary issue.

The language of shared values is key, argued Jeff Levi of Trust for America's Health. Raising the example of gay marriage, he noted that the tide of public opinion in the United States turned "when we stopped talking about being anti gay marriage as being homophobic and we started to present it as freedom to marry and marriage equality." By reframing that issue in terms of personal freedom, the marriage equity movement connected with values shared by a majority of Americans rather than challenging personal beliefs regarding marriage.

Changing Values Versus Changing Attitudes

Sanne Magnan, president and chief executive officer of the Institute for Clinical Systems Improvement, contrasted Baxter's contention that successful movements rest more on values than on specific goals with Calonge's observation that while movements can change attitudes, they are unlikely to alter values. Is the walking movement articulating a clear set of values, she asked. Is it really possible to change someone's values?

Values, like relationships, are very powerful and motivating, Baxter responded; there is great opportunity to build support for a movement around those elements, even among people who have divergent, even opposing, interests. People less often behave according to their interests than to their values, he said; therefore, it is important to be aware of the values of the people one wants to engage in a movement and to show how they align with what movement builders are trying to achieve.

Calonge agreed with Baxter's remarks and noted that shared values represent the common denominator of people committed to a social movement. For example, he said, in Colorado the concepts of fair opportunity and personal choice were initially raised in support of smokers, but eventually they were interpreted as favoring the right to breathe smoke-free air. These kinds of connections with values propel public health movements forward, he said.

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The Role of States in Health Movements

A member of the webcast audience asked what roles state health departments and governments could play in a movement for public health improvement and equity, as compared with the roles of national entities such as the IOM.

Twiss responded that two recent initiatives in California, the Office of Health Equity and the Strategic Growth Council, could provide examples for other state-based entities. In general, she advised, states "need to support, but then get out of the way" of community-driven approaches to improve public health. State participation in public health initiatives is shaped by the party in power, Calonge said. However, despite shifting ideologies at the state level, movement momentum can be maintained by connecting with local health departments on issues that matter to them.

George Isham remarked on the contrast between Twiss's nonpartisan approach and Calonge's single-party focus. He also observed that political parties have mastered the art of changing attitudes, which has divided the country to its detriment and made consensus building around public health a difficult challenge. So, he wondered, "what are the values for population health and how do you get to them?"

"I don't think what Ned and I said was all that different," Twiss replied, noting that they had both found windows of opportunity in any state government scenario. If one is partisan, she continued, one risks losing everything one might gain with a particular administration when times change. Instead, it is better to take a long-term view and build the case for population health on core human values rather than on partisan postures. This, she said, was her group's approach to introducing a Healthy Cities resolution in the California legislature, which eventually garnered support from both extreme liberals and conservatives. Similarly, Colorado's Office of Health Disparities was created by a Republican governor, a fact Calonge noted may or may not seem unusual, but fits the political context of the time.

Opening the Circle

Pittman applauded Levi's example of how the language of equity and freedom "opened the circle" to allow more people to support gay marriage, and she commented that this lesson was one she learned by working in the early days of AIDS activism. It is important to portray an issue in ways that make sense to people with different points of view, she said; narrow framing shuts out people who could contribute to and support a movement.

Indeed, Baxter added, the AIDS movement provides a great example of the power of an open circle. Although there was tension between

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scientists and activists as to how to address this problem, the National Institutes of Health and ACT UP (AIDS Coalition to Unleash Power) resolved to work together to figure out how to accelerate vaccine research and other interventions. "I view that as a great moment rather than a problem," Baxter said, and he suggested that it can serve as a valuable example for those who are looking to create change in population health.

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Investing in Healthy Communities: One Foundation's Approach

The California Endowment's investment in community health is guided by the belief that the quest for health is a political "struggle over the allocation of scarce and precious public goods," according to Anthony Iton, the Endowment's senior vice president for healthy communities. "In a struggle you have to arm yourself appropriately with data, you have to arm yourself with information, you have to use your relationships, you have to use your people power in any way that you can," Iton said. The social goods obtained in the projects that the Endowment undertakes in cooperation with low-income communities are amenities that wealthier communities take for granted, such as grocery stores and parks. These gains are accomplished by building capacity within communities to drive change through political, social and economic power; through participation by a broad spectrum of community members; through empowering narratives; and through financial and other resources.

The ingredients described above are key factors in fueling a movement for health improvement and equity, Iton said, because facilitating opportunities for vulnerable populations is critical to assuring equity. Also, as he and several other speakers noted, there is a need to build a "movement narrative" that shapes public recognition of the social determinants of health. "Personal responsibility does matter," Iton said. "It is necessary, but not sufficient. Access to health care does matter. Necessary, not sufficient. You have to meet people where they are, and you have to expand their understanding of what health is."

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Typical of The California Endowment's investments was its early support for the national Healthy Food Financing Initiative, whose Pennsylvania model (the Fresh Food Financing Initiative) was described earlier by Thompson of PolicyLink. The project has since drawn broad-based support, Iton said. "What we do is buy down other people's risk. That allows us to expand and leverage the resources of the private sector." He added that a national movement for improved health and health equity will also need to leverage diverse forms of capital.

POLITICAL EXCLUSION AND HEALTH INEQUITY

The Centers for Disease Control and Prevention (CDC) defines health equity as occurring when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of his or her social position or other socially determined circumstance.[1] In order to achieve health equity, it is not enough simply to define the goal, Iton argued; it is equally critical to understand the roots of health inequity, which can be found in intentional policies and practices. It is also critical that those who have suffered injustices take control of the movement for health equity, he said, recalling Ganz's assertion that "agency is good for you." Being in control provides "a sense of help and hope and future" that counteracts stressors and discourages unhealthy behaviors, Iton emphasized.

Maps showing average life expectancy by neighborhood in several urban areas—including Alameda County, California—provide a graphic illustration of health inequities, Iton observed. Understanding how to undo this phenomenon is impossible without understanding the history of how it was created, he said. "You have to have people see the invisible realities that are occurring throughout society. You have to make the invisible visible to people. That is part of changing the narrative." Low-income neighborhoods struggle with health because policies such as racially restricted covenants—which the Federal Housing Administration supported during the last century—created neighborhoods deprived of resources (Federal Housing Administration, 1938). Medicaid, Social Security, immigration, incarceration, and housing policies have only served to deepen this divide, as have the practices of redlining (the denial of loans or insurance to people deemed to live in risky areas) and predatory lending, he said.

The common factor among these factors—exclusion—creates a narrative of unworthiness for a marginalized population, Iton explained.

[1] See http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/overview/healthequity.htm (accessed June 13, 2014).

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"That narrative traumatizes people and isolates and leads to internalized oppression and self-hate. It leads to sidelining valuable human capital that the country needs to be successful in the 21st century." Therefore, he concluded, it must be acknowledged that inequity was created by a set of policies that devalued certain populations, which restricted and restrained access to important health resources.

TOWARD A NARRATIVE OF INCLUSION

In order to describe the "landscape of opportunity for intervention" for health equity, The California Endowment developed the framework shown in Figure 4-1. The medical "downstream" components of health, shown on the right side of the diagram, are addressed by health care through interventions that attempt to prevent death and reduce the burden of disease; these interventions constitute the vast majority of health expenditures. Meanwhile, the non-medical "upstream" determinants of health, on the left side of the diagram, are being shortchanged, Iton argued—especially in low-income neighborhoods, but also among stigmatized populations, such as gays, lesbians, and the disabled. "The world of health disparities lives downstream," he remarked, and the situation can only be resolved by intervening to mitigate socioeconomic inequities, the often hidden upstream conditions that underlie more obvious health consequences.

Management of the health consequences of socioeconomic inequity is expensive and potentially unending, Iton said. "We have to figure out how we address some of the conditions and do it in an organized, evidence-based, intelligent, rational way that takes into consideration the historical patterns and legacies." Although interventions exist to prevent death and disease and change behavior, he said, "we don't have great interventions for communities that are on life support."

Identifying such interventions should be a key mission of public health [practitioners and researchers], as it is for The California Endowment, Iton said. Their practice, called "building power in place," is a multi-pronged effort to demonstrate the socioeconomic causes and consequences of health inequity, to advocate for health in all policies, and to examine and shift the biases and beliefs that underlie the narrative of exclusion. "We need to broaden who is talking about health [beyond] just the guy with the stethoscope around his neck talking about the latest cholesterol drug," he said.

Returning to the notion of "drivers of change," Iton described strategic leverage points that the Endowment seeks to address in disadvantaged communities: building a narrative of inclusion and also of sustainability, supporting a health in all policies approach, and creating resilient

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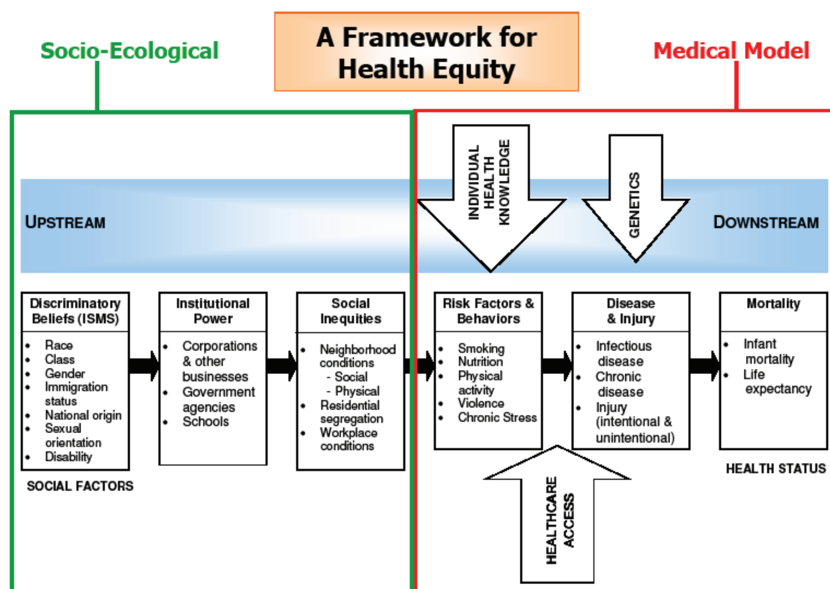

FIGURE 4-1 A framework for health equity. Adapted by Alameda County Public Health Department from the Bay Area Regional Health Inequities Initiative, Summer 2008.
SOURCE: Iton presentation, December 5, 2013.

and transformed communities whose residents have hope and opportunities. To fuel action toward these goals, the Endowment hires community organizers; provides opportunities for collective, multisectoral discussion of community needs; attempts to recruit leaders within communities, particularly among the youth; and seeks private funding and investment to support local programs and economies.

"We have 14 sites across the state of California where we are spending about $1 billion over the next 10 years," Iton reported, but the money is not being spent to build a movement for health equity because that is not the purview of foundations such as The California Endowment. However, he said, foundations can potentiate movements by creating structures that allow people to use their own ideas to improve their communities.

DISCUSSION

The panel discussion began with a question about how members of the two roundtables might inform the dialogue in the quest for health

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equity. Iton suggested that roundtable members could "corral and organize the evidence base," which could be used strategically by community organizers to advance the cause of public health improvement. "I don't think public health has applied itself to figure out where the evidence is and how it applies to improving health outcomes," he said. It is particularly important to support health departments in the difficult task of addressing the policies and practices that create inequity and in contributing to reversing disadvantages by building power within communities.

