

# HEALTH + EQUITY FOR ALL

## THE CASE FOR HEALTH EQUITY

The term *health equity* is increasingly used to refer to the differences in the health of population groups called disparities. This evolving terminology reflects a growing concern for the social justice aspect of health. Key to the concept of health equity is the principle that all population groups should have an equal opportunity to be healthy, regardless of their relative social advantages and disadvantages (Braveman and Gruskin 2003).

Giving people the opportunity to be healthy means addressing every aspect of their social condition. In the words of Nobel Prize-winning economist Amartya Sen (2002):

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*Health inequities put disadvantaged groups at further disadvantage with respect to health, diminishing opportunities to be healthy (Braveman and Gruskin 2003).*

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Health equity cannot be concerned only with health, seen in isolation. Rather it must come to grips with the larger issue of fairness and justice in social arrangements...paying appropriate attention to the role of health in human life and freedom. Health equity is most certainly not just about the distribution of *health*, not to mention the even narrower focus on the distribution of *health care*. Indeed, health equity as a consideration has an enormously wide reach and relevance.

Evolving social and economic conditions in the United States make the goal of health equity both more pressing and more challenging than ever before. In the past 20 years, racial and ethnic diversity has grown significantly, while in the past decade poverty and wealth inequality have increased exponentially. Meanwhile, improvements in the population's health have been modest at best, with static progress or declines for African Americans and Hispanics.

- Today, many U.S. communities have life expectancies well below those of high-performing developed nations that are our global counterparts (for example, Canada, Japan, and the United Kingdom). Between 2000 and 2007, life expectancy in more than 85 percent of American counties declined, even though the United States spent more per capita on health care than any other country during this period (Kulkarni et al. 2011).
- Twenty-two of the country's 100 largest metropolitan

areas, including New York City and Washington, DC, are now "majority-minority," meaning that ethnic minorities account for more than half of the population. There were just five such cities 20 years ago (Frey 2011). As the minority population increases, costly preventable health conditions are becoming more prevalent – one legacy of historical patterns of racial and ethnic health disparities. Hypertension, diabetes, and stroke are among a number of conditions that are more common among African Americans and Hispanics than among non-Hispanic

whites. The excess rates of disease in these populations cost an estimated \$23.9 billion in 2009 and are projected to cost approximately \$337 billion over the next 10 years (Beal 2011).

- In the past decade there have been precipitous declines in the social and economic conditions that shape people's health. Between 2000 and 2010, food insecurity – that is, limited or uncertain access to adequate food – increased from 10.5 percent to about 15 percent of households (Economic Research Service/USDA 2002; Economic Research Service/USDA 2011). Meanwhile, severe housing cost burdens (defined as spending more than 50 percent of income on housing) increased during the decade, as did homelessness.
- The net worth of all households has fallen since 2005, but for blacks and Hispanics the drop has been rapid and steep. The racial/ethnic wealth gap is now a canyon: white households have 20 times the median wealth of black households and 18 times the wealth of Hispanic households (Taylor et al. 2011).

## BUILDING INTERNAL CAPACITY FOR EQUITY PROGRAMMING

Some foundations have recognized that in order to address race, racism, equity, and social justice in their grantmaking, they needed to improve their internal capacity to talk openly

about these issues. The Racial Justice Grantmaking Assessment, developed by the Applied Research Center and the Philanthropic Initiative for Racial Equity, is a tool some foundations have used to measure how well, or not, they are institutionally prepared to advance racial justice.

*Catalytic Change*, a report describing the results of a pilot of the Racial Justice Grantmaking Assessment, is instructive for all foundations interested in advancing the related goal of health equity (PRE 2009). Highlighting the challenges that building internal capacity entails, the report advises that:

- Foundation leaders are not investing enough time and deliberation into internal discussions about race and racism at all organizational levels. Understanding structural racism requires a significant investment of time and intellectual energy. Without sufficient discussion, competing definitions of racial justice can take root and frustrate efforts to generate new outcomes, such as a reduction in racial disparities.
- Foundations that adopt racial justice as an organizational framework should anticipate pushback from some staff, board members, grantees, and others who may not share the same perspective. This is one of the key reasons to make sure that stakeholders at every organizational level are well-equipped with a shared racial justice language and analysis.

## TAKING ACTION

Achieving health equity means assuring the highest level of health for all Americans, not only by eliminating health and health care disparities, but also by raising the quality of care, ensuring access to care, and working upstream to reduce preventable diseases (Beal 2011). Meeting this goal will require both taking action and expanding how we think about health. For example, the World Health Organization Social Determinants of Health Commission's report, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, recommended a shift in orientation in order to focus on outcomes (equity) rather than health problems (disparities), on population health rather than individuals, and on structural and institutional change to address the conditions that produce illness and disease (DRA Project 2009).

