

Background

HIDDEN EPIDEMIC: How Inequality Is Making Us Sick [working title]

A Four-Hour Series and Public Engagement Campaign

Produced by California Newsreel with Vital Pictures

Presented by the National Minority Consortia and KCET/Los Angeles

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SUMMARY

Shortly after Hurricane Katrina, a FEMA official rationalizing the agency's response to the storm noted that FEMA had run many different emergency simulations to evacuate New Orleans but each had overlooked one thing: "We never anticipated that so many of the poor would be so sick."

What FEMA failed to recognize then (as many pondering the lessons of Katrina continue to overlook still) was that the poor of New Orleans, like the poor throughout the country, had spent their lives being battered by hundreds of mini-Katrinass in the shape of social and institutional abuse, deprivation and neglect. These "tempests of daily life" take a huge, cumulative toll on the body over the years. The wear and tear of a lifetime of weathering was starkly evident in the large numbers of poor and African American 40-, 50- and 60-year-olds – relatively young people - who limped and wheezed into the New Orleans Superdome and Convention Center with their oxygen, insulin, canes and wheelchairs.

Hidden Epidemic is a four-hour limited series that will for the first time on television sound the alarm about our huge and disturbing socio-economic and racial/ethnic disparities in health--and search for their causes. But those causes are not what we might expect. While we pour more and more money into drugs, dietary supplements, and new medical technologies, and we focus on what we as individuals can do to be healthier, *Hidden Epidemic* criss-crosses the country investigating the growing body of evidence that there is more to our health than bad habits, our meds, or unlucky genes. As it does so, it circles in on a slow killer in plain view: The social circumstances in which we are born, live and work can actually get under our skin and put us at risk for stroke, heart disease, asthma, hypertension, diabetes, kidney disease and even cancer.

Note that the series will not simply illustrate differential health care access and treatment but why some populations get sicker more often in the first place, i.e. the role of inequality, racism, poverty, segregation and neglect in breeding disease and despair.

There are by now thousands of studies tracing the social determinants of health. Yet the popular perception remains that poor and minority populations, like those left behind in New Orleans, get sick as a result of bad genes or because they lack the character and discipline to eat right, exercise and abstain from drugs and booze. Similarly, most Americans still believe it's top executives who are dropping dead from heart and artery disease when in truth it's their subordinates. There is virtually no popular media that brings the research-based counter-story to policy makers, engages a broad public, and can mobilize impacted communities.

Hidden Epidemic will not dismiss the role individuals can play in safeguarding their own health. On the contrary, healthy behaviors are critical. But they're only one part of the picture. As University of Michigan epidemiologist (and series advisor) David Williams points out, increasing opportunities, providing education and training for better jobs, investing in our schools, improving housing, integrating neighborhoods, giving people more control over their work – these are as much health strategies as diet, smoking, and exercise. These are the stories *Hidden Epidemic* will tell.

Broadcast in tandem with an ambitious public engagement and outreach campaign conducted in association with leading health, public policy and community-based organizations, *Hidden Epidemic* can confront American myths and misconceptions about our health and stimulate a broad debate about what we as a society can and should do to reduce our glaring health disparities.

OBJECTIVES

What's happening to our health? The United States, the richest country in the world, spends twice per person on health care than any other nation. Yet American life expectancy ranks 29th; Costa Ricans live longer. Infant mortality? We're tied with Hungary, Poland and Slovakia for next to last among the industrialized nations. Illnesses cost American business \$260 billion year in lost productivity.

Hidden Epidemic explores a paradigm shift that connects our health not just to individual behaviors and health care but to underlying social conditions. As Sir Michael Marmot, chair of the WHO's new Commission on the Social Determinants of Health put it: "Real people have problems with their lives as well as with their organs. Those social problems affect their organs. In order to improve public health, we need to improve society." The following six objectives underscore how the series can help rupture the prevailing individual bio-medical model and move our health discussion "upstream":

- Increase public awareness of the alarming socio-economic and racial disparities in health and their human and financial costs.
- Promote understanding of the pathways by which class, racism and disempowerment get under the skin and influence health outcomes and thus move the health discussion "upstream."
- Inject social and economic policy--around housing, racism, education, jobs and wages, community development, social supports, and tax policy--into discussions of health; and evaluate social and economic policies by their impact on health.
- Demonstrate to the white middle classes that health disparities are not limited to the poor and people of color but harm them too, and that it is in their interest to support efforts that can improve the conditions of health for all.