Given that many rural communities lack a diversified economic base with which to build public–private partnerships, an audience member asked, how might such communities harness their resources or tap into national funding streams to support local efforts in support of health equity? Iton replied that about half of the 14 communities in which the endowment works are rural and that in these settings—while there is indeed a lack of infrastructure and economic diversity as compared with urban communities—it is relatively easily to organize across sectors and to collaborate because local officials tend to wear several hats. "The ability of people to leverage relationships to use resources in the most effective way is something rural communities have to their advantage, that should be essentially taken advantage of," he said.

Connie Mitchell from the Office of Health Equity in the California Department of Public Health reported that her office, which is charged with defining and describing health inequities, is adopting the "drivers of change" framework Iton proposed. She said that she expects pushback on her office's report on inequities because it will challenge many people's personal narratives about choice and personal responsibility, and she wondered what form that reaction might take.

"I encourage you to be provocative, not just to get attention, but because you don't have much hope of making change unless people feel uncomfortable," Iton advised. He also encouraged Mitchell to embrace the dominant narrative of personal responsibility and to expand it in order to emphasize that personal responsibility is vested in community responsibility. Tell stories about people who cannot eat healthily because the only food they can easily purchase is junk or who cannot exercise for fear of flying bullets, he suggested. "You have to provoke them a little bit, but you also have to embrace their core understanding that is unshakable. . . . In my experience, people welcome that."

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5

Lessons from Social Movements Beyond Health

The workshop's second panel, moderated by Winston Wong of the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, featured social movement practitioners from different fields who shared their perspectives on how movements are built and how social change is accomplished. Although some presenters discussed work that encompasses health equity—and in so doing, connected their experiences to observations made by previous speakers—these panelists generally placed health within the broader context of social empowerment, economic justice, democratic self-government, and equal rights.

COMMUNITY ECONOMIC DEVELOPMENT AND EDUCATION

Karoleen Feng, community development manager for the Mission Economic Development Association (MEDA),[1] described MEDA as an organization that for nearly 40 years has worked to achieve economic justice for the low- and moderate-income Latino residents of San Francisco's Mission District. Over that time, MEDA has grown from its initial focus on small business technical assistance to broad-based asset building, including recent expansion to include education. MEDA, she said, has a history of success in community planning and building cross-sector networks of partners beyond economic development. "We are good at raising funds,"

[1] See http://medasf.org/home (accessed June 13, 2014).

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she said, adding that such funding generally benefits the work of partner agencies as well as MEDA.

Since the founding of MEDA, the once predominantly Latino population of the Mission District, which comprises approximately 60,000 people within an area of 20 square blocks, has diversified. Today, according to Feng, 41 percent of Mission residents are Latino, 40 percent white, 12 percent Asian, and 3 percent black; a total of 40 percent of all residents are foreign-born. Median family income in the Mission District is nearly $68,000, but there is significant disparity among its residents, with Asian and white families earning about $85,000 annually as compared with $45,000 for Latino families. Feng noted that, across the United States, the net worth of white families is approximately 18 times that of Latino families.

Feng highlighted information that illustrates the connection between poverty and health in the Mission District:

- One-third of students do not have a medical home, with first- and second-graders least likely to have access.
- Less than one-quarter of students meet criteria for healthy weight and height for their age.
- Fourteen percent of families with children live in poverty; of them, 68 percent are Latino.
- More than one-third of Latino adults in San Francisco work in low-wage jobs (paying $10-$15 per hour).

In addition to poverty and health, other challenges Mission District residents face, Feng observed, including low academic achievement and limited access to technology.

The Mission Promise Neighborhood

In 2012 MEDA was awarded 1 of 12 5-year grants from the U.S. Department of Education, designating the Mission District as a Promise Neighborhood.[2] Feng described the Mission Promise Neighborhood (MPN)[3] effort as culturally relevant, place-based, and focused on the academic achievement of children and the economic success of families. "We feel if you don't alleviate poverty, if you don't change the income levels of families and help them to build assets, you will not change" the futures of their children, she explained. To address this goal, the MPN integrates

[2] See http://www2.ed.gov/programs/promiseneighborhoods/index.html (accessed June 13, 2014).

[3] See http://missionpromise.org (accessed June 13, 2014).

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a spectrum of services for residents and coordinates with many partner agencies in order to maximize the collective impact. Feng shared the following vision statement, which reflects MPN's broad goals:

> The Mission Promise Neighborhood builds a future where every child excels and every family succeeds. Students enter school ready for success, and graduate from high school prepared for college and career. The Mission District thrives as a healthy and safe community that provides families and their children the opportunity to proser economically and to call San Francisco their permanent home.

Feng also described the MPN mission statement that explains the strategy for reaching the vision:

> The Mission Promise Neighborhood links family economic security with student academic achievement. It creates a comprehensive, integrated framework of evidence-based services that responds to urgent needs and builds on the foundation of student, family, community, and school strengths and assets. Together, parents, neighbors, and partner organizations work block by block, guaranteeing that all Mission children, youth, and their families achieve academic excellence and economic self-sufficiency.

Feng identified four ingredients to achieving the goal of academic achievement and economic success: Spanish language capacity; cultural relevance; needs-based, evidence-based services; and service integration.

Integrating Services to Support Success

Feng described the numerous diverse services that MEDA and its 26 partners provide in order to accomplish the MPN vision. According to the project's strategic planning framework (see Figure 5-1), in addition to the "universal services that everybody has to get," such as instruction in English as a second language, benefits screening, and legal services, there must also be collective efforts toward systematic improvements in such areas as communication, family engagement, policy, and governance. The two primary goals—academic achievement and economic success—underlie all the other goals, she said. For example, they help to build assets that allow residents to take personal responsibility for their health.

Feng described how typical MEDA clients might experience service integration as part of the MPN. For example, those who come to MEDA's headquarters at Plaza Adelante for help with tax preparation are also offered information on starting a business and becoming homeowners, along with the necessary financial education. Clients are asked about the financial challenges they face, for which they may receive assistance from MEDA—including individual family coaching—or they may be referred to MEDA's partners as appropriate. Plaza Adelante also incorporates a

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FIGURE 5-1 Mission Promise Neighborhood "wheel of promise" strategic framework.
SOURCE: Feng presentation, December 5, 2013.

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technology center that serves both residents and neighborhood schools, all of which have traditionally been among the state's poorest performers and are recent recipients of improvement grants, she said.

MEDA employs a broad range of metrics to measure the effects of its programs on family economic success, Feng said. MEDA gathers data on a variety of indicators, including income, credit scores, savings, and debt-to-income ratios; employment, job creation, and business expansion; home purchase, foreclosures, and affordable housing availability; and obtaining tax refunds and public benefits. In addition to using their results to attract further funding, MEDA is building its own evidence base through evaluation, she said.

TACKLING HEALTH INEQUITY BY BUILDING DEMOCRACY

Doran Schrantz, executive director of ISAIAH,[4] described her Minnesota-based organization as a "faith-based community organization of 100 member congregations" and "a vehicle for people of faith to act collectively and powerfully for racial and economic justice." ISAIAH is also affiliated with a national network of organizations involved with racial, economic, and social justice called People Improving Communities through Organizing (PICO). Both ISAIAH and PICO are examples of structures that mobilize people to take action on the conditions that affect them and their communities, she said.

Although it is not originally directed toward achieving public health objectives, ISAIAH's organizing work has increasingly involved health issues because of its interest in social conditions, Schrantz said, and she quoted two definitions that have guided work in this area. The World Health Organization defines the social determinants of health as "conditions in which people are born, grow, live, work, and age, including the health system," and it also notes that "these circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels" (WHO, 2014). The second definition she mentioned appeared in the IOM report *The Future of Public Health* (IOM, 1988, p. 1): "Public health is what we as a society do collectively through organized actions to assure the conditions in which all people can be healthy."

Elements of Community Organizing

Referring to Iton's characterization of social conditions that result in health consequences, Schrantz described ISAIAH's mission as one of helping vulnerable populations build the necessary capacity to engage in

[4] See http://isaiahmn.org (accessed June 13, 2014).

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democratic self-governance as a path toward better health through better living conditions. "Health is the condition in which we live," she stated. "People can impact the conditions in which they live if they have the capacity to act on those conditions." Although social movements do not just happen, as Polletta noted, Schrantz observed that the mobilization of people to act—the building of democratic self-governance—requires difficult and skilled work that often remains invisible. Every grassroots protest, demonstration, or march involves, she said, "months and months of infrastructure building, months of leadership development, months of strategy conversations." Organizing requires a great deal of training, a unique set of skills, and experience. People talking to people about what they value is central to building a social movement, she continued, and it is far more demanding than is widely appreciated.

What happens in these conversations? Community organizers learn what matters to community members and help them build the necessary skills and strategy to acquire the power to change their communities for the better, Schrantz said. She described three components of community organizing, which she depicted as interconnecting cogs driving the larger mechanism of change. The first component, grassroots leadership development, is critical to any community-led process. On this foundation, organizers strive to build the second component: democratic, accountable, sustainable, community-driven organizations, whose participants are "exercising democracy with each other." "Every aspect of a powerful community organization allows people to practice at every level of it what it feels like to lead and to make decisions," she said.

The third component of community organizing, the theory of change, postulates that the power or the ability to act drives change. "The reason why there is a struggle for resources, for scarce social goods, is that there are differentials in power," Schrantz explained. "Differentials in power do not change because somebody else who has more power gives it to you. Differentials in power change because you take ownership and collective and community responsibility for negotiating for the power and the resources you need. When that power structure is in place, that is when change happens."

Grassroots Leadership Development

Among ISAIAH's many accomplishments, the most important is also the most difficult to describe to people not directly involved in community organizing, Schrantz said. It is the work of stimulating the emergence of community leaders as they "begin to imagine the reality that their story could be at the center of politics"—a process she described as "deeply transformative," even "sacred." Most importantly, she concluded, it lies

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at the heart of social movements, because "no amount of policy change or even structural change will be sustainable until people are really the agents of their own lives."

BUILDING SOCIAL MOVEMENTS FROM THE BOTTOM UP

"I stand here before you because of organizers," said Martha Argüello, executive director of Physicians for Social Responsibility–Los Angeles (PSR–LA).[5] What she learned from the work of the Black Panthers and others who taught her the basics of community organizing as a teenager saved her life, she said, and set her on a path of "leadership development that has always been in opposition and in fighting for my place at the table."

Serving the Grassroots

Argüello came to PSR–LA "to change the narrative about pesticides," she said. In the course of her work, she contributed to a coalition of 175 organizations that successfully pushed for new legislation to regulate pesticides in California. However, she said, while the initial efforts of the coalition [Californians for Pesticide Reform] got some attention, it became clear that in order to be successful, their efforts needed to address the issues faced by the people most affected by pesticides: farmworkers, residents of California's Central Valley, and women and children. PSR–LA and other members, transformed the coalition and eventually became more effective in building grassroots support for this issue, which in turn led to it gaining traction with policy makers.

These changes in leadership and the subsequent expansion of its coalition changed the coalition and in many ways transformed PSR–LA, Argüello said. It was PSR–LA's work with the coalition that led to the development of PSR–LA environmental health programs addressing air quality, land use, and toxic chemicals. Because it is a small organization, it multiplies its impacts by creating strong coalitions that create bridges between grassroots, policy, and advocacy groups. Coalition building has made it possible to challenge some large adversaries, including the oil industry, makers of flame retardants, and agricultural companies. As its name implies, PSR–LA also represents physicians. "My purpose in life is to unite the powerful voice of communities with a credible voice of health care professionals," Argüello said. "That can really create a movement for change." She also emphasized the need to work from the bottom up to craft policy.

