CommonHealth *ACTION*

THE WELL COMMUNITY PROJECT: MOVING BEYOND HEALTH

Addressing the Missing Dimension

A Community Premise Paper by CommonHealth *ACTION*

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INTRODUCTION

In the U.S., we tend to define health in terms of doctor visits and sick days.[1] Despite spending more on health care than any other nation—16 percent of our gross domestic product, or twice as much as other wealthy countries—our health care system ranks 37th in the world; we continue to lag behind other developed countries in terms of life expectancy and health outcomes.[2] People of color and poor communities are disproportionately more likely than their white or wealthy peers to suffer from poor health, driven by inequities in systems rather than biological destiny. Even our recent national health care reform law is primarily concerned with restructuring how we pay for medical services rather than transforming our systems to promote health.

We are faced with this conundrum in part because we have built our medical and public health systems around responding to illness and disease rather than fostering conditions that produce wellness. As a nation, we must develop a new paradigm of health and wellness that helps communities to grow and flourish. We must identify conditions and practices that support healthy communities as central, rather than extraneous, to the health system. Quality of life should be inextricably linked with health. This vision for a new model of community wellness is essentially pragmatic, as our ability to remain a global power is tied to the well-being of our population.

The Well Community Project, a collaborative between Samueli Institute, CommonHealth ACTION, and Institute for Alternative Futures with funding support from the W.K. Kellogg Foundation, attempts to develop this new paradigm by redirecting us from the conventional view of health from illness-orientated, individualized health care to developing healthy communities and promoting whole-person wellness. Critical to the project is the meaningful and respectful engagement of community members in the planning and implementation of strategies. Together, we seek to develop an evidence-based and community-informed framework to reorient efforts that promote holistic wellness and greater health equity.

THE PREMISES
OF THE WELL COMMUNITY PROJECT

At CommonHealth ACTION, we believe that the **Well Community Project** offers an innovative opportunity to transform community health systems to produce equitable health and wellness. We present the following premises and questions for exploration and validation with community leaders, healers and practitioners, and researchers exploring the science of wellness.

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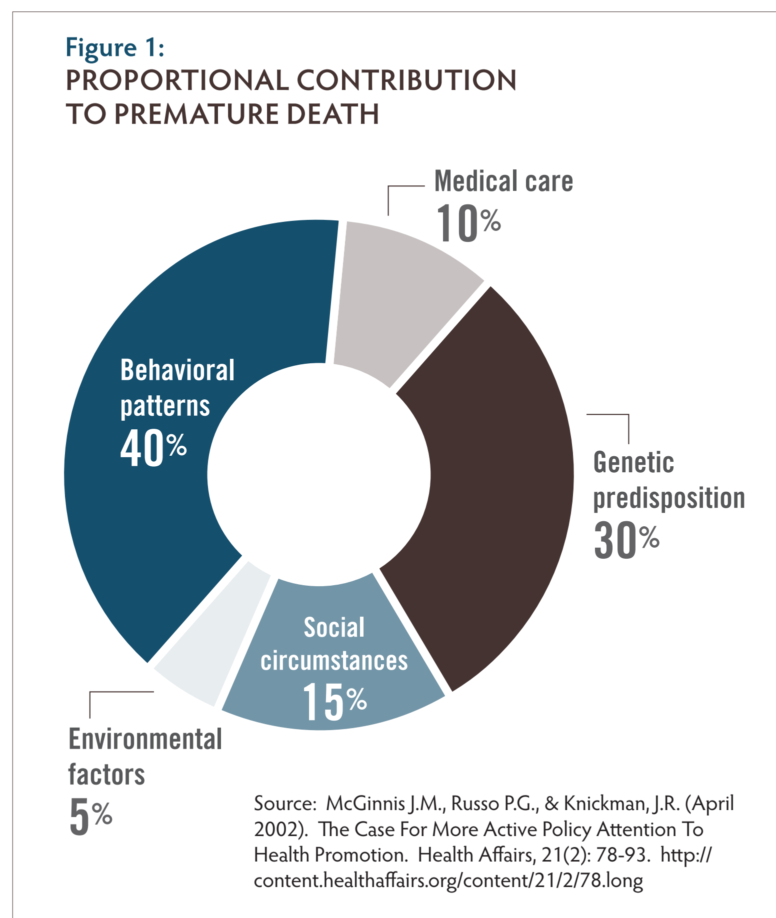
[1] This premise paper was prepared by CommonHealth ACTION (CHA) to complement a paper by Samueli Institute exploring the science of wellness and healing. Both papers provide background information for an expository discussion with community leaders, researchers, and practitioners that explore the places, practices, and conditions that produce wellness and quality of life.

