THEORY

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Building Communities That Create Health

SYNOPSIS

Typically, public health policy, program design, and resource allocation are based on issue-specific, targeted interventions directed at specific populations or sub-populations. The authors argue that this approach fails to meet the goal of public health—to improve health for all—and that the key to health improvement is to create a social context in which healthy choices are the norm. The authors present as case studies two Pennsylvania cities that used multisectoral approaches to achieve community health improvements.

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Many observers believe that our health is determined 20% by genetics, 20% by the natural environment, 10% by the medical system, and 50% by health behaviors. Using 1990 data, McGinnis and Foege found that approximately half of all deaths could be attributed to non-genetic or external factors.[1] Shifting the focus from the leading causes of death (heart disease and cancer), the authors determined that tobacco use was the actual cause of 19% of the deaths in 1990; diet and activity patterns caused another 14%; and alcohol another 5% of the deaths that year. The conclusion of the study was that "if the nation is to achieve its full potential for better health, public policy must focus directly and actively on those factors that represent the root determinates of death and disability."[1] This is guidance that is appropriate not only for public policy but for any community wishing to improve the health of its members.

Public health, health care providers, and human services historically have targeted health promotion services and programs to selected sub-

communities or sub-populations. The intent has been to improve the health status of those populations by focusing on specific risk factors or causes of mortality. For example, one program may focus on tobacco use, another on diet, another on exercise, and another on screening. The high costs, time required, and limited measurable impact of those interventions have historically frustrated organizations that fund and implement them. Heart disease, for example, is affected synergistically by many risk factors (tobacco use, poor diet, sedentary lifestyle, and lack of early screening). Efforts directed at one risk factor have limited impact that cannot be causally related to the improvement or worsening of the health status of a population.

Public health program efforts are also usually directed at modifying the behavior of a sufficient number of individuals to have a positive impact on the overall health status of the group of which the individuals are members. For example, program efforts may aim at increasing the number of pregnant women who seek prenatal care in their first trimester or at decreasing the number of teenagers who choose to use tobacco. These targeted efforts to change individual behavior, however, appear to be the antithesis of our widely accepted definition of what public health is and does: "Public health is what we, as a society, do to assure the conditions in which people can be healthy."[2] Public health, by this definition, should be directing its policies, programming, and resources at changing the social environment.[3,4] For example, public health should seek to create a social environment that provides opportunities, norms, and encouragement to seek care and to not use tobacco.

Rather than focusing on sub-populations and targeted program interventions, the most sophisticated Healthy Communities efforts focus on the factors in the community that create health and on the environment in which those factors can be developed and strengthened. "Nationwide, people concerned with their community's health have found that the essential building blocks of good health—such as strong families, good jobs and education, to name a few—lie largely outside the health care system."[5] Other building blocks of health include social networks, economics, social conditioning, safety, and a clean environment. "Optimal health is a byproduct of people realizing their potential and living in a community that works."[6]

HEALTH THROUGH SUPPORTIVE SOCIAL ENVIRONMENTS

Health is a function of (*a*) opportunities and choices provided and (*b*) actions or behaviors in response to those choices. "Behavior change is motivated not by knowledge alone, but also by a supportive social environment and the availability of facilitative services."[1] A healthy community will provide opportunities for healthful choices and behaviors and, as important, will provide norms and encouragement for making the choices that will help members achieve their highest potential. For example, some years ago the United States decided that every person would have the choice of using safety vehicle restraints in automobiles. Every car that rolls off an assembly line for purchase in the US includes seat belts. We are provided the choice to use them or not. The determining factor of people making that choice is not the intellectual knowledge that, if in an accident, they are much less likely to die if wearing the seat belt; if it were, everyone would wear them every time they were in a car. The determining factor must be the *norms and encouragement* that a person's community (family and friends) provide.

According to Healthy Communities principles, *how* results are achieved is as important as *whether* they are achieved.

Another simple example is tobacco use. It is clear that at least the initial use of tobacco is a response to one's social environment. We have recently seen data that show college-age women increasingly smoking cigarettes: their friends are smoking, young people in the movies are smoking, and it is socially more acceptable to be thin and smoke than overweight and smoke-free. A healthy community would, of course, encourage seat belt use and discourage tobacco use.[6,7]