[5] See http://www.psr-la.org (accessed June 13, 2014).

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From Networks to Movements

Recognizing how a single issue can transform a network of groups into a coalition is key to understanding movement building, Argüello said. For example, the health effects of pesticides interested groups that were advocating for tenants' rights (including the right to inhabit a building not treated with toxic pesticides). This led to the creation of a program (Healthy Homes and integrated pest management pilot) that trained hundreds of *promotores* and tenant organizers in integrated pest management and is bringing new urban voices to the pesticide reform movement. In another example, she stressed the value of unusual allies. The ability to bridge different movements has proved critical to progress toward stricter safety regulations in California for flame retardants, she said. By talking about the impacts of these chemicals on women, a coalition of affected groups was created that has been effective in changing flammability standards to promote toxic-free fire safety The same networks are now being activated to take on the issue of air quality and its effects on birth outcomes and reproductive health.

"We have to be nimble," Argüello said of PSR–LA. "We have to be brave and not worry about pushing at the limits of our mission." Instead, the mission is fluid and often defined or refined as a result of relationships with groups working on issues such as social justice or equity. For example, when residents in south Los Angeles discovered a lead hazard site in their midst, they knew from prior experience to contact Argüello, who was able to provide expert help to the community. Those informed and engaged residents, she said, are "really good organizers." Although PSR–LA does not usually work on soil contamination issues, their network of relationships with, science, policy, and community organizing groups, called on them to help support local efforts to demand clean-up and redevelopment of the site.

Much as community organizers' work is often invisible, so is that of organizations such as PSR–LA, Argüello said; both, however, are key agents of change and should be valued as such. Institutions such as the IOM could support community organizers and those they serve by making their research more accessible and by communicating its significance to community health, she added. "We're always looking to the horizon [for] the next emerging issue" that PSR–LA's partner organizations will raise and to which PSR–LA will bring its expertise in health, coalition building, and policy development.

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A PERSPECTIVE AT THE INTERSECTION OF MOVEMENT AND POLITICS

Gregory T. Angelo, executive director of the Log Cabin Republicans, set out to describe to the workshop "that moment when movements become partisan." To establish the context, he provided a brief history of his organization, which was founded in 1977 by a group of gay Republicans in California who backed Governor Ronald Reagan during his campaign for President of the United States. They were inspired to organize on Reagan's behalf due to his opposition to a voter initiative that—had it been upheld by referendum—would have made it illegal for openly gay individuals to be teachers in California public schools. Instead of passing as expected, the proposition failed by a two-to-one margin, a shift that has been attributed to Reagan's influence. To pay homage to the history of the Republican Party's longstanding support for civil rights, the group chose a name associated with the party's first president, Abraham Lincoln.

The Log Cabin Republicans have since federated and are headquartered in Washington, DC, with 39 chapters in 24 states. As a 501(c)(4) organization,[6] it engages Republicans on issues of lesbian/gay/bisexual/transgender (LGBT) equality and advocates for other issues from a conservative perspective, including the repeal of the ACA—a position not supported by other gay and lesbian organizations. Log Cabin Republicans also has a 501(c)(3) sister organization, the Liberty Education Forum, which is not involved in explicitly partisan activities, but which promotes gay acceptance by conservatives and people of faith. "We're able to advocate and really educate on those issues while we are advocating and lobbying Republicans in Washington," Angelo said, "so the two [organizations] work in complementary fashion."

The Partisan Moment

Prior to leading the national organization, Angelo chaired its New York State chapter, and he was there when, for the first time in U.S. history, a Republican-controlled legislature passed civil marriage equality legislation. This victory followed the defeat of similar legislation under a Democratic administration and legislature, which occurred in part, Angelo said, because advocates of the issue did not communicate with

[6] The federal tax code designates tax-exempt nonprofit organizations as either 501(c)(3) or 501(c)(4). The former are public charities, private foundations, or private operating foundations with open membership, while the latter are civic leagues or associations operated exclusively for the promotion of social welfare or local associations of employees with limited membership. See http://www.nj.com/helpinghands/nonprofitknowhow/index.ssf/2008/07/the_difference_between_501c3_a.html (accessed June 13, 2014).

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each other. The then newly elected Governor Andrew Cuomo supported an umbrella organization which included the Log Cabin Republicans as its only partisan member. The group was part of that coalition, he said, "because even the liberal advocates, even the advocates who were nonpartisan, understood that there's a moment when movements like the marriage equality movement become political—that if you want to achieve change . . . you need to get Republicans on board." The best way to do that, he said, "is to make sure you're engaging with Republicans who can speak the language of other Republicans who can engage with them on those issues."

Internal and External Challenges

Some of the toughest challenges faced by the Log Cabin Republicans come from within the organization, Angelo said. "The reason gay Republicans exist is because gay individuals, LGBT individuals, are just that," he said. They have different opinions and priorities with regard to a variety of issues, including those that have little to do with sexual preference. Anytime the organization takes a specific policy stance, it inevitably excludes a portion of its membership, he reported; however, he was confident that its membership would stand the test of time, as long as the members are satisfied with the balance of the policy positions and see them as consistent with the organization's mission.

With regard to coalitions, Angelo said, "It's not just like everyone gets under the umbrella [saying], 'We're going to go and achieve change, and all we need to do is just agree on everything.' . . . Grassroots is unified in the organizing, and policy positions are unified, [but] at the end of the day, no one organization ultimately gets to—or should—claim credit for any legislative victory, because you're doing it as coalitions." This situation makes it hard to get foundation funding and satisfy donors, he said. "I don't think it's any mistake that after the Marriage Equality Law passed in New York State . . . everyone [in the coalition that supported the law] went their separate ways." After all, their mission was accomplished, and the coalition partners needed to assert their independence in order to continue operating.

In conclusion, Angelo said that while he considers his job to be one of the most frustrating in the world, it is also sometimes the most thrilling. "Just in the past year that I've been head of Log Cabin Republicans, we have had three sitting United States Republican senators announce support for civil marriage quality," he said. "We had 10 Republicans in the United States Senate vote for the Employment Nondiscrimination Act. We've had over 250 Republicans around the country vote for civil marriage equality for committed same-sex couples. And just this afternoon,

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. . . Speaker [of the House of Representatives John] Boehner said that Republicans should support openly gay Republicans who are running for the United States Congress." These are the moments that make his work worthwhile, he said.

PANEL DISCUSSION

George Isham asked Feng about the role of health in the "wheel of promise" framework for MPN (shown in Figure 5-1). She replied that MEDA has constructed several versions of that diagram to highlight different components of its overall strategy for a healthy community. "We've actually taken out the academic achievement and put health or housing or something else in there," she said. This version was prepared to support MEDA's application for funding by the U.S. Department of Education, which required specific indicators for health, such as the medical home, mental health services, and nutrition and exercise—guidelines that MEDA has exceeded, she added. "Over the next 5 years, the intent is to move those health indicators, along with all the other indicators [in the framework], so that we really do see changes in our families and children in the Mission."

In response to a request from Terry Allan, Schrantz described two key ways in which community organizing is poorly done. The first she described as "a tactical transactional way of doing quick, shortcut mobilization." This tends to happen during electoral work or national campaigns when staff is "parachuted" into an area, then leaves without having benefited the community—a practice that can erode residents' confidence in the potential usefulness of politics or agency, she observed. Second, she said that a lot of organizing is too poorly resourced to be effective; often such efforts, uninformed by careful political analysis, lack a long-term agenda and mismanage important relationships. "The field of community organizing is in a state of great change over the last 15 years," she added. "There has been a lot of reflection, evaluation and experiments in trying to get to scale, struggling with narrative and message."

Allan also remarked on the challenge of finding language to make a strong case for health equity across political party lines and on the similarity of that challenge to the one presented by marriage equality. Would Angelo recommend similar tactics, he asked. How can we convey the issue of health equity without making it partisan?

To communicate with Republicans, the term "equity" is probably counterproductive, Angelo said, because it sounds like "something that comes from the progressive dictionary." Instead, he urged a focus on "equal access" to health care—much as the Log Cabin Republicans framed the issue of marriage equity—and on empowering individuals

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and on freedom. "Those are words that resonate across the board with Republicans," he said. However, he added, one cannot just perform a "find and replace" in one's documents "in order to create the dossier for Republicans and expect them to entirely get on board. I think you need to find particular policy positions and think about them and . . . engage with Republicans who do health care advocacy."

Karen Anderson, an IOM staff member, noted that both ISAIAH and the Log Cabin Republicans do "movement work within movements"—promoting social justice within the faith community for the one, and promoting LGBT issues within the Republican Party for the other. What, she asked, are the challenges of doing that sort of organizing?

Schrantz replied that her work and the challenges it presents differ considerably from that of Angelo, in part because the "faith community" is composed of many institutions with varied connections rather than a single political party. This in itself leads to challenges, such as the common assumption that everyone in faith communities regards the relationship between religion and politics in the same way—a polarizing and partisan concept. Thus, she said, "a lot of our work is about deconstructing some of those categories and compartments that people have in their minds and helping people and congregations and communities of faith re-imagine that they can define their own voice and their own role and can contest in the public arena for what it means to be a person of faith in America."

"My biggest challenge," Angelo answered, "is constantly having to answer the question, 'Why are you a Republican?' I'm only being half glib about that because it opens up the broader question as to why does Log Cabin Republicans exist in the first place. And that's why I'm always very fond of telling the story of our history to remind people . . . that the Republican Party, at its core, is a party that has placed equality for all Americans at the fore."

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Reaction and Response

George Isham of the Roundtable on Population Health Improvement introduced the day's final session, which began with remarks from a two-member "reactor panel" charged with reflecting on how lessons from social movements can inform the field, including those who work to garner public support for, investment in, and policy directed at improving population health and health equity. Lessons learned include basic frameworks or elements of successful movements, ideas for next steps for the field, and potential solutions to address gaps and barriers.

Isham urged other roundtable members to ponder these questions as well, following the presentations by Jeff Levi and Sanne Magnan, members of the Roundtable on Population Health Improvement.[1]

INITIAL REACTIONS TO THE DAY

Although he praised the inspiring insights and examples presented over the course of the day, Levi noted that some discussion on creating social movements struck him as rather abstract, particularly from his perspective as a participant in the AIDS and LGBT movements and as a staff member of the National Gay and Lesbian Task Force. If those movements had deliberately employed framing as an approach, he wondered, "would we have gotten things done better or faster?" The concept of framing is

[1] The third scheduled panel member, Pattie Tucker, of the Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities, was absent.

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interesting, and theories of change are fascinating, "but the people who are usually in the middle of doing this work are not thinking that way. They're out there doing what has to be done because of the urgency of now," he observed. Thus, he urged the audience to focus on "what it's going to take to get the work done for the people that we are so concerned about," and, to that end, he offered several observations and suggestions for action.