[2] Murray, C.J.L. & Frenk, J. (January 2010). Ranking 37th — Measuring the Performance of the U.S. Health Care System. *New England Journal of Medicine* 362: 98-99; Davis, K., Schoen, C., & Stremikis K. (June 2010). Mirror, Mirror on the Wall: How the Performance of the U.S. Health Care System Compares Internationally. http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2010/Jun/1400_Davis_Mirror_Mirror_on_the_wall_2010.pdf

PREMISE 1: Health is more than the absence of disease. In the U.S., we commonly define health as the absence of illness or impairment. This definition, however, falls short in multiple respects. It implies that health is primarily a function of physical health, marginalizing the importance of mental, social, and spiritual well-being. It treats health as a condition that we either possess (good health) or do not (poor health), rather than a continuum along which we move throughout our lives. It fails to adequately incorporate quality of life. For instance, it is certainly possible for a person living with disability to be well. Finally, it does not incorporate the significant role of systemic factors, including the environment in which we live, in the production of health in our communities. When discussing health in this paper, we use the multi-dimensional definition adopted by the World Health Organization in 1948, which defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[3]

PREMISE 2: Community context is critical to health production. Our genes are neither the only nor the most important factor in poor health outcomes (see Figure 1).[4] Determinants of health—social, economic, and environmental factors outside of the health care system—shape the opportunities we have and the choices we make. The neighborhoods where we live, work, and play—whether there is affordable housing, economic opportunity, safe streets, green space, available fresh food, strong local schools—are all involved in the production of health for our residents. Moreover, due to the history of residential segregation, redlining, and other policies, people of color are more likely to live in areas where poverty is concentrated and resources are lacking. A recent study that followed low-income families who moved from economically distressed neighborhoods to "high



Source: McGinnis J.M., Russo P.G., & Knickman, J.R. (April 2002). The Case For More Active Policy Attention To Health Promotion. Health Affairs, 21(2): 78-93. http://content.healthaffairs.org/content/21/2/78.long

3 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

4 McGinnis J.M., Russo P.G. & Knickman, J.R. (April 2002). The Case For More Active Policy Attention To Health Promotion. *Health Affairs*, 21(2): 78-93. http://content.healthaffairs.org/content/21/2/78.long

5 Turner, M.A., Nichols, Austin & Comey, J. (September 2012). Benefits of Living in High Opportunity Neighborhoods: Insights from the Moving to Opportunity Demonstration. http://www.urban.org/UploadedPDF/412648-Benefits-of-Living-in-High-Opportunity-Neighborhoods.pdf

opportunity" neighborhoods with low levels of poverty and unemployment and high levels of education found significant positive outcomes in physical health for adults and children and lower levels of adult anxiety.[5]

PREMISE 3: Stress—at the individual and community levels—affects all aspects of health.

Evidence suggests that when people are repeatedly exposed to stressful environments, hormones that trigger a fight-or-flight reaction are constantly activated, resulting in wear and tear on the body. This stress can have lifelong effects on health and well-being; children exposed to this high level of stress in their environments are more likely have learning and behavioral problems that follow them into adulthood.[6] For example, a study of adolescents living in "low socioeconomic status neighborhoods" found cortisol levels consistent with chronic stress, even when controlling for the teens' household income.[7] This high level of stress is not only found in people living in economically distressed neighborhoods; a growing body of research examines potential links between racial discrimination and poor health outcomes.[8] For instance, socioeconomic status is linked to infant mortality and low birth weight but does not fully explain differences in birth outcomes for black and white women; in fact, black women with at least a college degree are more likely to have a low birth weight baby than white women without a high school education.[9] Building resilience—the ability to be protected (and more easily recover) from distressing or damaging experiences—may be an important strategy for mitigating the negative health impacts of stress. However, the effects of individual and community stress, and strategies to manage that stress and build resiliency, are often deprioritized by our health systems.

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PREMISE 4: Public health and medical care systems are centered on preventing & treating disease rather than producing health.

Despite the fact that only a small portion of premature death is attributed to poor medical care access, the U.S. continues to invest heavily in a fragmented, reactionary health care system as the primary strategy to improve health and manage disease. The nation spends a much smaller fraction of its health care dollars on public health and prevention efforts. Even when substantial investments are made, they are not seen as essential; take, for example, the Prevention and Public Health Fund, a stream of mandatory funding for prevention activities created by the health reform law that was raided soon after its establishment to

[6] Shonkoff, J.P., Garner, A.S., Siegal, B.S., Dobbins, M.I., Earls, M.F., McGuinn, L., Pascoe, J., & Wood, D.L. (January 2012). The Lifelong Effects of Early Childhood Adversity and Toxic Stress. Vol. 129 No. 1 January 1, 2012: e232 -e246 (doi: 10.1542/peds.2011-2663).

[7] Chen, E & Paterson, L.Q. (November 2006). Neighborhood, family, and subjective socioeconomic status: How do they relate to adolescent health? Health Psychology 25(6): 704-714.

[8] See Vickie M. Mays, V.M., Cochran, S.D. & Barnes, N.W. (2007). Race, Race-Based Discrimination, and Health Outcomes Among African Americans. Annual Review of Psychology 58 (201-225); Duru, O.K., Harawa, N.T., Kermah, D. & Norris, K.C. (Janarury-February 2002). Allostatic Load Burden and Racial Disparities in Mortality *Journal of the National Medical Association* 104(1-2): 89–95.