- Draw public and policy-maker attention to innovative community-based initiatives for health equity
- Provide a new health ‘story,’ one that connects the conventional American frame of individualism (in this case our desire for a healthy life) to a new language of connectedness, a story that centers social justice and empowerment as fundamental to individual health and well-being.

Hidden Epidemic will demonstrate that inequality and racism are not abstract concepts but hospitalize and kill even more people than cigarettes. "There is an Axis of Evil," David Williams says, "an Axis of Evil of inequality, of racism, of poverty, of economic deprivation that is adversely affecting the health of the American people." Our nation has a choice: We can address the racial and economic inequalities that lead us down the path to disease now. Or we can pay to repair the bodies later.

KEY THEMES

It's long been known—and is rather obvious--that the poor have worse health than the rich. Edwin Chadwick's Sanitary Report warned back in 1842 that squalid conditions were devastating England's urban poor. But it was the pioneering Whitehall studies of the British civil service that turned heads when it revealed unmistakable evidence of a health gradient that runs throughout society.

What Whitehall found surprising was not just the four-fold difference in morbidity and mortality between the top and bottom quartile of English civil servants, but that those in Level Two--professionals and managers and lawyers one step below the top--had rates of disease twice as high as the executives running the departments.

This same health gradient has since been found for virtually every disease in every industrialized country in the world. Whether measured by income, by educational attainment, or by occupational status, there is a socio-economic gradient to health. And the greater the inequality in a society, the steeper the gradient. The United States has the greatest inequality of all--and the greatest health disparities.

Yet at each socio-economic level, African Americans are worse off than their white counterparts. In many cases, so are other populations of color. And the mortality gap has been growing. U.S. Surgeon General Dr. David Satcher and his colleagues calculated that in 2002, 83,570 African Americans died who would not have died if black-white differences in health did not exist, a rate of 229 "excess deaths" per day. That's the equivalent of one Boeing 767 being shot out of the sky and killing everyone on board every day, 365 days a year. And they are all black. According to a by-now landmark study by Drs. Colin McCord and Harold Freeman, African American males over age five in Harlem are less likely to reach age 65 than men in Bangladesh. Among Latinos, the prevalence of diabetes is 100% higher than among white Americans.

But how do socio-economic status and racism affect our biology? Through what channels does inequality--the cumulative disparities in housing, wealth, jobs, and education, combined with the lack of power and control over one's life--translate into bad health? What is it about our poor neighborhoods, especially poor neighborhoods of color, that is so deadly? How are the lifestyle choices we make (e.g. diet and exercise) constrained by the choices we have?

There's controversy, of course, over the most critical pathways that lead from inequity to disease and how best to address our health crisis. But as we tap into the research, several themes are emerging that will inform our series. These include:

1. The environment as an independent, disease-causing factor. How can a neighborhood become what Amani Nuru-Jeter has termed "a reservoir of disease pathogenesis"? Why, for example, is cancer more common among poor people who smoke the same number of cigarettes as rich people? The environmental justice movement has shown us how disadvantaged neighborhoods and communities of color face greater exposure to pathogens and carcinogens - polluting industries, lead paint, asbestos, water pollution, and toxic waste and landfill sites.

But differential exposure to chemicals and other pollutants is only part of the picture. Columbia University's Mindy Fullilove, Harvard's Dolores Acevedo-Garcia and many others are investigating how the social, economic and physical characteristics of a place, especially the oppressive conditions of poor, segregated urban space, can affect healthful behaviors. We know that smoking, diet, drinking and lack of exercise are huge risk factors for disease. What we don't readily acknowledge is that behavior isn't just a mark of individual character strength.

A tour of two neighborhoods--one wealthy, one poor--can help us understand what kind of built environments engender healthy choices. Are there supermarkets and produce stores nearby with fresh produce or just fast food joints, liquor stores and mom-and-pops immersed in a sea of liquor and cigarette billboards? A safe place to walk, jog, bike or play? Is the neighborhood a happy place to be? How much green space? Good schools with gym classes, art, music and after-school programs? And how does access to what Harvard's Ichiro Kawachi refers to as "social capital" - including mutual trust, social networks, and community efficacy - affect physical as well as mental well-being?