In practice, of course, it is not "either/or." If good health for all Americans is the goal, then there is a role for improve-

ments all along the spectrum, from working to improve access to health care and the quality of health care services, to modifying individual behavior and risk factors, to tackling factors like race and income that shape people's social and environmental living conditions. When it comes to taking action, no one organization can accomplish all of these goals,

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*A record number of Americans – nearly one in two – have fallen into poverty or are scraping by on earnings that classify them as low income (CBS News 2011).*

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nor can philanthropy as a whole. But through information sharing, collaboration, and partnership, progress can be made (Mitchell and Sessions 2011).

The goals and achievements of some of the organizations that have made a commitment to health equity illustrate the importance of working across the spectrum, from communities to health care settings; the need to involve multiple partners in order to be effective; and the value of, and opportunities for, working not only at a national level, but also regionally and within states.

► **National Initiatives: Healthy People 2020** – Even though there was broad public and private commitment to the goals of Healthy People 2010, the plan had little to no effect on disparities. In fact, in the past decade much of the movement on Healthy People 2010's disparities-related objectives has been either stagnant or negative (Torres 2011). Specifically, among 169 objectives with available racial and ethnic data, health disparities decreased for 27 objectives, increased for 25, and exhibited no change for 117. Health disparities among income groups – and by geographic location and disability status – did not change for the most part (CDC 2011).

This poor record raises the ante for Healthy People 2020, which restates the federal government's commitment to ending disparities, adds the new goal of achieving health equity, and establishes goals and benchmarks for both improving equity and fostering multisector engagement in this effort.

The overarching goals of Healthy People 2020 are to:

- attain high-quality, longer lives free of preventable disease, disability, injury, and premature death;
- achieve health equity and eliminate disparities;
- create social and physical environments that promote

good health for all; and

- promote quality of life, healthy development, and healthy behaviors across all life stages.

To accomplish these goals, primary strategies include:

- increasing public awareness and understanding of the determinants of health, disease, and disability, and the opportunities for progress;
- providing measurable objectives and goals that are applicable at the national, state, and local levels;
- engaging multiple sectors to take actions to strengthen policies and improve practices that are driven by the best available evidence and knowledge; and
- identifying critical research, evaluation, and data collection needs.

The Affordable Care Act (ACA) is expected to support Healthy People 2020's health equity goals in several ways.

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*Immediate action must be taken with a community-driven plan recognizing that regardless of income, education, or ethnic background, all people should have the same opportunities to make choices that allow them to live healthy lives (Joint Center for Political and Economic Studies 2011).*

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For example, the ACA requires both the collection of race and ethnicity data and the reporting of quality performance measures stratified by race, ethnicity, and other demographic data. As health care plans and providers implement this requirement, opportunities will potentially surface to improve care for all (Beal 2011). In addition, there are major provisions that increase both access to, and the affordability of, care for underserved populations; strengthen the health care system to improve quality of care; expand community-level care through health centers and teams; increase prevention efforts for underserved groups; and strengthen community-based strategies for eliminating local barriers to health, such as promoting health in schools, workplaces, and neighborhoods (Koh et al. 2011).

The U.S. Department of Health and Human Services' *National Stakeholder Strategy for Achieving Health Equity*, which provides a common set of goals and objectives for public and private sector initiatives and partnerships, complements the goals of the ACA. The strategy is designed to increase the effectiveness and strength of existing programs by helping stakeholders raise awareness, strengthen leader-

ship, improve health outcomes, foster cultural competency, and facilitate the collection and diffusion of research and data (NPA 2011).

- **National Initiatives: Place Matters** – Place Matters, funded by the W.K. Kellogg Foundation, is a nationwide initiative of the Joint Center for Political and Economic Studies' Health Policy Institute. The initiative is intended to improve the health of communities by addressing social conditions that lead to poor health. The Place Matters national learning community consists of 16 teams responsible for designing and implementing health strategies for residents in 21 counties and three cities.

The Place Matters approach identifies the root causes of health disparities, such as employment, education, poverty, and housing, and defines strategies to address them. Place Matters team members are drawn from many sectors of society, including local government, public health organizations, business entities, educational systems, faith-based groups, and community-based organizations.

One Place Matters team is located in the Detroit/Wayne County area of Michigan. In June 2011 this team, along with other stakeholders, released a report

on infant mortality called *Already Broken: A Call for Upstream Action through Community Collaboration to Reduce Infant Mortality in Detroit*. The report is an urgent call to action in a city where the black infant mortality rate is three times that for white infants (15.9/1,000, in comparison to 5.2/1,000). The team identified five social determinants of health – education, employment, social isolation, social perception of girls and women, and structural racism – that most powerfully affect a woman's ability to have a healthy baby (Joint Center for Political and Economic Studies 2011). Through a series of presentations the team is successfully bringing attention to the problem of infant mortality in Michigan.