CREATING SUPPORTIVE SOCIAL ENVIRONMENTS

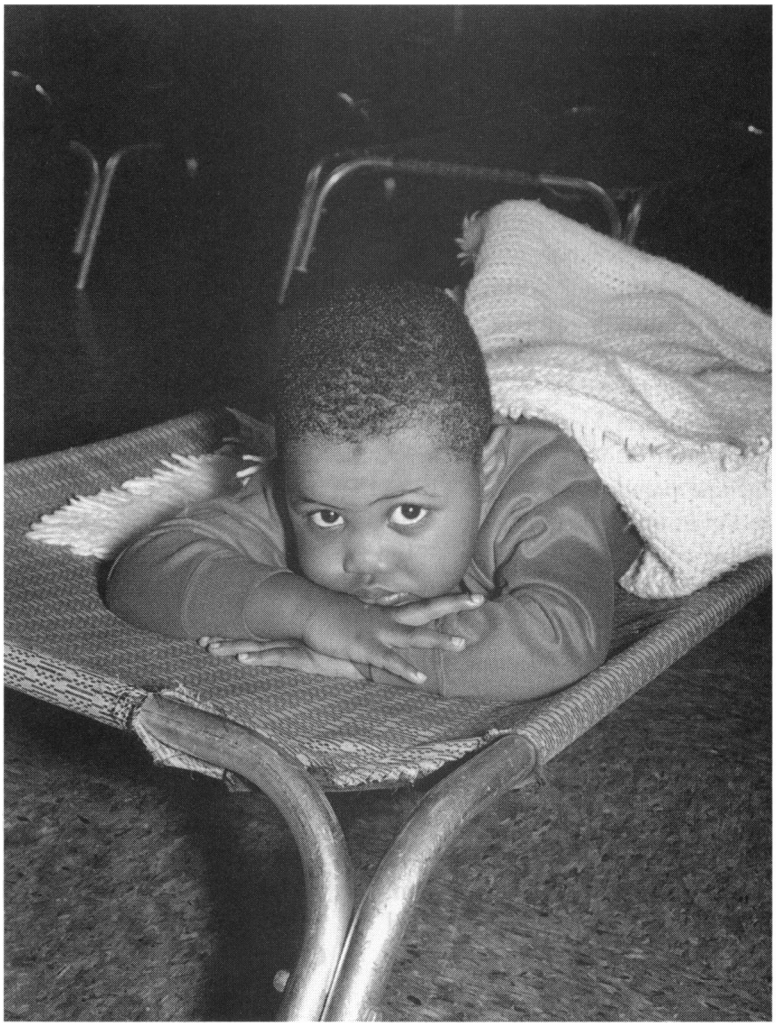
If health is a result of the choices, actions, and behaviors that are provided, encouraged, and supported in and by the community, then health status can most effectively be affected by changing or sustaining characteristics of

the community. This requires comprehensive approaches involving a broad cross-section of the community. "A basic premise of the Healthy Communities movement is that well-informed people, working together in an effective process, can make a profound difference in the health and quality of people's lives within communities."[5] Further, "the single defining feature of a healthy city or community is that its citizens, in all their various roles, have joined forces to pursue positive change."[8]

Social capital. A key concept is that of "social capital," meaning the obligations and resources available to community members on an interpersonal and organizational basis.[9,10] Social capital creates bonds between neighborhoods, families, and individuals, on the one hand, and the greater society on the other.[11]

While every community is unique and has its own history, characteristics, and resources, there are community health practices that have common elements that can be used to create a healthier community and improve community members' health status. Building communities and their social capital begins with the notion that every community has individuals, institutions, and organizations, and public, private, and not-for-profit sectors that have vested interests in the health and productivity of the community. Further, every community already has resources that can be used in new and different ways to improve the health of those who live, work, and play there. Sectors of the community, working together, can increase the impact of their resources and expand the capacity of the community to work internally to improve its health status. "The key to neighborhood regeneration, then, is to locate all of the available assets, to begin connecting them with one another in ways that multiply their power and effectiveness."[12] Additionally, when community organizations are working together to coordinate their existing resources, they not only build social capital, they are also in a better position to access additional outside resources where needed for long-term or more costly priority initiatives.

Means and ends. According to Healthy Communities principles, *how* results are achieved is as important as *whether* they are achieved. Successful healthy communities require that communities "place equal emphasis on the process of promoting change as well as the ultimate consequences of that process."[8] The process of ongoing dialogue, in and of itself, creates healthier communities.



Community-building activities must be continuous and ongoing. The history of public health has repeatedly demonstrated that short-term "quick fixes" do not improve a population's long-term health status. Community infrastructures must be developed to ensure that there are mechanisms for continuous and sustainable community health improvements. The following examples from Pennsylvania illustrate these points.

TWO EXAMPLES OF COMMUNITY-BUILDING

Pottstown, Pennsylvania. Pottstown is an example of a community that drew on its assets—the transit authority, health care agencies, the YMCA, area businesses—to make it easier for indigent residents to get and keep jobs. Drawing on the resources of various community sectors, Pottstown removed the obstacles preventing people from

working, thereby transforming the social environment in that city.

The Tri-County Health Partnership (TCHP) was formed in Pottstown in 1996 to address issues identified by the community as priorities for developing a healthy community. Its goals are to create a community where people want to live, work, and play as well as raise children, where children want to stay or return for a better quality of life, and to collaborate to utilize and enhance existing services and resources. TCHP sees its role as a vehicle to nurture and protect its members, provide opportunities to be healthy, communicate norms, and encourage the adoption of healthy behaviors.