2. The social environment as a source of chronic stress. The lower one's position in the socio-economic hierarchy, the greater the exposure to stressful life events such as job loss, eviction, death, crime, and sickness and the larger the impact of these events on psychological well-being. But the on-going hassles of daily life are also more formidable and stressful in disadvantaged neighborhoods than in wealthier, white neighborhoods--dealing with poor schools, lousy and time-consuming transportation, unresponsive or over-aggressive police, lack of childcare, imperious or racist supervisors at work.

Researchers like Rockefeller University's Bruce McEwen and UCLA's Teresa Seeman are circling in on the biological pathways by which the chronic stress response can actually change our physiology, especially our neuro-endocrine, immune and cardiovascular systems. McEwen calls this measurable wear-and-tear of persistent micro-insults to the system *allostatic load*. He and Seeman are demonstrating how chronic stress puts people at risk of immune system suppression, increased glucose levels, obesity, heart and artery disease, depression, and even impaired memory. As Stanford's Robert Sapolsky points out: Turn on the stress response for five minutes and it can save your life; turn it on for 30 years and it puts you at risk for every disease of western man.

There's also increasing evidence that repeated exposure to stressors early in life inhibits children's ability to develop "resilience," increasing the chances they will develop helplessness and depression later in life, additional high risk factors for obesity and illness.

3. Power and control. England's pioneering Whitehall studies turned conventional wisdom on its head when it uncovered that it's not high-powered executives who are made sick by stress but their underlings. This finding isn't as counter-intuitive as it seems once we understand that pressure can either be an invigorating challenge or a health-damaging threat. Which one depends not only on the demands made but whether the individual perceives that he or she has the power and resources to cope with those demands. Executives usually do. But power and control over one's life decrease with each step down the socio-economic ladder. The lower people are in the hierarchy, the greater they struggle to access the money, power, status, knowledge, social connections and other resources needed to manage and gain control over the many tempests that threaten to upset their lives.

But it's not only those at the bottom of the ladder harmed by lack of power. So are many middle managers, working people, and especially people of color. High demand / low control jobs are particularly risky. City bus drivers, for example, must keep to a schedule and are penalized when they are late (or early). Yet bus drivers have no power over traffic and unruly passengers. 80% of San Francisco city bus drivers over age 50 suffer hypertension.

Further down the ladder, stressors mount—and health worsens. That becomes clearer if we look at the women working the gut line at a catfish plant, cashiers on the night shift at 7-11 stores, stock clerks at Wal-Mart, or cleaners of office buildings. Their hopes may be modest - climb up the job ladder, buy a home, send their kids to a good school, a decent life - but their aspirations to succeed are often thwarted by barriers of an interpersonal and institutional kind over which they have little control, including prejudice and racism. This is the stress of marginalization.

Interestingly, Whitehall and other research suggest that above a certain threshold relative wealth and income inequality seem to have a bigger impact on health than absolute wealth. This is a still a controversial finding. Perhaps one explanation for this can be found in how inequality and stratification increase feelings of hopelessness, frustration and despair among those closer to the bottom. How social status and hierarchy are linked to health has been studied by Robert Sapolsky and other scientists observing patterns of dominance among baboons and macaques. Several experiments are now beginning to demonstrate that when humans--families and communities--have the resources and power to take more control over their lives, their health improves.

4. Genetic reductionism and the myth of innate racial difference. So, despite these findings, why are millions of dollars still rushing into SNP studies and pharmacogenomics in a search for the holy grail of genetic differences between "races" to explain health disparities while attempts to research and mitigate the impact of social conditions go begging? A story such as BiDil - the new cardiac medicine aimed at African Americans and which is being touted as the first 'racial' drug - reveals the reward system that drives so much health policy and research in America. Such emphasis on genetic causes of racial health disparities may not only be misguided but, by reviving old ideas of innate differences between 'races,' distracts attention from the underlying social determinants of health and lets society off the hook. As medical anthropologist William Dressler has said, "So many medical conditions are differentially distributed to African Americans - heart disease, diabetes, hypertension, low birth weight babies - are we to believe that black people were so evolutionarily unlucky that they got all the genes that predisposed them to every malady?"

In contrast, Dressler, Sherman James, Richard Cooper and others have been investigating why African Americans have among the highest rates of hypertension in the world. This was long assumed to be genetic, a marker of 'blackness' itself. But then it was discovered that West Africans have among the world's lowest hypertension rates, lower than white Americans. What is it about the lived experience of African Americans, as opposed to 'black' genes, that could be creating biological feedback loops with profound consequences for health? The NIH's CARDIA study (Coronary Artery Risk Development in Young Adults), which has been tracking 5,000 black and white Americans in four cities over 15 years, provides another opportunity to isolate the social risk factors for coronary artery disease.