Michigan Governor Rick Snyder has included infant mortality on the state's health and wellness dashboard that charts progress in relation to access to care, selected health indicators, healthy communities, and health behaviors (Danish 2011; Michigan.gov 2011). Next steps for the team include informing communities, public officials, and the media through press releases, town hall meetings in strategic locations, and meetings with key state legislators and local officials.

► **State Initiatives: New Hampshire** – Although New Hampshire ranks 48 out of 51 in diversity in the United States, the minority population has grown by 60 percent since 1990 (Endowment for Health 2011a). The Endowment for Health is taking a proactive role in improving health equity and reducing health disparities among racial, ethnic, and linguistic minorities in New Hampshire and has made this one of the foundation's four program priorities.

Recent achievements of the endowment's equity grantmaking include:

- improved state, local, and organizational engagement, such as a collaborative effort with the New Hampshire Office of Minority Health and Refugee Affairs, the Foundation for Healthy Communities, the University of New Hampshire, and others that led to the creation of the *Plan to Reduce Health Disparities and Promote Health Equity in New Hampshire*;
- increased access to culturally and linguistically appropriate health care, such as a community-based health project for Somali refugees in southern New Hampshire that provided medical interpretation and case management to increase access to health services and community health education by a local hospital;
- improved cultural effectiveness of health care providers through projects like the New Hampshire Nursing Diversity Pipeline, which enhances awareness of nursing careers among minority students in middle and high school, supports minority nursing students enrolled at local colleges, and promotes minority nurses as Future of Nursing Scholars while seeking advanced degrees; and
- increased social inclusion and social connectedness through a planning effort to examine promising state and national immigrant integration practices, the formation of a statewide Immigrant Integration Working Group, and New Hampshire's first ever Immigrant Integration Conference planned for April 2012.

Over the next three years (program years 2012-2015), the endowment's strategies to support health equity will:

- support efforts to develop and strengthen pipelines for minority students in health professions;
- support efforts to help minority health care profession-

als maximize their contributions to the health care system;

- bolster efforts to develop health literacy and capacity to navigate the health care system, particularly for ethnic and language minorities;

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*Achieving good health for all of New Hampshire's people requires our society's understanding of the causes of disparities and collective action to promote health equity (Endowment for Health 2011a).*

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- encourage inclusive and appropriate opportunities and environments for physical activity, access to healthy foods, and safety for racial and ethnic minorities where they live, learn, work, and play;
- support initiatives that facilitate multiethnic and intercultural collaboration to achieve integration;
- engage scholars/researchers to examine data on disparities to generate and disseminate knowledge of the prevalence, causes, and solutions for addressing disparities and promoting health equity in New Hampshire;
- educate and engage nontraditional partners, including stakeholders from nonhealth fields, who have an impact on where minorities live, learn, work, and play; and
- help build advocacy capacity by and on behalf of racial, ethnic, and language minorities to advance health equity and reduce health disparities in New Hampshire (Endowment for Health 2011b).

► **Metropolitan Initiatives: Washington, DC** – The mission of the Consumer Health Foundation (CHF) is to achieve health justice in the Washington, DC region through activities that advance the health and well-being of historically underserved communities. The foundation is committed both to assuring that all residents in the region have equal access to quality health care, and to addressing the social and economic conditions that shape the health of communities.

One of the experiences that launched CHF's pursuit of health equity was the Community Health Speakouts it held in 2004 and 2005. The Speakouts attracted more than 500 people who talked about their personal challenges and shared ideas on how to improve the community's health. In the words of CHF President and CEO Margaret O'Bryon:

Hearing their stories was the first time that it really began to click with us that health is about so much more than access to a doctor. People spoke about the things that they were “sick” of – the poor quality of the local schools, issues of neighborhood safety, the lack of affordable housing, no access to healthy food, and the lack of good jobs in their communities – problems in our region with which we were very familiar...It becomes clear how these problems interact in ways that do indeed make people sick (CHF 2009).

In a subsequent strategic planning process, CHF revised its mission, vision, and core values statements, and created a new theory of change and logic model to guide its work and reflect its commitment to health justice.

Using what it learned in the Speakouts, CHF created Wellness Opportunity Zones, place-based initiatives that

development decisions would also think about things like the availability of jobs, transportation, and affordable housing, as well as clean air, parks, sidewalks, and public safety.

CHF uses its logic model and theory of change to guide grantmaking so that board and staff know what investments are going to be made, what activities are going to be pursued, and what outcomes are expected. The foundation acknowledges that it is very difficult work and that it will take at least a generation or more to begin to see change (CHF 2009).