One of the priorities of the Partnership is the low-income population. Specifically, the Partnership wanted to better understand why community members were not taking advantage of existing job opportunities. Not surprisingly, a survey revealed the major hurdles to employment were lack of day care (especially during after-school and evening hours) and lack of transportation. The TCHP partnered with the area transit authority, successfully convincing the authority to expand service routes and extend hours of operation from 7 p.m. to 10 p.m. The Partnership also received funds to purchase vans. Several employers in the area are paying part of the cost for van delivery of their workers.

To address the childcare problem, two members of the Partnership, the Pottstown Memorial Medical Center and the YMCA, developed "night care" from 2 p.m. until midnight for parents working the middle shift. These parents pay for childcare on a sliding scale. While the school district provides transportation for the children to the YMCA, the parents are responsible for picking up their children at midnight. This has raised another transportation problem—lack of automobile ownership. The Partnership is currently seeking donations of older, used company cars with a two-fold objective: first, the cars will be lent to students to gain experience in auto repair and, second, the restored cars will be donated to needy families.

Since many of the people now able to work because of improved transportation and accessible day care had no previous work experience, TCHP organized training sessions on employment skills and workforce readiness. This training was extended to include displaced workers who needed to be reoriented, many of whom had lost their jobs when large industries left town.

Once people secured jobs, employers had trouble retaining them. When Partnership members learned that one problem was missed work days due to sick children, the Pottstown Medical Center obtained a license to provide sick care in a day care setting. The Partnership is currently working to find a partner in the community to house a "sick day care" center.

Another issue was that many newly employed people had never worked, and required continued guidance beyond the workforce readiness training. TCHP developed a mentor program through which an employee of a company is able to volunteer as the new co-worker's mentor for one year. Examples of assistance include guidance on protocol when a car breaks down, when a child is sick, or when an employee needs to go to a doctor's appointment. What may seem simple and straightforward to many can be difficult for an employee who is new to the workplace.

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In addition to educating employees in the community, TCHP is working to educate employers. It has distributed surveys, not only asking what assistance business needs for new hires, but also explaining to them the benefits of hiring individuals off welfare. TCHP is currently developing a resource book that will further explain these benefits and also provide guidance on how to retain these new employees. The county has offered to provide the funding to publish the resource guide. A future goal is to develop a resource guide for both businesses and community members.

Doylestown, Pennsylvania. Healthy Communities efforts in Doylestown were directed at changing the atmosphere of the town to be more aware and nurturing of its teens. Doylestown used a multisectoral approach, drawing on the resources of local government, hospitals, public transportation, business, and others.

The Central Bucks Healthier Community (CBHC) Team was formed in 1996 to develop strategies concerning how individuals, agencies, and community leaders would develop a healthier community for all area residents. In response to an article in the local newspaper in which merchants expressed anxiety over the "swarming mobs of unruly students" who loitered, made noise, lit-

tered, and caused adult patrons to avoid the downtown area during after-school hours, the Healthier Community Team realized that there was a need to focus on the youth in the community. In addition, the Team found that once most young adults left for college, they usually did not return to Doylestown, at least not until they were ready to raise a family. With these challenges in mind, the team organized the Teen Task Force (TTF) with a goal to create a community where kids grow up and don't want to leave.

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The TTF's philosophy is that the projects must belong to the teens, and all of the activities and events are planned and designed by teens. This way of operating takes patience and nurturing. It has taken some time, but teens now realize that the events are not the adults' agenda, but programs designed and organized by their peers. Starting with a handful of interested teenagers, the program has grown to attract thousands of local teenagers. TTF has held youth summits and formed 18 action groups. These groups' efforts have included district-wide dances, band jams, service projects, a drama club, a ski club, arts festivals, bicycle stunt shows, in-line skating events, a website (**www.teentaskforce.org**) and discussion groups. Four area restaurants began offering fixed and reduced price dinners for teens before dances, sending teens the message that they were welcome in their establishments. With the creation of the TTF, teens feel more respected in the community, young people are excited about the support they have gotten, and no teen can seriously say, "There's nothing to do."

The TTF is a collaborative effort involving all sectors of the community. The public library provides meeting space for the action group meetings; the hospital foundation funds a coordinator's salary; the school district provides buses; and other segments of the community provide financial support, chaperones, facilities, and donations of goods and services. As a result of these projects, fewer teens will be home alone, engage in vandalism, abuse substances, and be disconnected from their peers. The TTF is able to meet its goals of reducing harmful and risky behaviors without saying "Don't smoke and don't take drugs." As Elizabeth Gavula, Chair of the Partnership, says, "You lose them when you preach."

CONCLUSION

Overall, improved health status and a healthier community will not be effectively or efficiently achieved by focusing only on special populations, specific risk factors, or causes of mortality with targeted interventions or increased access to various services. Improved health status, quality of life, and social capital are inextricably linked. All sectors of the community—health care, human services, education, business and industry, the faith community, cultural and recreational organizations, government, media, voluntary organizations, and the people who live, work and play in the community—are a part of the equation for a healthier community. If we are to successfully decrease the disparities of health status among population groups, we must build healthier social environments for all.

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