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“It Takes a (Healthy) Village to Raise a Child:” A Case for Integrating Public Health and Social Work Research to Eliminate Health Disparities

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"If you always do what you have always done, you will always get what you already have." (Drs. Gilbert H. Friedell and Lovell A. Jones)

The National Cancer Act of 1937 established the National Cancer Institute (NCI) to address U.S. cancer research initiatives and training of researchers, public health practitioners, physicians, and other professions necessary for the "prevention, control and eradication of cancer" (National Cancer Institute, 2017a). Over three decades later, *The National Cancer Act of 1971* earmarked \$100 million to ostensibly fund a national campaign to cure cancer, then the second-leading cause of death among Americans (National Cancer Institute, 2017b). This "War on Cancer" greatly enhanced our understanding of the biological, social, and environmental aspects of cancer, while also stimulating innovations in basic and clinical trials research, pharmacology, and medical technology. However, the "war machine" also shed a bright spotlight on existing cancer disparities endemic among racial/ethnic minorities and other groups who were traditionally underrepresented and underserved.

In 1987, fifty years after the landmark 1937 Cancer Act, a multicultural and multidisciplinary group of researchers, policymakers, and community members met at the inaugural Biennial Symposium on Minorities and Cancer (later known as The Biennial Symposium on Minorities, the Medically Underserved & Cancer; King, Hurd, Hajek, & Jones, 2009). This group went on to create The Intercultural Cancer Council (ICC; www.interculturalcancercouncil.org) in 1995 and secure Congressional funding to establish the Center for Research on Minority Health (CRMH) at the University of Texas M.D. Anderson Cancer Center in 1999. The CRMH then led efforts to develop the Health Disparities Education, Awareness, Research and Training Consortium (HDEART-C; www.hdeartconsortium.org), which developed the "Disparities in Health in America: Working Towards Social Justice" semester-long academic course and 6-day summer workshop. Since 2002, the course and workshop have featured a diverse array of researchers, policymakers, lawyers, physicians, bioethics experts, and public health practitioners. While these efforts were initially focused on cancer-related research, education, and policies, they have expanded over time to include all aspects of minority health and health disparities (King et al., 2009). ICC Co-Founder and HDEART-C Founder, Dr. Lovell Jones estimates that over 9,000 trainees have participated in the

Biennial Symposium Series, ICC, and HDEART-C programs (Lovell A. Jones, PhD, personal communication, July 25, 2017), including undergraduate- and graduate-level social work, public health, medical, and nursing students, post-doctoral fellows, and junior faculty.

During this same time period, *The Health Revitalization Act of 1993*, created the Office of Research on Minority Health led by Dr. John Ruffin, which then transformed into the National Center on Minority Health and Health Disparities after passage of *The Minority Health and Health Disparities Research and Education Act of 2000* [National Institute on Minority Health and Health Disparities (NIMHD), 2017a]. In 2010, the Center transitioned into the NIMHD as part of the *Affordable Care Act* and serves as the lead agency in the National Institutes of Health mission to end health disparities. The NIMHD Director, in consultation the Agency for Healthcare Research and Quality Director, has the power to define health disparity populations. For example, in Fall 2016, current NIMHD Director, Dr. Eliseo J. Pérez-Stable, designated sexual and gender minorities as a disparity population (NIMHD, 2016), simultaneously expanding the formal definition and authorizing development of research and training pathways to address health disparities within this population.

We are now 80 years beyond the 1937 Cancer Act as of publication of this Journal of Family Strengths special issue on *Innovative Practices to Eliminate Health Disparities*. Cancer, cardiovascular disease, mental disorders, and other complex medical conditions continue to claim millions of lives each year in terms of deaths and changes in ability. A disproportionate burden of disparities in access to high-quality healthcare, screenings, timely-diagnoses, evidence-based treatments, and patient-centered health outcomes fall on racial/ethnic, gender, and sexual minorities, especially those with lower socioeconomic status and educational attainment. We need 21st-century solutions to this ongoing legacy of previous generations.

The field of public health promotes multi-dimensional wellness by using health education and promotion and primary disease/injury prevention (within the medical model) to improve the health of communities [American Public Health Association (APHA), 2017]. While individuals may receive direct benefits from (primary, secondary, or tertiary prevention) public health interventions, the target or unit of analysis is often population-based. The social work profession incorporates biopsychosocial-spiritual and ecological systems lenses to competent practice with individuals, families, groups, organizations, and communities (Council on Social Work Education, 2015). While increasingly sharing these lens with other helping professions, including public health, hallmarks of the social work profession

include its strengths perspective; empowerment approaches; and social (and economic and environmental) justice orientations. The latter provides the ethical impetus for social workers to specifically target and provide services to the most vulnerable and marginalized individuals and groups within our communities (National Association of Social Workers, 2008).

Consequently, public health and social work researchers and practitioners commonly address issues creating and reinforcing health disparities, as well as biopsychosocial-spiritual concerns resulting from these disparities. However, their underlying philosophies and resulting targets for intervention may or may not intersect. We are, in effect, the proverbial blind (wo)men attempting to describe the health disparities elephant based on a tusk or trunk, and utterly missing the understanding that can only come from a united whole.

So, how then can public health and social work fulfill the promise of their respective disciplines in terms of eliminating health disparities? We lack a comprehensive answer to this question, but recent articles by King et al. (2009) and Dr. Georges Benjamin (2015), APHA Executive Director, offer sage advice pointing to a need for uniting the disciplines. The past few decades of advocacy and research have legitimized health disparities as a "recognized scientific field of study" (NIMHD, 2017b) and many are answering the call to action.

A number of articles appearing in this special issue were co-authored by a multidisciplinary cadre of current and former speakers and trainees of the Biennial Symposium Series, ICC, and HDEART-C, as well as NIMHD grant recipients. We hope you will enjoy the commentaries and original research articles. If you are new to disparities research, perhaps you will find "food for thought" that helps you conceptualize your own potential contributions to health disparities research. If you are currently focusing on disparities in your research, we hope that you will feel a sense of community and shared purpose with the authors.

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