Organizing is associated with social movements, such as ISAIAH's efforts toward racial and economic justice, and also with political activism, as practiced by the Log Cabin Republicans, Levi said. The sort of movement that could help achieve the goal of improving the public's health has to reside "outside the partisan arena," he said. "There will be those who appropriate it for partisan purposes," he acknowledged, but he argued that the movement itself "should be able to embrace everyone across the spectrum, if we find the right arguments, and if we find the right evidence." Argüello questioned this point, asserting that fundamental change in the social determinants of health may require addressing inequities in ways "that have clear partisan implications." Levi acknowledged that the quest for health equity may spark such debate, but he emphasized that broad, bipartisan support will be needed to achieve necessary change, which does not, he argued, have to involve the direct redistribution of income; for example, he noted, capitalist investments in community redevelopment have allowed people to make profits while improving communities. Levi urged openness to multiple approaches—policy and other—to help reach the desired outcomes.

Levi said that his recent experience at the New York State Population Health Conference led him to question the need to catalyze a population health movement, and he argued that it is already embodied in successful programs and thriving in many locations across the United States. "That work is already happening," he said, and the audience, including roundtable members, could embrace, support, and connect to efforts already under way. "Too often our conversations are about despair, when there's all this exciting work happening that we just need to shine a light on."

The population health movement rightly challenges government policy, Levi said, but many public health professionals work for or are funded by the government and so they cannot lead the movement. Although the government will ideally support change that improves population health, such internally driven reform is necessarily limited. Outside resources, such as from private philanthropy, will be needed to push for more cutting-edge changes to be proven effective.

To the earlier question, "Do we need an enemy?" Levi responded, "I am not convinced about that at all," and he referred to the decades-long interaction between the HIV community and the pharmaceutical industry,

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which was by turns combative and collaborative. That sort of "constructive antagonism" got results, he said, and could serve as a model for the population health movement.

"Do we need a population health movement or do we need a health equity movement? I would argue we need the latter," Levi said. "Population health is a means for achieving health equity. It is not an end in and of itself." Moreover, he continued, a movement for health equity will be much easier to catalyze than one for population health, which still lacks a clear definition, even among public health professionals; meanwhile, messages about fairness and equity resonate with the public and fall into a "sweet spot" in the current political debate. He noted, for example, that President Obama had given a major speech on equity the previous day in which he had mentioned economics and social class as a factor in health outcomes. Levi concluded his remarks by suggesting next steps for the field such as illuminating work under way toward population health and health equity so that other groups and communities can learn from and replicate it; helping to build the evidence base for effective interventions and, more generally, to show the value of empowering communities; and comparing the frameworks for population health and health equity presented over the course of the workshop (e.g., by Larkin, Calonge, and Iton) as a source of research questions.

Magnan began her talk with a synopsis of a theory of leadership, known as "Theory U," which she said resonated with much of what she had heard during the workshop. Discussed in books by Otto Scharmer,[2] Theory U is "about leading as the future emerges," she said, and it provides a model for addressing complex problems. The tendency is to move straight right to find the solution at the upper right top of the U. However, those who are beginning the process—the upper left of the U—are trying to clarify what they hope to accomplish, their goals and values, and what it would look like to have a movement that achieves population health in health equity, Magnan said. From here, according to the theory, they should find common purpose with collaborating organizations ("open heart") and, on common ground at the bottom of the U, they can progress to new thinking and principles ("open mind"), which in turn will lead to new processes and structures ("open will"), and finally to solutions, at the right-hand top of the U.

Magnan then discussed several considerations, raised in the day's presentations and discussions, that those seeking to contribute to a movement for health and health equity could address:

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[2] See http://www.ottoscharmer.com/publications/summaries.php (accessed June 13, 2014).

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- Find ways to legitimize and energize the work of organizers and organizations already working toward population health and health equity, whether that is conducting research or simply lending a respected name to their efforts.
- Articulate goals and values and have a clear picture of what is being fought for (or against).
- Recognize and take advantage of health care costs and cost-ineffectiveness in the United States as an opportunity to explain to the public (e.g., through editorials) how these problems can be mitigated by addressing the social determinants of health, which contribute more to an individual's health and well-being than health care; and the consequences of these problems for the nation's economy and future (IOM, 2013; Pittman, 2010).
- Find more ways to serve as a connector between grassroots and "treetop" sectors of the movement.
- Find ways to challenge the powers and power structures that skew the health system toward the treatment of disease rather than toward the promotion of health.
- Consider how to educate movement leaders to use appropriate and effective language as a tool to mobilize participants and build broad support for health improvement and equity.
- Draw encouragement from Ganz's reflections that social movements are inspired by a combination of pain and hope, find effective ways to send the message that there is healing to be done.

Magnan ended by saying that the day's proceedings could inspire participants to continue to take up, in the words of Ganz, the "mantle of leadership," to contribute to the "healing that needs to be done in our land" to achieve population health and health equity.

ROUNDTABLE AND AUDIENCE RESPONSES

Individual workshop participants, including members of the two roundtables, responded thoughtfully to the three questions posed to the reactor panel. Their remarks are summarized below, by question.

How Do the Day's Proceedings Change What We Do?

Several participants recognized not only that successful social movements "bubble up" from the grassroots, but that such activity is already occurring and has been occurring for some time. With that understanding as a foundation, several participants identified possible ways that the

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organizations such as those represented on the roundtables might become effective participants in a movement already under way.

Argüello suggested that it would be helpful to examine and publicize the evidence base on the social determinants of health and health inequity.

Several individual participants noted that there is a need to bring together experts who can assess the evidence base for existing and potential interventions to then convey the information obtained from such analysis. More specifically Phyllis Meadows of The Kresge Foundation and Melissa Simon of Northwestern University suggested that grassroots practitioners be included in gatherings such as the IOM workshops, and that proceedings be made available to other grassroots groups.

Terri Wright of the American Public Health Association suggested that such efforts be directed by asking movement leaders what kinds of information and evidence they most need. José Montero, president of the Association of State and Territorial Health Officials and director of the New Hampshire Division of Public Health Services, also emphasized the importance of showcasing the evidence on the relationship between income and health. Christine Bachrach suggested that new research models for population health improvement be explored. Cathy Baase underscored the importance of acting with urgency to communicate a vision of a movement for health and health equity to the public and to policy makers.

Other suggestions included

- Taking advantage of public interest in the ACA as an opportunity to raise awareness of the social determinants of health as something missing from the ACA (Argüello).
- Highlighting the interdependence of population health improvement and health equity, as pointed out by Levi and also by Judith Monroe of the CDC. Wright observed that such an alignment needs to emphasize the contribution of population health to general equity, as embodied in the "wheel of promise" developed by the Mission Economic Development Association (described in Chapter 5).
- Laying the groundwork for an IOM consensus study on proposing and testing interventions to address social determinants of health (Calonge).

Elements of a Movement for Population Health and Health Equity

Mary Lou Goeke, executive director of United Way of Santa Cruz County, provided the following comprehensive response to this question:

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> The movement would be a success if in every local community in America young people, neighbors, civic organizations, faith communities would be gathered together, engaged with each other, setting their goals, their priorities, their strategies with all the other sectors who want to live in healthy communities. They would have skilled professional paid community organizers in strong, stable, backbone organizations that will last. They would use evidence-based practices, grounded in solid research; they would have good success measures; and, they would celebrate publicly their successes and critically analyze their failures. They would be linked to good, strong state and national organizations to magnify their policy work at all levels.

Several participants commented on the importance of narrative to any social movement—narrative that must be sustained to keep a movement viable, noted Antonia Villarruel of the University of Michigan. Monroe emphasized the importance of including youth and senior citizens when mobilizing grassroots support for a movement.

Noting the importance of leadership at all levels in a social movement, Octavio Martinez of the University of Texas at Austin, recommended training community leaders in the skills necessary for shaping policy on issues of concern to them. Montero took up the issue of "constructive antagonism" from his perspective as a member of government. Rather than occurring between the same parties, such conflicts engage different groups at different times, he said, so it is probably unproductive to define an "enemy" for this movement. Moreover, he observed, "regardless of where we sit, we are still members of our community, users of health services, and have families who are in the same position."

Filling Existing Gaps and Overcoming Barriers

Several individual participants, including David Kindig and Winston Wong, described different areas for future study and discussion, including studying the use of technology and the media—especially social media—to mobilize support for a movement to advance population health and health equity; the use of metrics to illuminate the many facets of health inequity; the development of a deeper understanding of the spectrum of values with regard to health, so as to be able to communicate concepts such as the social determinants and health equity to the public; and the exploration of the potential usefulness of big data in characterizing population health, identifying problems to be addressed, and measuring the impact of interventions. Wong, who discussed the potential of health data, also cautioned about the dangers of privatizing big data and thus favoring profit making over supporting population health and health equity.

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CLOSING REMARKS

After offering some observations that indicated population health and health equity are so closely connected that they may be seen as virtually indistinguishable, Mildred Thompson listed several key concepts and ideas she had gathered from the day's presentations:

- Democratic self-governance. The work being discussed represents an assertion of democracy, she said, because health is a human right.
- Who is organizing matters. "We've got to make sure we're a part of helping those who are organizing the work," she advised.
- The importance of access to technology. Although Occupy Wall Street did not succeed as a movement, that effort demonstrated the power of technology in the form of social media to galvanize interest in and support for a movement and its cause. "We could have broader reach and have much more engagement if we were able to figure out these new technologies and make them work for us," she observed.
- The power of narrative. Thompson noted that a 2008 public television documentary series on health inequality, *Unnatural Causes*, reached a broad audience and continues to be used along with supporting materials to educate various audiences. She recommended such approaches that require something more active or engaging than simply viewing.

Thompson said that arming a community with information and data can be powerful. To make her case, she described how, as a member of a public health department, she advised and supported a community group in its successful effort to stop a local factory from polluting the air. "We armed them with the data and the resources they needed to make something happen," she recalled. "That's a simplistic idea of a small movement, but it shows how it makes a big difference."

Thompson suggested that roundtable members reach out to new partners with common interests in public health, such as the Federal Reserve Bank. They and other "unlikely partners" could increase both the breadth and depth of a social movement for health equity, she said. Achieving health equity is long-term work, requiring sustained dialogue, she concluded. "This isn't going to be the only time for it to be discussed," she said. "There's going to be layers that we still have to reveal, and I'll look forward to sharing in that unveiling with everybody else here."

Kindig echoed the sense of humility expressed by other participants with regard to their role in a movement for improved population health and health equity. However, he also recalled Ganz's observation that

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medical and public health professionals possess a moral authority that can be brought to bear to further this cause. Kindig reminded the audience of the state of the U.S. health care system relative to those of peer countries, and he argued that substantial, sustained changes in resource flows, particularly in the direction of the social determinants of health, are needed—whether these changes result from strategies such as reducing Medicare waste or from some yet unknown solution. Dismantling and reversing current policies of "disinvestment" in public health will be a huge challenge, he acknowledged. "I don't know if we're up to it," he said, "but that's what we're about if we're serious about our goal."