5. The interplay of race and class. While socio-economic status has huge consequences for health, the impact of race is additive and can be found both upstream and independent of class. Upstream, educational, housing and wealth-accumulating opportunities have been shaped by a long history of racism that confers advantage to some groups while disadvantaging others. But racism also works its pathology through several other vectors: isolated and segregated space, the cumulative impact of persistent racist micro-insults on chronic stress, the degree of hope and optimism people have, the location of doctors and

hospitals, and differential access to and treatment by the health care system. Each adds an extra burden to people of color no matter what their class. But how do you measure the impact of racism? Several projects are looking into this, including the Centers for Disease Control's Measures of Racism Working Group and the National Research Council.

6. Cumulative disadvantage. Our series is also informed by the understanding that risk factors are cumulative, their impact growing through the life course. Pre-natal and childhood exposures and deprivations matter later in life, even if that child eventually carves a path into the upper middle class. "You can move up," observes Makani Themba-Nixon, executive director of The Praxis Project, "but you can't move away."

Moreover, the sources of health outcomes stretch back even further in time than conception to past generations. What happened in the past matters today and sets the starting line for the future. Parents with health deficits tend to have lower birth weight-babies and less healthy children. But perhaps more importantly, wealth is also inherited. Economists estimate that up to 80% of family wealth comes from intergenerational transfers and the worth of one's home. Socio-economic status is very much affected by our past history of discrimination, segregation and racialized markets. Today the median household net worth of white families is an astonishing ten times that of African American families, more than eight times that of Latino families. And that wealth gap has been growing not narrowing. The chances of someone being born poor and growing up to reach the upper middle class are worse today than they were 100 years ago. England, the very symbol of the static, class-cleaved society, now has more class mobility than we do. Horatio Alger is dead.

THE PRODUCTION

Hidden Epidemic is ambitious and groundbreaking, with the potential for extensive and continuing national impact. We take as our brief these words from the WHO's Commission on the Social Determinants of Health: "Evidence is rarely if ever sufficient by itself to catalyze political action. In political terms, what might be at least as crucial as the evidence itself is the 'story' in which it is embedded." And that's how we are approaching our subject.

A Medical Detective Story. In the hit series, *CSI: Crime Scene Investigation*, forensic specialists conduct autopsies and analyze physical evidence to determine the cause of death and track down criminals. In *Hidden Epidemic* we do the same. Ours is a medical detective story out to solve the mystery of what's stalking and killing us before our time, especially those of us who are less well off and darker skinned. But our investigators - epidemiologists, neuro-biologists, doctors and health workers - keep peeling back the onion, broadening their inquiry beyond the immediate, physical causes of death to the deeper, underlying causes that lurk in our neighborhoods, our jobs and even back in history. The perpetrators, of course, aren't individuals but rather societal and institutional forces. And theirs are not impulsive crimes of passion. These are slow deaths - the result of a lifetime of grinding wear and tear, thwarted ambition, segregation, and neglect.

- **Episode One: *Sick of It* (wt).** The centerpiece of the series is the hour-long opening episode, *Sick of It*. It's a story about health, but it's not about doctors or drugs. It's about why some of us get sicker more often and die sooner in the first place. What are the connections between healthy bodies, healthy bank accounts and skin color? How does social policy and the way we organize society affect health? Solutions, the show suggests, don't lie in more pills but in more equality. *Sick of It* sets out the series' overarching themes: that health and longevity are correlated with socio-economic status, that people of color face an additional burden, and that the problem is an urgent public policy matter.

This opening episode is supported by six additional 30-minute stories set in different racial and ethnic communities that will deepen understanding of the root causes of disease. Each will render visible pathways by which social conditions affect our physiology and bring viewers face to face with innovative initiatives for health equity. The stories will be packaged into three additional hours for broadcast, two to an hour. But they will also be distributed singly and together on video and DVD for use as community-directed outreach and educational tools.