[9] Centers on Disease Control and Prevention (2012). Health, United States, 2011. (Table 10, Low birthweight live births among mothers 20 years of age and over, by detailed race, Hispanic origin, and education of mother: United States, selected reporting areas 2007 and 2008).

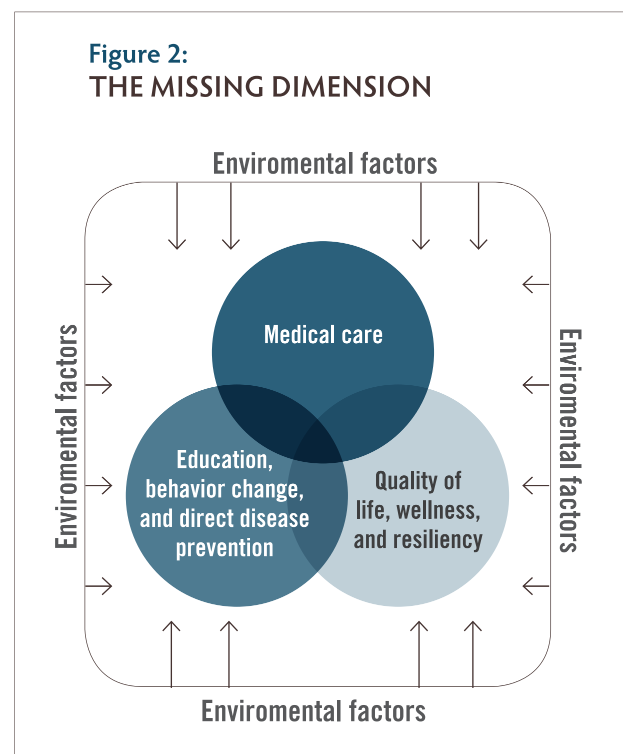
[10] "Health Policy Brief: The Prevention and Public Health Fund," *Health Affairs*, February 23, 2012.

pay for other policy priorities—including medical care.[10] Yet, even these prevention and public health efforts are predominantly geared toward responding to and managing disease or promoting behavior change in the context of preventing, or detecting early, infectious and chronic diseases.

PREMISE 5: Even public health approaches designed to target structural factors are ultimately disease-oriented. Public health professionals have increasingly embraced approaches that target social determinants of health for systems change. Programs and policies that target these structural factors are often still developed and evaluated not according to whether health and wellness is produced, but whether prevalence of chronic conditions, their symptoms, or risk behaviors can be measurably decreased. For instance, community transformation grants (authorized by the health care reform law and administered by the Centers for Disease Control and Prevention) provide funds for communities to create healthier environments with the goal of reducing prevalence and incidence of specific chronic diseases linked to tobacco use, obesity, and high levels of blood pressure or cholesterol.

PREMISE 6: We should reframe the community health discussion away from deficits toward wellness creation. Strategies to address health disparities and improve community health should be framed positively, build upon assets in communities, and integrate concepts such as quality of life. More than performing a series of interventions on an individual or structural level, creating community wellness requires us to consider the ways in which people interact (with each other and their environments) and make collective decisions. Fostering interconnectedness—a sense of belonging, a shared culture and history—may be as important to creating health and wellness as investing in a neighborhood's built environment. We believe that it is this missing dimension of wellness, resilience, and quality of life that that must be explored and meaningfully integrated to create healthier communities.

Figure 2:
THE MISSING DIMENSION



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PREMISE 7: Much can be learned from fields that have not traditionally been part of the public health system. Understanding how communities and their residents can build resilience, overcome setbacks, and heal from trauma is a valuable component of the conversation. As we explore the potential to create health and wellness, we should seek out perspectives, experiences, and wisdom from practitioners that are not regularly integrated into public health programming. For example, we believe experts in the fields of racial healing, health equity, mind-body medicine, alternative and traditional healing, stress management, and others will have substantial insight into building a well community framework.

PREMISE 8: We must explore whether and how these concepts are integrated into communities. Organizing to improve community health is not a new notion; it has often been developed in response to a lack of access to systems or threat of harm. For example, the community health center model was developed in the 1960s in the spirit of the civil rights and anti-poverty movements to extend access to medical care to both urban and rural underserved populations. Communities have mobilized for environmental justice when local planning decisions would disproportionately harm the health of low-income residents. Yet, we need a better understanding of how communities are galvanizing their residents to proactively incorporate the missing dimension of wellness to improve health and create equity.

QUESTIONS FOR EXPLORATION

1. What places, practices, and conditions produce health and wellness?
2. How are communities integrating the "missing dimension" into health promotion?
3. What is the relationship between quality of life and health?
4. How can we measure the creation of wellness?
5. How can we build community and individual resilience?
6. How can we create intergenerational wellness in communities?
7. Are there elements of this "missing dimension" that we have overlooked?
8. What are the rules of engagement for working with communities to promote wellness?
9. How can we establish and support a language for community wellness, healing, resilience, and quality of life that is accessible to residents?

CommonHealth *ACTION* (CHA) works with communities and organizations to create equal opportunities for all people to achieve optimal health.

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