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Appendix A

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Appendix B

Workshop Agenda

Roundtable on Population Health Improvement and

Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

Workshop:
Accelerating a Movement to Improve Health and Promote Health Equity

December 5, 2013

Location: Auditorium, Beckman Center, Irvine, California

WORKSHOP OBJECTIVES:

1. Identify key elements of a theoretical and practical framework for movement building to improve population health and health equity
2. Examine and learn from recent or contemporary health and other social movements
3. Identify principles and tools and likely challenges and solutions for a process of accelerating a movement for population health improvement and health equity

8:30 a.m. **Welcome and Context**

David Kindig, co-chair, Roundtable on Population Health Improvement; professor emeritus of population health sciences, emeritus vice chancellor for health sciences, University of Wisconsin School of Medicine and Public Health

Mildred Thompson, co-chair, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities; director, PolicyLink Center for Health and Place

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8:50 a.m. **Presentation:** Insights from the Sociology of Social Movements

Francesca Polletta, professor of sociology, School of Social Sciences, University of California, Irvine

9:15 a.m. **Presentation:** Lessons from the Front Lines of a Social Movement

Marshall Ganz, senior lecturer in public policy, Harvard University (by video)

9:40 a.m. **Discussion with Polletta and Ganz**

10:10 a.m. **Break**

10:25 a.m. **Panel I:** Lessons and Insights from Practitioners in Health-Related Movements

PANEL OBJECTIVE: *To highlight lessons that could be adapted to a broader movement for health and health equity, and to discuss challenges and identify potential solutions.*

Moderator: *Mary Pittman, executive director, Public Health Institute; member, Roundtable on Population Health Improvement*

Mildred Thompson, director, PolicyLink Center for Health Equity and Place; co-chair, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

Michelle Larkin, assistant vice president, Health Group, Robert Wood Johnson Foundation; member, Roundtable on Population Health Improvement

Joan Twiss, executive director, Center for Civic Partnerships

Ned Calonge, president and chief executive officer, The Colorado Trust; member, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities

Raymond J. Baxter, senior vice president, Community Benefit, Research and Health Policy; president, Kaiser Foundation International, Kaiser Foundation Health Plan, Inc.

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11:15 a.m. **Discussion with Panel I**
Moderator: Mary Pittman

12:00 p.m. **Lunch**

1:00 p.m. **Presentation:** A view from The California Endowment
Anthony Iton, senior vice president for Healthy Communities, The California Endowment

1:15 p.m. **Discussion**

1:30 p.m. **Panel II:** Lessons and Insights from Other (Non-Health or Not Specifically Health) Social Movements

PANEL OBJECTIVE: *To elicit from movement practitioners from other domains of social change lessons and key ingredients of movement building.*

Moderator: *Winston Wong, medical director, Kaiser Permanente Community Benefit, Disparities Improvement and Quality Initiatives; member, Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities*

Panelists:
Karoleen Feng, community development manager, Mission Economic Development Association

Doran Schrantz, executive director, ISAIAH

Martha Argüello, executive director, Physicians for Social Responsibility–Los Angeles

Gregory T. Angelo, executive director, Log Cabin Republicans

2:15 p.m. **Discussion with Panel II**
Moderator: *Winston Wong*

3:00 p.m. **Break**

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3:15 p.m. **Reactions to the Day and Significance for Future Action**

- How do the day's proceedings change what we do?
- What would a social movement focused on generating broad public support for, investment in, and policy directed at improving population health and health equity look like? What is the basic framework or the key elements, and how do we get there?
- Advice for the roundtables on filling existing gaps/overcoming barriers?

Moderator: *George Isham, co-chair of the Roundtable on Population Health Improvement; senior advisor, HealthPartners, senior fellow, HealthPartners Institute for Education and Research*

Reactor Panel:
Jeff Levi, executive director, Trust for America's Health; member, Roundtable on Population Health Improvement

Sanne Magnan, president and chief executive officer, Institute for Clinical Systems Improvement; member, Roundtable on Population Health Improvement

3:40 p.m. **Open Discussion**
Moderator: *George Isham*

4:30 p.m. **Final Reflections on the Day, Discussion, and Opportunity for Public Comment**
David Kindig
Mildred Thompson

5:00 p.m. **Adjourn**

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Appendix C

Considerations for Building a Population Health Movement: Five Key Debates

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INTRODUCTION

In the past two decades the notion that medical care plays only a partial, and often limited, role in population health outcomes has become widely accepted among health researchers, even as they continue to debate the relative contributions of individual behaviors, socioeconomic status, and the physical environment, among other influences. This work has generated a useful vocabulary, and speaking of "upstream" and "downstream" influences, "social determinants" and "fundamental causes of health" is now commonplace in scholarly circles (Braveman et al., 2011). A corollary and equally prominent branch of research has documented persistent health disparities between population groups, especially defined along ethnic and racial lines, and has offered multiple explanations for them, ranging from accumulated day-to-day stress to institutional arrangements and public policies that result in unequal health risks (Williams et al., 2010). Whatever internal disagreements and nuances remain, there is little disagreement that health is an inextricably social, not just medical, matter.

Whether this population health perspective (Kindig, 2007) has crossed academic borders into the policy world and general public, however, remains an open question. The debate around the Affordable Care Act (ACA) serves as one barometer and suggests limited success. The ACA discussion has focused almost exclusively around expanding medical care access, with "health reform" becoming more or less synonymous with "health care reform," notwithstanding lesser known components of the

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ACA that address non-medical influences. This suggests a need for a more coordinated effort—a movement—to diffuse population health thinking into orbits beyond the scholastic.

But while declaring the need for a movement is easy enough, defining its exact contours is another matter altogether. Who will be its main participants? What will be its primary objectives? Will it constrain itself to stakeholders within the health sector or aim more broadly? This brief will explore these issues via five interrelated key problems[1]:

- The first concerns *desired outcomes*, or, put more simply: What is a population health movement trying to accomplish? What is the metric for success, failure, and everything in between?
- The second addresses *participation*. Who exactly will be propelling the movement? Will it be primarily elite-driven and "top-down" or take on a more popular or "bottom-up" character? And what resources will it draw upon to further its goals?
- The third considers *political tenor*. Should a population health movement push for fundamental transformations of current social configurations? Or should it be more ameliorative and try to work within existing practices? Will its overall character be one of conflict or consensus?
- The fourth is the *single-sector dilemma*, that is, whether a population health movement should restrict itself to the health sector (defined broadly) or try to broaden its appeal to people or organizations with no initial or obvious interest in health.
- The fifth, and final, item is *coalition building* and what kinds of alliances, short and long term, will have to be built to achieve the movement's desired goals.

The next section of this brief will consider these five problems in turn.

PROBLEM ONE: IDENTIFYING CONCRETE GOALS

Recent calls for a population health movement are hazy on concrete objectives, and more precision is necessary concerning exactly what such a movement would try to accomplish. One useful question to ask is whether a movement would primarily be a consciousness-raising endeavor or

[1] I have drawn heavily from the sociological and historical literature on social movements for this brief but have avoided grafting my discussion onto exact constructs used by the field's scholars. In part this is because unresolved debates and disagreements exist within it—much of it useful for the discussion that follows—and I did not want the brief to appear to endorse one camp over the other.

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would go further and catalyze fundamental policy outcomes. The distinction is a useful one to make because some of the most prominent social movements in American history have not necessarily led directly to policy outcomes. Most of the general public and politicians of the time reviled the early abolitionist movement, viewing it as extreme and beyond the pale of acceptable mainstream discourse, and a so-called gag rule prevented discussion of anti-slavery petitions in the U.S. Congress from the mid-1830s to mid-1840s (Stewart, 1996). Rather, the movement's importance was forcing the slavery issue, however slowly, onto the national public stage, setting in motion the events that eventually led to the formation of the new Republican Party. The late 19th-century farmers' movement, broadly referred to as populism, similarly saw scattered success in the formal political sphere, especially at the federal level (Goodwyn, 1978; Kazin, 1995). But it generated a political vocabulary that successfully captured widespread frustrations—even beyond the agricultural economy—over economic inequality at the time, much of which carried over to the Progressive Era and the New Deal era a few decades later, long after the original populist movement had withered.

Limiting a movement's initial goals to diffusion of ideas—in this case, the population health approach—may seem like self-constriction. But it can provide more focus and direction and be more realizable at this time. Altering the parameters of debate in turn widens the possibilities for actual institutional and policy transformation. Within health, the history of disease labeling offers many examples of this process. Sickle cell anemia and miners' diseases, to name just two examples, achieved medical recognition after prolonged agitation first raised awareness of symptoms and then forced physicians, medical researchers, and policy makers to respond to human suffering by naming a problem and implementing policies to address it (Derickson, 1998; Nelson, 2011; Rosner and Markowitz, 1991; Wailoo, 2001).

If policy change does become a movement goal, whether at the initial stage or at later stages, identifying clear policy objectives will be necessary to avoid rudderlessness. (Disagreement about objectives—and whether concrete objectives should even exist at all—was one reason why much of the discursive shift generated by the recent Occupy Wall Street activities did not gain as much subsequent traction as it might have in the actual policy arena.) Some considerations for identifying and assessing targets will be discussed in more detail below, but they include *level* (local, state, federal, global), *political realizability* (amount of realistic support a policy can actually attain), *efficacy* (the relative benefits that would result if a policy were enacted), and *form* (whether by "policy" we mean strictly legislation or something broader, such as the institutional practices of

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medical schools, local health departments, and community multisectoral coalitions).

PROBLEM TWO: THE PARTICIPATION QUESTION

Population health debates have occurred almost exclusively in rarefied settings, namely academia, research institutions, nonprofit organizations, and governmental bodies. This raises the question of *who* exactly will propel and participate in a population health movement, whatever its goals. The answer carries many ramifications. Movements shepherded mainly by professionals or experts can arouse suspicion and accusations of elitism and non-inclusiveness. At worst, too little input from broader constituencies beyond policy makers and thought leaders themselves can result in policies that fail to consider the actual needs of those they purport to serve. At the same time, a movement oriented around population health no doubt requires a certain amount of expertise, technical and otherwise, and this may be one reason why most of the contemporary debates about population health have occurred in more closed settings.

In a number of 20th-century policy reform movements, a tension surfaced between top-down, paternalistic approaches and ones that were bottom-up and more inclusive or "grassroots." Take, for instance, the strides made in sanitation and housing quality during the Progressive Era and into the middle of the 20th century. These initiatives reduced and eliminated many health risks posed by the built urban environment of that period. At the same time, they were often planned and implemented in a top-down manner that ignored their human cost, as municipal officials deemed entire neighborhoods irredeemable cauldrons of disease and marked them for clearance—a practice, known widely as "urban renewal," that targeted mostly immigrant and black neighborhoods and continued into the 1960s (Roberts, 2009). Still, however much we may recoil instinctively over more paternalistic and professional-driven movements, larger inclusion is a principle easier to support on paper than to realize in real-world practice. During the War on Poverty era, pilot programs mandated "maximum feasible participation" from "community" representatives, but who exactly the latter were and how much real input they should actually have on programs' directions often became the subject of heated dispute (Chowkwanyun, 2011). A more recent example of the tension occurred in the 1980s, during the onset of AIDS, when lay activists, many recently diagnosed with the condition, challenged the process by which Food and Drug Administration officials approved early anti-retroviral drugs like azidothymidine, or AZT (Epstein, 1996).