- ***People Behaving Badly?*** travels to the O’odham Indian reservations of southern Arizona who are marked with the dubious distinction of perhaps the highest rates of Type 2 diabetes in the world. There we explore a conceptualization of chronic disease as the body’s response to ‘futurelessness’, a condition arising from decades of oppression and historical trauma. We look at the prospects for a new approach that places taking control of a community’s own destiny as fundamental to regaining health.
- ***Place Matters.*** Recent Southeast Asian immigrants, along with Latinos, are moving increasingly into what have been neglected black urban neighborhoods--and now their health is being eroded too. What policies and investment decisions create neighborhood environments that can harm – or enhance – the health of residents, and what actions can make a difference?
- ***When the Bow Breaks.*** African American infant mortality rates remain twice as high as white Americans. Black mothers with graduate degrees face the same risk of having low birth-weight babies as white high school drop-outs. As we investigate possible causes, we come to understand how the chronic stress of racism over the life-course can become embedded in the body.
- ***Is America Making Us Sick?*** New Mexican immigrants, though poorer, tend to be healthier than the average American. But the longer they’re here, the worse their relative health becomes even as their socio-economic status improves. This is known as the “Hispanic Paradox.” Is there something about life in America that is harming their health? Conversely, what is protective about new immigrant communities that we can all learn from?
- ***Saving Our Town.*** How does employment policy and job insecurity affect our health? Residents of western Michigan struggle against depression, domestic violence and an uptick in heart disease and diabetes when the largest refrigerator factory in the country shuts down and runs away to a maquiladora in Juarez, Mexico. Ironically, the plant is owned by a Swedish company, where shutdowns, far from devastating lives and communities, are relatively benign events, even for some an opportunity.
- ***Specks on a Map.*** Patterns of uneven development mark the Pacific islands and diabetes, cardiovascular, and kidney and diseases are taking a growing toll on our Pacific Islander populations. Many end up in Honolulu, where there are too few facilities, too few doctors, too few beds, and no money. How much longer can our over-burdened health system take the strain before collapse? Isn’t it time to intervene “upstream”?

Production Plan

Hidden Epidemic is being produced by California Newsreel, the country’s oldest non-profit documentary production and distribution center, in association with the five Minority Consortia of public television and presented by KCET / Los Angeles. California Newsreel co-director Larry Adelman is the executive

producer. Llew Smith is co-executive producer and series producer. Llew directed the final episode of Newsreel's PBS series *RACE - The Power of an Illusion*. Since then he served as producer/director for American Experience's *Reconstruction* special as well as a forthcoming Nova on the pioneering African American chemist Percy Julian. Among his many other credits over the years are as a producer/director for *Africans in America*, associate producer for *Eyes on the Prize* and eight years as story editor for the PBS series, American Experience.

Shooting on the series has already begun and post-production should be completed by January 2007. The PBS broadcast will most likely take place in late spring 2007.

DISSEMINATION: A Campaign to Confront American Myths about Health

The efficacy of any social change oriented film must ultimately be measured by how well it intervenes in public debate. *Hidden Epidemic's* PBS broadcast has the potential to be a high-profile national television event, attracting considerable press coverage because of its new and fresh perspective (as did our series *RACE - The Power of an Illusion*). This visibility offers an opportunity to confront American myths about health and to help reframe the national debate about what we as a society can and should do to reduce our glaring health disparities. But that will only happen if the series is accompanied by a well-planned public engagement and outreach campaign.

Sir Michael Marmot might have penned our challenge when he wrote: "Health status should be of concern to all policy makers, not merely those within the health sector. If the health of a population suffers it is an indicator that the set of social arrangements needs to change...If the major determinants of health are social, so must be the remedies...Wider social policy will be crucial to reduction of inequalities in health."

Whether this message is amplified and resonates with the public or is the tree that falls in the forest that nobody hears is dependent in part upon the effectiveness of the public engagement campaign that accompanies the broadcast and release of the series.

The campaign will operate on several levels and will be scalable up and down depending upon how much money is raised and how much initiative and effort partner organizations put into it. To the extent we can coordinate our efforts with other health equity initiatives, each cross-promoting and increasing the visibility of the other, we increase our chances of pushing the country towards a tipping point on this issue. We note here a few preliminary components that are suggestive of the possibilities:

1. BROADCAST PUBLICITY

Health disparities are becoming an increasingly big story, as the recent New York Times series on diabetes indicates. But the media has mostly missed the story of the underlying causes and efforts to gain health equity, focusing instead on gene studies, personal behavior and medical breakthroughs. In addition to the standard TV reviews and publicity placements that drive viewers to a broadcast, our publicist, McKinney & Associates, will target selected health writers, columnists and feature writers in key opinion-leader media (e.g., New York Times, NPR, Los Angeles Times, Associated Press, Time, Nightline, etc.), on radio and TV talk-shows, and in the ever-expanding health and lifestyle press. McKinney will also reach out to the growing ethnic and immigrant press through groups such as New California Media. Perhaps most interestingly, we're already working with selected prominent news weeklies, radio shows and other media platforms to develop their own pieces that will run concurrent with the broadcast, thus helping bring public attention to a tipping point.