Whoever the key participants, a movement also requires resources and will thus need to consider what kinds of resources it needs, in what

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quantities, and where it will attain them. Until recently, many social movement theorists focused heavily on resources in a narrower sense, defining them mainly in economic and political terms. This work focused on the material pre-conditions necessary for movements to gain followings and take off. A more recent—and vibrant—branch of research, however, has criticized these older "resource mobilization" perspectives and underscored the importance of other types of resources, such as emotions, rhetoric, language, frames, stories, interpersonal interactions, social networks, and local cultures, in order to explain the appeal and success (or lack thereof) of many movements (Goodwin et al., 2001; Polletta, 2008). This new social movement literature complements the burgeoning literature in health communications research on appeals that do (and do not) resonate with the public, but a more explicit linking of the two bodies of work has been lacking. Given widely held, individually centered beliefs about health in the United States and the limited exposure the population health perspective has actually gained with the larger public, careful attention to these latter aspects will be critical to the success of any future population health movement.

PROBLEM THREE: CONSENSUS AND CONFLICT

Many signal developments in the history of health reform—air pollution control, water fluoridation, and food and drug inspection, for example—have occurred because of consensus over their widespread and universal benefits. Others, however, have passed in the wake of sustained political protest and conflict. The formation of the Occupational Health and Safety Administration (OSHA) and of the Mine Safety and Administration came only after decades of agitation from militant labor unions such as the United Mine Workers of America and the Oil, Chemical, and Atomic Workers (Leopold, 2007; Markowitz and Rosner, 2002). A population health movement will have to debate where it sits on a continuum between consensus and conflict. The answer, in turn, will determine what goals are more desirable to pursue in the current moment and which ones will have to wait until a more hospitable political environment exists for them down the line.

Many recent examples suggest that some amount of contention is unavoidable when it comes to health. The acrimony over the ACA, itself the result already of considerable compromise by President Barack Obama, is the most obvious illustration. But other examples exist, too, such as raging battles over food and beverage regulation, including taxes and proposed bans on high-volume sodas or trans fats (Nestle, 2002); calls for bans on common compounds in household products, such as bisphenol A and flame retardants (Vogel, 2006); and efforts to reduce or

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completely end certain forms of energy extraction, such as mountaintop removal of coal, offshore drilling, or hydraulic fracturing (Palmer et al., 2010). All four of these examples potentially disrupt the status quo of influential interest groups.

Another particularly provocative example comes from the 2013 National Research Council and Institute of Medicine report *U.S. Health in International Perspective*, which notes better general health outcomes in states with stronger collective bargaining traditions and in expansive welfare states; both collective bargaining rights and welfare systems have been the subject of extended political conflict around the world, including street protests and rioting in some countries, particularly after the crisis of 2008 (NRC and IOM, 2013). A population health movement, especially one in incipient form, will need to decide if it is worth tackling issues and aiming for policies that could result in considerable political resistance, or whether, at least in the beginning, it should adopt a more risk-averse and cautious course, opting to identify policies that appeal to the widest possible swath of people with the least potential political acrimony.

An additional axis for thinking through this problem (and the second problem, the question of participation) is the insider–outsider continuum. Insiders (policy makers who hold official titles) are often inhibited from taking positions deemed too radical and outside mainstream boundaries of debate. Outsiders, however, have much more liberty to adopt and advocate such stances, and a future movement will need to clarify insider–outsider roles. In the past, outsiders have served as a critical reference point that makes insiders' stances appear much less extreme than might otherwise be the case. For example, Franklin Roosevelt was elected and his New Deal legislation passed during the peak and heyday of the American Communist Party and labor militancy in the 1930s, which attained and public visibility and held views that made Roosevelt look relatively moderate in comparison.

PROBLEM FOUR: THE DILEMMA OF SINGLE-SECTOR ADVOCACY

In 1946 the Textile Workers Union of America's Solomon Barkin declared that "deficiencies in basic living conditions . . . are the breeding ground for disease and poor health. . . . No program for the improvement of the Nation's health is complete which does not have the elimination of . . . deficiencies in basic living conditions . . . as one of its goals" (as quoted in Fairchild et al., 2010). Barkin's remarks suggested, in ways that would be more systematically captured by population health research decades later, that multiple domains influenced one's health, including one's housing and the ability to earn a sustaining wage. Given this pano-

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ply of influences, should a population health movement's activities be primarily restricted to domains labeled as addressing "health" (a single-sector model)? Or should it move broadly, identifying health ramifications across domains without regard for formal labels and boundaries?

The advent of the "health in all policies" approach suggests that the latter path is becoming more desirable. Who would not, after all, want to find ways to improve population health in as many sectors—whether labeled "health" or not—as possible? But real-world impediments to doing so may exist. Administrative boundaries, for one, sharply demarcate formal duties at all levels of government (Rigby, 2011). For instance, while energy extraction has enormous health ramifications, the U.S. Department of Energy's duties are largely technical and infrastructural, and contact with the nation's several health agencies is quite limited. Within academia, interdisciplinary work has experienced renewed traction, allowing health research to appear in departments where it was previously not very visible, but the balkanization of knowledge no doubt still exists within universities.

Context aside, single- and multisector approaches also have inherent pros and cons that movement organizers must weigh. A multisector approach can be overly diffuse, spread resources thin, and lack the expertise and credibility of a single-sector alternative, wherein participants are often more well versed in the details of a particular sphere than are advocates working in multiple areas at once. At the same time, there are many examples in the history of health organizing where multisector organizing has been critical. During the War on Poverty era, the Office of Economy Opportunity sponsored countless experiments and policy initiatives, which included housing, health, education, job creation, and early child development, under a big tent (Orleck and Hazirjian, 2011). Historically, labor and conservation movements provided considerable resources (monetary and human) for pushing through hallmark occupational and environmental health legislation, especially in the 1970s run-up to OSHA and the Environmental Protection Agency. The present-day environmental justice movement is an example of another multisector approach, one that unifies civil rights, environmental, and health advocates (Bullard, 1990). At its best, multisector organizing greatly expands population health's appeal and helps it avoid simply calcifying into a niche concern of limited interest. In the 1960s and 1970s, movement stagnation became an important factor when many quality-of-care struggles around hospitals and medical schools experienced a boom in interest that gradually subsided without a larger base to sustain initial energy (Mullan, 1976).

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PROBLEM FIVE: CREATING WIN-WINS AND COALITION BUILDING FOR POPULATION HEALTH POLICY

The dilemma of single-sector organization raises our final problem: identifying constituencies that might also support population health improvement, though perhaps not for the same reasons as people initiating a movement for it. Identifying such win-win "wedge" constituencies is crucial, as political bedfellowism has contributed to many social movements' success. In the antebellum era, many Northerners who harbored enormous racial animus nevertheless came to support stronger anti-slavery positions because of fears that the expansion of slavery would mean growing Southern power and a threat to Northern white labor. The early 20th-century movement for workers' compensation gained the support of many businesspeople who wanted to shift the costs of caring for injured employees onto the government (Rodgers, 1998). Support for civil rights by politicians stemmed not only from commitments to racial justice but also from Cold War concerns about the United States' public standing on the global political stage. Many geopolitical rivals cited American racism in an attempt to undercut the nation's moral authority to criticize the repressiveness of Eastern Bloc communism (Borstelmann, 2001; Dudziak, 2000). Political support for the Vietnam War fell not only because of street agitation but also because of internal dissent within the Army and anger from congressional fiscal conservatives over the war's budgetary drain and economic consequences (Zelizer, 2007). In a manner similar to these cases, a population health movement will likely have to find points of commonality with wedge constituencies if it is to catalyze a following beyond obvious supporters. Identifying allies within medical care may be especially important, given the enduring "boundary issue" between medicine and public health that has existed throughout the 20th century (Brandt and Gardner, 2000).

Any discussion of coalition building requires one important caveat. While it is often politically necessary to form coalitions, the creation of coalitions (and the compromises often associated with them) should adhere to clear principles outlining when they are acceptable and when they are not. After all, one of the most successful political coalitions of 20th-century social policy, which led to the flurry of New Deal and Fair Deal legislation passed in the 1930s and 1940s, was also a Faustian bargain. Advocates of the Social Security Act and the G.I. Bill, among others landmark legislation, acquiesced to a powerful segregationist Southern Democratic bloc, which pushed for local-level (and discriminatory) distribution of new funds and excluded entire swaths of the population from benefits. This in turn resulted in the denial of benefits to millions of African Americans, with one leading scholar of the period writing that "new national policies enacted in the pre-civil rights, last-gasp era

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of Jim Crow constituted a massive transfer of quite specific privileges to white Americans," one with residual consequences that are still present today (Katznelson, 2006). Although most coalitions do not result in as morally anguished and explosive a trade-off as this one did, it is important to consider whether adopting more pragmatic rationales for certain measures or allying with certain unexpected constituencies in the short-term may undercut other moral and ethical commitments.

CONCLUSION: POPULATION HEALTH—PREVENTING MARGINALIZATION

This brief has outlined five considerations to guide discussion on what a population health movement would look like. It urges those interested in seeing such a movement to consider goals, the nature of participation, political tenor, and strategic direction, that is, its relationship to non-health sectors and potential allies in coalitions.

Looming above these five points is a larger overarching question of why major tenets of the population health perspective have become marginalized, revived, and then marginalized again. After all, the idea that collective health outcomes are rooted in the social is not new, and it is traceable (at the very least) to the public health enterprise's early Victorian roots in the 1830s and 1840s, when some of the very same boundary issues above were actively debated (Coleman, 1982; Hamlin, 1998). Closer to the present, future Surgeon General Julius B. Richmond co-authored a 1954 piece titled "Total Health: A Conceptual Visual Aid," which sorted the various influences of health into three categories, the emotional environment, the internal environment, and the physical environment (Richmond and Lustman, 1953). "To balance the trend toward specialization and compartmentalization fostered by rapid advances in the medical sciences," Richmond and his co-author wrote, "it is desirable to emphasize a comprehensive approach to the understanding of man and his relationship to his environment in health and disease" (p. 29). They emphasized further that one should think of health as "dynamic relationships among the multiplicity of types of forces operative upon and within the organism at any given moment" (p. 29). A decade later, Harold Light and Howard J. Brown, who founded one of the first neighborhood health centers on the Lower East Side of New York, summarized the facility's underlying philosophy: "The patient functioned as part of a larger milieu—in his own home and in the broader community—and these forces, therefore, must be take into account if the service rendered was to be meaningful" (Light and Brown, 1967). At around the same time, in 1964, Kurt Deuschle, who would go on to a three-decades career at Mount Sinai School of Medicine, declared:

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> Merely providing more health services or larger appropriations from the public purse without formulation of a new and more effective approach will not solve the long range health problems of these people. In short, when a community is as sick as this one, this sickness is reflected in the members of the society. An attack on the health problems of such an area must be combined with an attack on the social, economic, political, and educational ills if any solutions are to be permanent. . . . What are the most appropriate public health *and* medical care solutions which society at large can afford to provide for such a rural slum neighborhood? (Tapp et al., 1964)

In the early 1970s, the social demographer Thomas McKeown ignited a debate on the causes of the so-called epidemiological transition in the 20th century, in which the incidence of contagious disease and mortality declined precipitously in the advanced industrial economies, and he examined the relative contribution of medical care versus other factors, including better nutrition, sanitation, public health reforms, and economic development. The subsequent debate centered on the very issues that have captured the attention of population health science (McKeown, 1976, 1979).

Other examples abound. And, to be sure, the recent research referenced at the start of this brief has examined these questions with undoubtedly greater empirical detail and conceptual clarity. But its core insight about multiple and non-medical influences on health is not new and remains strikingly similar to that of its predecessors. This suggests a phenomenon at work similar to what the social scientist Herbert Gans has called "sociological amnesia" in another context (Gans, 1992). From the perspective of movement building, we should consider what causes periodic forgetting, then remembering, of the population health perspective, and try to sustain interest this time round.

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Appendix D

Glossary of Movement Terminology

Prepared by Merlin Chowkwanyun

Note: Considerable disagreement exists over the exact definitions of these terms, and they should be viewed only as general and broad definitions written for non-specialists coming to the December 5, 2013, meeting from a variety of academic and practitioner backgrounds.

Campaign Although some may use "campaign" as synonymous with "social movement," the former might be better thought of as a tool for movement participants to use. It refers to attempts, usually public, to drum up support for a cause, claim, or idea, typically those underpinning a social movement itself. These attempts usually draw on slogans, visual symbols, and political motifs and are often waged via mass media, pamphlets, and other ephemera.

Framing This term refers to the terms of debate and the parameters of discussion on which a discussion does (and does not) take place. Framing can also refer to strategic diction, choices of connotation, and special overtures to certain interest groups or specialized audiences. A conscious decision by policy makers to discuss education as a population health issue (or deciding not to do so) is an example of framing.

Grassroots Though often used loosely, this term denotes a more informal, localized, democratic, and less rigidly structured and organized approach to political mobilization and social movements. Grassroots movements often include ordinary people without professional status or direct access

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to policy makers or elected officials, and they often work outside more formal channels.

Narrative This refers to storytelling, implicit and explicit, when movement participants try to amass support. Narratives include both individual anecdotes and causal explanations of why phenomena like racial health disparities occur.

Networks The social, political, and organizational/institutional ties among people that can be mobilized in service of a social movement.

Resource mobilization An older school of social movement scholarship that analyzes how movement participants marshal and utilize economic, political, and other resources. A new generation of scholars has critiqued this approach and underscored the importance of narratives, frames, and emotional appeals, which are often as influential in determining movement momentum and ultimate success.

Social movement A collective effort, usually by groups but sometimes by coordinated individuals, to make claims on states and private entities and/or spread ideas, beliefs, or practices among a population in the hope of achieving societal change. Social movements are frequently in tension or open conflict with a status quo.

Further general reading:

Goodwin, J., J. Jasper, and F. Polletta. 2001. Introduction: Why emotions matter. In F. Polletta, J. M. Jasper, and J. Goodwin, eds., *Passionate politics: Emotions and social movements*. Chicago, IL: University of Chicago Press. Pp. 1–26.

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Appendix E

Speaker and Moderator Biographies[1]

Gregory T. Angelo is the current Executive Director of Log Cabin Republicans. Prior to his current position, Mr. Angelo served as the Chairman of Log Cabin Republicans of New York State, where he led Log Cabin Republicans as part of New Yorkers United for Marriage, a coalition that collaborated to make marriage equality legal through legislative vote for the first time in a Republican-controlled legislature. Angelo is also the Executive Director of the Liberty Education Forum, a non-partisan think tank that advocates a message of gay acceptance among conservatives and people of faith throughout the United States. He has been featured in numerous media outlets, including *The O'Reilly Factor*, *Hardball with Chris Matthews*, *The Wall Street Journal*, *USA Today*, CNBC, ABC News, NPR, NBC, C-SPAN, and more.

Martha Argüello has served in the nonprofit sector for the past 32 years as an advocate, community organizer, and coalition builder. She joined Physicians for Social Responsibility–Los Angeles (PSR–LA) in 1998 to launch the environmental health programs, and became Executive Director in November 2007. She is committed to making the credible voice of physicians a powerful instrument for transforming California and our planet into a more peaceful and healthy place. Ms. Argüello grew up in the

[1] Notes: Names appear in alphabetical order; "†" = member of the workshop planning committee; "*" = member of the IOM Roundtable on Population Health Improvement; "**" = member of the IOM Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

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Pico-Union area of Los Angeles. At the young age of 14, she made a lifelong commitment to effect social change after seeing her friend killed by a school security guard. While working as a health educator in the 1990s, Ms. Argüello had an epiphany—she realized that although early detection can prevent death from breast cancer, it does not prevent breast cancer, which has been increasingly linked to the exposure of environmental toxicants. Since that realization, Ms. Argüello has dedicated her career to the environmental justice movement, and has lectured nationwide on the use of precautionary principle policies. As a coalition builder, Ms. Argüello has emphasized the need for local grassroots advocacy working in partnership with statewide policy actions. She is an active board member of numerous organizations, including Californians for Pesticide Reform, and Californians for a Healthy and Green Economy. She also co-founded the Los Angeles County Asthma Coalition and the Coalition for Environmental Health and Justice, and was appointed to Cal/Environmental Protection Agency's Environmental Justice Committee and the California Air Resources Board's Global Warming Environmental Justice Advisory Committee.

Raymond J. Baxter, Ph.D., is Kaiser Permanente's (KP's) senior vice president for Community Benefit, Research and Health Policy. As a member of Kaiser's National Executive Team, Dr. Baxter leads the organization's activities to fulfill its social mission, including care and coverage for low income people, community health initiatives, health equity, environmental stewardship and support for community-based organizations. He also leads KP's work in research, health policy and diversity, and serves as President of KP International. Dr. Baxter has more than 35 years of experience managing public health, hospital, long-term care and mental health programs, including heading the San Francisco Department of Public Health and the New York City Health and Hospitals Corporation. Dr. Baxter also led The Lewin Group, a noted health policy firm. Dr. Baxter holds a doctorate from the Woodrow Wilson School of Public and International Affairs, Princeton University. He serves on the Advisory Boards of the University of California, Berkeley, School of Public Health and the Duke University Institute for Health Innovation, the Board of the CDC (Centers for Disease Control and Prevention) Foundation, the Global Agenda Council on Health of the World Economic Forum, and is a member of the Institute of Medicine's (IOM's) Roundtable on Population Health Improvement and the Roundtable on Value & Science-Driven Health Care. In 2001 the University of California, Berkeley, School of Public Health honored him as a Public Health Hero for his service in the AIDS epidemic in San Francisco. In September 2006 he received the CDC Foundation Hero Award for addressing the health consequences of Hur-

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ricane Katrina in the Gulf Coast, and for his longstanding commitment to improving the health of communities.

Ned Calonge, M.D., M.P.H., is the President and CEO of The Colorado Trust, a health equity foundation, which was created in 1985 with the proceeds of the sale of PSL Healthcare Corporation. The mission of the Trust is to advance the health and well-being of the people of Colorado, with a vision that all Coloradans should have fair and equal opportunities to lead healthy, productive lives regardless of race, ethnicity, income or where they live. Dr. Calonge is an Associate Professor of Family Medicine at the Colorado School of Medicine, University of Colorado, Denver, and an Associate Professor of Epidemiology at the Colorado School of Public Health. Nationally, he chairs the CDC's Evaluating Genomic Applications for Practice and Prevention Working Group and the Agency for Healthcare Research and Quality's Electronic Data Methods Forum Advisory Committee, and is a member of the CDC's Task Force on Community Preventive Services and of CDC's Breast and Cervical Cancer Early Detection and Control Advisory Committee. Dr. Calonge is a past Chair of the U.S. Preventive Services Task Force and is a past member of the Secretary's Discretionary Advisory Committee on Heritable Disorders in Newborns and Children. Prior to coming to the Trust, Dr. Calonge was the Chief Medical Officer of the Colorado Department of Public Health and Environment. Dr. Calonge received his B.A. in Chemistry from The Colorado College, his M.D. from the University of Colorado and his M.P.H. from the University of Washington, where he also completed his preventive medicine residency. He completed his family medicine residency at the Oregon Health Sciences University. He was elected to the IOM in 2011.

Karoleen Feng, M.C.P., is Community Development Manager of Mission Promise Neighborhood initiative at Mission Economic Development Agency where she coordinates policy and program partnerships for housing, violence prevention, nutrition and physical fitness for the Mission neighborhood in San Francisco. Formerly as Associate Director of the Real Estate Department at East Bay Asian Local Development Corporation, her role spanned planning and advocacy as well as real estate development of office, retail, multifamily residential and for-sale single family homes. She has assembled and managed complex mixed-use real estate development projects ranging $4 million to $50 million from site acquisition through planning entitlements and construction to operations and/or sales. Ms. Feng has a master's of City Planning from the University of California, Berkeley, and a bachelor of arts from the University of California, Berkeley, in Political Economy of Industrialized Societies.

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Marshall Ganz, Ph.D., M.P.A., Senior Lecturer in Public Policy, entered Harvard College in the fall of 1960. In 1964, 1 year before graduating, he left to volunteer as a civil rights organizer in Mississippi. In 1965, he joined Cesar Chavez and the United Farm Workers; over the next 16 years he gained experience in union and community issues, and political organizing, and became Director of Organizing. During the 1980s, he worked with grassroots groups to develop effective organizing programs, designing innovative voter mobilization strategies for local, state, and national electoral campaigns. In 1991, in order to deepen his intellectual understanding of his work, he returned to Harvard College and, after a 28-year "leave of absence," completed his undergraduate degree in history and government. He was awarded an M.P.A. by the Kennedy School in 1993 and completed his Ph.D. in sociology in 2000. He teaches, researches, and writes on leadership, organization, and strategy in social movements, civic associations, and politics. He has published in the *American Journal of Sociology, American Political Science Review, American Prospect, Washington Post*, *Los Angeles Times*, and elsewhere. His newest book, *Why David Sometimes Wins: Leadership, Organization and Strategy in the California Farm Worker Movement* was published in 2009, earning the Michael J. Harrington Book Award of the American Political Science Association. He was awarded an honorary doctorate in divinity by the Episcopal Divinity School in 2010.

Anthony Iton, M.D., J.D., M.P.H., is Senior Vice President for Healthy Communities at The California Endowment. In the fall of 2009, Dr. Iton began to oversee the organization's 10-Year, Multimillion-Dollar Statewide Commitment to Advance Policies and Forge Partnerships to Build Healthy Communities and a Healthy California. Dr. Iton served for 7 years as the Alameda County Public Health Department Director and Health Officer where he oversaw a budget of $112 million with a focus on preventing communicable disease outbreaks, reducing the burden of chronic disease and obesity. He has worked as an HIV disability rights attorney at the Berkeley Community Law Center, a health care policy analyst with Consumers Union West Coast Regional Office, and as a physician and advocate for the homeless at the San Francisco Public Health Department. Dr. Iton's primary focus includes health of disadvantaged populations and the contributions of race, class, wealth, education, geography, and employment to health status. His awards include the Champion of Children Award from the United Way and the National Association of City and County Health Officials Award of Excellence for the use of information technology in public health. In February 2010, Dr. Iton was recognized by the California Legislative Black Caucus with the Black History Month Legends Award and presented on the floor of the

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California State Assembly with a resolution memorializing his life's work and achievements. Dr. Iton serves on the board of directors of the Public Health Institute, the Public Health Trust, the Prevention Institute, and Jobs for the Future. Dr. Iton received his medical degree at Johns Hopkins University Medical School and subsequently trained in internal medicine and preventive medicine at New York Hospital, Yale, and Berkeley and is board certified in both specialties. Dr. Iton also holds a law degree and a master's of public health from the University of California, Berkeley, and is a member of the California Bar.