Outreach to the media will be enhanced by a press kit (print and electronic) and our companion Web site (see below). The press kit will include backgrounders and copies of the forthcoming handbook of the MacArthur Network on Socio-Economic Status and Health summarizing the research. Collateral materials, such as quizzes and tip sheets that publications can run as side-bars, will help readers and listeners make the conceptual shift from a biomedical to a social determinants model of health. For example, borrowing from York University's Dennis Raphael, we might contrast the conventional, individual-centered *Top Ten Tips for Better Health* such as eat 5-7 servings daily of fresh fruits and vegetables, manage stress levels, and get 30 minutes of exercise daily, with *What Your Doctor Didn't Tell You*:

- Have wealthy parents
- Work in a rewarding, well-paid job
- Live in a leafy neighborhood with good supermarkets, produce stores and parks
- Don't reside in damp, low-quality housing
- Don't get laid off
- Live in a society without racism
- Go on a foreign holiday and sunbathe
- Live and work where the gap between top and bottom, and rich and poor is small

Some of these collaterals could double as effective viral marketing messages in graphic or video clip form if funny and clever enough.

2. ENGAGING ELECTED OFFICIALS AND POLICY LEADERS

Elected officials and the policy community are critical audiences for this project. Three levels of activity are being proposed to engage policy leaders:

- **Level One: Engaging the Washington DC policy community**
- **Level Two: Reaching opinion leaders through our Coordinating Partners**
- **Level Three: Bringing other stakeholders to the table.**

Level One - Engaging the Washington DC policy community

A "be-seen" preview screening, symposium and reception at an appropriate Washington, DC venue and co-sponsored by a selected coalition of organizations can kick-off a week of briefings on Capitol Hill prior to broadcast. These briefings will be accompanied by fact sheets, issue briefs and other content that summarize the evidence-base regarding root causes of health status disparities and points towards remedies. We will re-purpose them as interactive web-based content as well as brief, two-page pdf files or other documents that can be E-distributed and downloaded. These documents will follow the research discussed in the series and will be geared towards policy audiences such as Hill staff, members of the media, and the policy community.

Level Two – Coordinating Partners

A second-level of events will be organized by Coordinating Partner organizations across the country. Coordinating Partners will direct outreach among their own constituents, take responsibility for organizing at least one viewing / launch event or initiative, and participate in local or relevant professional media relations to promote the series and its message framework. We will provide Partners support with messaging help, fact sheets and backgrounders, as well as an event "Toolkit" to help ensure

events effectively build interest in the series, build “brand” for the issue, and optimize the cumulative impact of the screenings.

For example, NACCHO has already gained the commitment of ten city and county public health departments around the country to invest the time and resources into organizing local “town meeting” screenings and forums to draw local attention to health disparities, win buy-in for upstream interventions, and spotlight local health equity initiatives. These pilot programs can themselves be presented at the summer 2007 NACCHO convention as possible templates for a national roll-out of health equity town meetings by public health agencies around the country.

There are two types of Coordinating Partners:

"Special Interest" Coordinating Partners. These are groups that, like NACCHO or PolicyLink, are already committed to health equity but are generally organized around specific issue-based constituencies or interests, e.g:

- Organizations that work with Federal, State, or Local Elected Officials
- Health Policy Advocates
- Public Health Practitioners
- Racial Justice Advocates
- Child Advocates
- Housing and Community development

"Regional" Coordinating Partners. These are health-equity organizations that have more of a regional focus, such as the Prevention Institute, Papa Ola Okahi, or the Northwest Federation of Community Based Organizations. We’ll look for one or two lead coordinating partners in the different regions of the United States: Pacific Northwest, Pacific Islands, Northern California, Southern California, Southwest, Deep South, Southeast, Midwest, Northeast, Mid-Atlantic

We also expect many other organizations to contact us as they learn about the project - either through the broadcast, our web site or other means – and generate screenings and discussions mostly on their own.