Michelle Larkin, J.D., M.S., R.N.,* As assistant vice president and deputy director for the Robert Wood Johnson Foundation's (RWJF's) Health Group, Ms. Larkin helps to shape the Foundation's strategies, policies, and programs to create a culture of health for the nation, including reversing the childhood obesity epidemic, driving fundamental improvements in the nation's public health system, and addressing the needs of the country's most vulnerable populations. Larkin also co-leads the Foundation's major initiative on public health law to establish effective public health laws, regulations, and policies; enhance the public health law infrastructure to support practitioners, advocates, and their legal counsel in improving health; and promote the use of law in fields that impact health. Previously, Ms. Larkin directed the Foundation's Public Health team in its work to improve federal, state, and local public health systems, build the evidence for effective public health practice and policy, and advocate for the use of law and policy to improve health. From 2003 through 2006, she co-led the Foundation's Tobacco team, promoting increased tobacco excise taxes, state and local smoke-free air laws, and funding for tobacco prevention and treatment. Before joining the Foundation, Ms. Larkin worked as a health policy analyst at the Office on Smoking and Health at CDC in Washington, DC; as a Presidential Management Fellow; as a legislative fellow for the U.S. Senate Labor and Human Resources Committee; and as a hematology-oncology nurse at the University of Maryland Medical System in Baltimore, Maryland. Ms. Larkin is a member of the American Public Health Association, the Public Health Law Association, the American Bar Association, and the New Jersey Bar. She also serves on the National Board of Public Health Examiners. Ms. Larkin received a J.D. from the Seton Hall University School of Law, an M.S. in nursing/health policy from the University of Maryland, and a B.S.N. from the University of Pennsylvania.

Jeff Levi, Ph.D.,* is Executive Director of the Trust for America's Health (TFAH), where he leads the organization's advocacy efforts on behalf of a modernized public health system. He oversees TFAH's work on a range of

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public health policy issues, including implementation of the public health provisions of the Affordable Care Act (ACA) and annual reports assessing the nation's public health preparedness, investment in public health infrastructure, and response to chronic diseases such as obesity. TFAH led the public health community's efforts to enact, and now defend, the prevention provisions of the ACA, including the Prevention and Public Health Fund and the new Community Transformation Grants. In January 2011, President Obama appointed Dr. Levi to serve as a member of the Advisory Group on Prevention, Health Promotion, and Integrative and Public Health. In April 2011, Surgeon General Benjamin appointed him chair of the Advisory Group. Dr. Levi is also Professor of Health Policy at George Washington University's School of Public Health, where his research has focused on HIV/AIDS, Medicaid, and integrating public health with the health care delivery system. In the past, he has also served as an associate editor of the *American Journal of Public Health* and Deputy Director of the White House Office of National AIDS Policy. Beginning in the early 1980s, he held various leadership positions in the LGBT and HIV communities, helping to frame the early response to the HIV epidemic. Dr. Levi received a B.A. from Oberlin College, an M.A. from Cornell University, and a Ph.D. from George Washington University.

Sanne Magnan, M.D., Ph.D.,* is the President and CEO of the Institute for Clinical Systems Improvement (ICSI) in Bloomington, Minnesota. ICSI is an independent, nonprofit organization that facilitates collaboration to improve health and health care value by medical groups, hospitals, nonprofit health plans, purchasers, and community stakeholders. From 2007 to 2010, Dr. Magnan served as Commissioner of Health for the Minnesota Department of Health (MDH) and was responsible for significant implementation of Minnesota's 2008 health reform legislation. Before working at ICSI and MDH, she was vice president and medical director of consumer health at Blue Cross and Blue Shield of Minnesota. Currently, Dr. Magnan also serves as a staff physician at the Tuberculosis Clinic at St. Paul-Ramsey County Department of Public Health, and a clinical assistant professor of medicine at the University of Minnesota. She is a board-certified general internist and serves on several community boards, including Minnesota Community Measurement and NorthPoint Health and Wellness Center, a federally qualified health center. Dr. Magnan is 1 of the 100 Influential Health Care Leaders named by Minnesota Physician in 2004, 2008, and 2012. Her medical degree and Ph.D. in medicinal chemistry are from the University of Minnesota.

Mary Pittman, Dr.P.H.,†* is president and chief executive officer of the Public Health Institute (PHI). A nationally recognized leader in improving

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community health, addressing health inequities among vulnerable people and promoting quality of care, Dr. Pittman assumed the reins at PHI in 2008, becoming the organization's second president and CEO since its founding in 1964. Her primary focus has been guiding the development of a strategic plan that builds on existing PHI program strengths to achieve greater impact on public policy and practice in public health. "In a changing environment, strategic planning is an ongoing process, not an end product," she said. Dr. Pittman's overarching goal is for PHI to become known for leadership in creating healthier communities. To this end, PHI continues to work closely with the state on many programs, including the Supplemental Nutrition Assistance Program. What's more, she advocates that all PHI projects take the social determinants of health into account to better address health disparities and inequities. Under Dr. Pittman's leadership, PHI has emphasized support for the ACA and the Prevention and Public Health Fund, the integration of new technologies and the expansion of global health programming. Other top priorities are: increasing advocacy for public policy and health reform, and addressing health workforce shortages and the impacts of climate change on public health. Under Dr. Pittman, PHI has created Dialogue4Health.com, the online platform for conferencing and social networking, and has been recognized as a preferred place to work. She strives for PHI's independent investigators to work together to achieve a synergy in which the sum of their contributions is greater than the whole. Dr. Pittman has deep, varied, and multisectoral experience in local public health, research, education, and hospitals. Before joining PHI, Dr. Pittman headed the Health Research and Educational Trust, a Chicago-based affiliate of the American Hospital Association, from 1993 to 2007. Previously, she was president and CEO of the California Association of Public Hospitals and a director of the San Francisco Department of Public Health. Dr. Pittman has authored numerous peer-reviewed articles in scientific journals and two books. She has served on the PHI board of directors since 1996. Dr. Pittman also serves on numerous boards and committees, including the World Health Organization's Health Worker Migration Global Policy Advisory Council and the National Patient Safety Foundation's board of governors.

Francesca Polletta, Ph.D., came to University of California, Irvine, from Columbia University, where she was an assistant and associate professor of sociology. She works in the areas of culture, politics, social movements, and law. Much of her work investigates how culture sets the terms of strategic action, but culture understood less as beliefs and worldviews than as familiar relationships, institutional routines, and conventions of self-expression. In her award-winning *Freedom Is an Endless Meeting: Democracy in American Social Movements* (University of Chicago Press, 2002),

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Dr. Polletta showed that activists over the course of a century have styled their radical democracies variously on friendship, religious fellowship, and tutelage—and fractured along the lines of those relationships. In her award-winning *It Was Like a Fever: Storytelling in Protest and Politics* (University of Chicago Press, 2006), she investigated the political advantages and risks of telling stories, especially for disadvantaged groups. Popular conventions of storytelling have served to reproduce the status quo, she argues, less by limiting what disadvantaged groups can imagine than by limiting the occasions on which they can tell authoritative stories. Dr. Polletta's current research focuses on new modes of citizen participation, and aims both to account for the new enthusiasm for participatory democracy and to determine whether popular participation has become effectively detached from power.

Doran Schrantz is the Executive Director of ISAIAH, a faith-based community organization of 100 member congregations in the Twin Cities metropolitan region, St. Cloud, and Rochester in Minnesota. Ms. Schrantz has been at the center of ISAIAH's development from a small, more locally focused organization of 64 member institutions, to an organization considered one of the most powerful voices in Minnesota around issues of racial and economic justice. In the past 5 years, ISAIAH has explored the intersection of community organizing, movement building, politics, policy, and research and has launched powerful partnerships at the state level such as Minnesotans for a Fair Economy, which is a collaborative of faith, community, and labor. This collaborative has been at the center of working to end income inequality, passing significant state legislation as well as winning a state-wide ballot initiative to defeat Voter ID in 2012. Working at the intersection of health and organizing, ISAIAH has led two significant, community-led health impact assessments funded by the Health Impact Project, one on the built environment and the other looking at education equity and integration policies. Ms. Schrantz has also worked to launch Healthy Heartlands, a collaborative of five Midwestern states working at the intersection of the social determinants of health and democracy building in order to stage interventions which reduce health inequities. Healthy Heartlands is currently working with the People Improving Communities through Organizing National Network to build a national center for health organizing. Ms. Schrantz is on the Board of Human Impact Partners, a lead organization in the field of health impact assessments. In 2012, Ms. Schrantz was awarded the Young Leader Award from RWJF, an award that recognized 10 leaders under 40 who are innovating around health and health care.

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Mildred Thompson, M.S.W.,[†**] is the Senior Director and Director of the PolicyLink Center for Health Equity and Place. She leads the organization's health team, with work focusing on healthy food access, improving the built environment, and the systemic integration of health equity. A significant component of her work involves exploring community factors that impact health and identifying effective solutions. Prior to joining PolicyLink, she was director of community health services for Alameda County's Public Health Department; director of Healthy Start; and director of the San Antonio Neighborhood Health Center. Ms. Thompson has degrees in nursing, psychology, and social work. She has taught at Mills College and San Francisco State University, and also worked as an organizational development consultant. Ms. Thompson is a frequent speaker on topics related to health equity and serves on several boards and commissions, including The Zellerbach Family Foundation and she is co-chair of the IOM's Roundtable on the Promotion of Health Equity and Elimination of Health Disparities.

Joan Twiss, M.A., is the founding executive director of the Center for Civic Partnerships, which provides leadership and management support to build healthier communities and more effective nonprofit organizations. She has more than 30 years of experience working in both the public and private sectors at the local, state, and national levels with extensive expertise in program planning, community indicators, implementation, technical support, training, policy development, and evaluation. Ms. Twiss is responsible for the center's development, strategic direction, management, and program evaluation in both community and organizational development. She designed and continues to direct California Healthy Cities and Communities, the first and largest program of its kind in the United States. She researches, publishes, presents, and consults on the factors that allow for aging well in communities. Ms. Twiss currently leads the coaching support function for the National Leadership Academy for the Public's Health, another PHI program. She has extensive experience leading multiple statewide technical support programs, often as part of comprehensive community health improvement initiatives. She has authored numerous articles for peer-reviewed journals and practitioner-oriented publications. Ms. Twiss has a master's in health education, with coursework in urban studies, from the University of Maryland. She also holds a bachelor's in public health from the University of Massachusetts. She is a certified charrette planner.

Winston Wong, M.D., M.S.,** joined KP in 2003 as Clinical Director, Community Benefit, with joint appointments at the Care Management

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Institute and the National Program Office of Community Benefit. In this role, he is responsible for developing and cultivating partnerships with communities and agencies in advancing population management and evidence-based medicine, with a particular emphasis on safety net providers and the elimination of health disparities. From 1993–2003, Dr. Wong was a Commissioned Officer of the U.S. Public Health Service, serving as both the Chief Medical Officer for the Health Resources and Services Administration, Region IX, and its Director of California Operations. He achieved the rank of Captain, and was awarded the Outstanding Service Medal from the U.S. Department of Health and Human Services. Dr. Wong received a master's degree in health policy and his medical degree from the University of California, Berkeley–San Francisco, Joint Medical Program. A board-certified family practitioner, continues a small clinical practice at Asian Health Services, a federally qualified health center in Oakland, California, where he served previously as Medical Director. Dr. Wong has served on a number of state and national advisory groups addressing issues in cultural competence, health care access, and improving health care for vulnerable populations.

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