Level Three – Other Stakeholders

The launch events above will be followed by events produced with other stakeholder organizations that have not yet fully “gotten” the social determinants analysis such as the League of Cities, the American Planning Association and the National School Board Association. These screenings and forums will often be for staff development or take place at their annual conventions. Such an improved understanding of the social determinants of health should help win greater “buy-in” for specific health equity initiatives while providing these more arguments and leverage for social and economic justice reform proposals whose impacts on health traditionally have not been taken into account in the policy and decision-making process.

3. JOURNALIST EDUCATION

Journalists are key gate-keepers. But health reporting is dominated by stories on new medical technologies and drug discoveries and the “eat your spinach” approach to individual health improvement. A journalist education initiative could advance five goals:

- Alert them to the extent of health disparities

- Illustrate the pathways by which economic and racial inequality affect health
- Encourage journalists to write stories spotlighting the wider social conditions that thwart individuals' aspirations for better health
- Demonstrate how health impacts are a big part of the missed story when it comes to reporting on other policy issues, ranging from schools to transportation to tax policies
- Alert them to local initiatives and health equity "experts" they can call.

Vehicles for achieving these goals include publishing a Newsroom Guide to Health Equity and organizing screenings and forums featuring our scholar partners at apposite professional journalist conventions, ranging from health care journalists and science writers to editorial writers and ethnic journalist associations. These events would also provide an opportunity for health disparities scholars and advocates to build personal relationships with reporters and columnists. We are also working with projects such as the Institute for Justice and Journalism at the USC Annenberg School of Journalism to develop fellowship programs that will allow journalists to reflect upon how they might write and report on the larger social determinants of health without losing the human element that editors and readers want.

5. ENGAGING HEALTH ORGANIZATIONS

Of course, even health organizations sometimes find their members lagging behind on this issue, imprinted with the conventional individual-centered biomedical understanding of health. Again, screenings of the film can be used for staff development and facilitate discussion and debate within organizations like APHA and NACCHO as well as the AMA, NMA and even the appropriate NIH institutes and CDC programs. We will also place a special emphasis on events involving the community outreach programs of hospitals and community health centers.

6. COMMUNITY-BASED EDUCATION.

The health equity stories spotlighted in the series should be especially useful educational and outreach tools for community organizations advocating for empowerment policies in their own communities. These will be directed specifically to Native American, African American, Asian American, Latino, and Pacific Islander health. We will develop a "Tool Kit" that can help community organizations sponsor public screenings, while using the broadcast and screenings to attract local press coverage to their own work and help them win a place at the local policy-maker table. Our companion web site will provide an annotated listing of "best practices" (apparently there is no such central information source) and possibly a chat room where community health advocates can exchange information and ideas.

The five National Minority Consortia of public television have invested significant funds in the series production. They recognize it as an opportunity to mobilize their respective communities for health equity and will organize grassroots events around the country, often led by board members. Some of these will be held at community health centers and other places people gather, such as barber shops. Other events will take place in conjunction with local health-related activities such as the Great Aloha Run and the Honolulu Marathon.

7. COMPANION WEB SITE

Like the award-winning companion site we created for our series *RACE - The Power of an Illusion* (www.pbs.org/race), the *Hidden Epidemic* site will be content-rich yet fun to explore and will highlight

interactivities. The site will serve as a unique online entry point for overlapping audiences: the public, students, teachers, health equity advocates, researchers, and the press. Featuring self-directed learning, audio and video streaming, discussion guides, teaching tools, and a valuable archive of research materials, the *Hidden Epidemic* Web site will offer something for casual learners and scholars alike.

Major components of the site include:

- **SOCIAL AUTOPSY CASE STUDIES** – featured set of interactivities centered on the idea of medical investigations that explore major themes of the series
- **READING ROOM** – interview transcripts, background information, research and scholarly articles
- **LEARNING CENTER** – lesson plans and classroom activities for educators
- **THE SERIES** – summary of the episodes and key issues
- **COMMUNITY ACTION CENTER** – a searchable database and Toolkit for local action
- **PRESS ROOM**—Press kits, backgrounders, photos and other resources

There are numerous additional possibilities, of course. Public engagement planning will begin in earnest in June, with the kick-off being the June 9 strategic planning meeting sponsored by the Health Policy Institute. A detailed public engagement proposal, including structures and partnerships, will emerge from that effort.

PROJECT PERSONNEL

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