## CONCLUSION

Every foundation, no matter its size or geographic scope, can contribute to the goal of advancing health equity. Achieving real and lasting improvements will clearly require a long-term commitment. It may also involve internal discussions

about values and goals and trying new approaches to grantmaking. Nonetheless, there is so much at stake that foundations must be willing to take

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*We, as a society, will have achieved health justice when health inequities – which are avoidable inequalities in health between groups of people, and are based on race – have been eliminated (CHF 2009).*

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seek to transform a community’s overall environment as a way to also improve the health of its residents. This means that community leaders responsible for planning and

risks and work differently. The country can ill afford another “lost decade” of stagnating and declining health among its most vulnerable populations.

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# HOW DO WE GET TO EQUITY?

Thomas Aschenbrener, President, Northwest Health Foundation

## LET US HELP EACH OTHER GET THERE

As I look toward my retirement as president of Northwest Health Foundation this coming June, I am very pleased to have been asked to write about the evolution of our health equity work over the past several years. While we have so much more to do as an organization and as a community to get to health equity, I am proud of what our staff and board have accomplished in this area. Because the goal for all of us is to get there together, I hope other foundations – and policymakers and businesses – may be able to gain from our insights. I also look forward to hearing more about how other organizations, philanthropic and otherwise, have evolved their work, because my work is not finished.

It is gratifying that, once again, Grantmakers In Health (GIH) has challenged us all to reach higher and further with our work. I hope that our experience in Oregon can provide insight to the many others of you who also seek a more fair and just society through the philanthropic sector.

## WITHOUT COMMITMENT THERE CAN BE NO CHANGE

Based on my experience, the most important consideration I can emphasize is that working toward health equity requires commitment. This commitment must be sustained and thorough. This commitment is about intentionality, not quotas or preferences in board and staff development.

For a grantmaker, this commitment must extend throughout the entire organization, from the board to the chief executive, and onto the rest of the organization.

Furthermore, to do this work successfully, an organization's commitment must be more than deep; it must also be long and enduring, like the commitment your organization has to fulfill its mission. This is not something you do for a single year and move onto the next "project."

At Northwest Health Foundation, we believe a "rising tide lifts all boats" approach is good, but simply not good enough to get where we need to go as a society. This is why one of

our guiding principles is:

*Deliberate strategies are required in order to effectively overcome health inequities.*

As a social justice funder, we recognize that reducing racial, ethnic, and income-based health disparities will not happen without deliberate strategies. Achieving health equity will certainly not happen through "trickle-down economics" or tax-cutting policies. Achieving health equity requires targeted efforts that directly challenge the status quo. For a grantmaker in health, this may mean advocating for changes in government and the health care system, which can be perceived as threatening to some. Examples of this can be found in efforts to institute midlevel dental providers, or building a pipeline for more community health workers, or by introducing a higher level of cultural competency in our health care system, all of which require change to the existing system.

## BUILDING COMMITMENT FROM WITHIN

As a grantmaker committed to health equity, our commitment begins at the top, namely our board of directors and the leader of the organization. For many organizations, this change might begin with a commitment to greater board diversity. To be clear, diversity should not be confused with tokenism. Having one person "representing" an entire community, and another individual "representing" another community will not work. What I do mean is intentionally building a board of directors that, as well as possible, represents the full spectrum of our multicultural society. Only

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*Our world has changed. If we are to thrive as a society, we need to embrace intentional multiculturalism, not the melting pot of assimilation.*

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when this commitment is in place will your board discussions and policies reflect the needs of the society at large, and only then will you achieve the level of authenticity that can lead to the changes in society that can get us to health equity.

With Northwest Health Foundation's 15-member board, we will never reflect every constituent in the community we

serve. Nevertheless, I am proud that our board has evolved from being mostly white men all over the age of 65 to where it is today: fully gender balanced, more than half identifying as representing communities of color, and with a few members even representing the leadership cohort of those in their 30s and early 40s. This last area – age – is very important, more so than many people realize. After all, the millennial generation is not only the cohort from which our future leaders will emerge, it is also the most racially diverse generation to ever come along in American history. Thus, I cannot emphasize enough how important it is to help this generation fill executive and board of director ranks at our most important institutions, particularly our philanthropic organizations.

Along with this evolution of the diversity of the foundation's board came an evolution of discussion about equity. For us, it meant long conversations – including an all-day board retreat – about what it means to be a social justice organization. It also meant recognizing what a commitment to health equity means and what it looks like. In our case, it became clear that committing to health equity meant infusing the concepts of equity into our guiding principles and other governing language. It has meant all of us asking questions of our grantees and community leaders, listening to the responses, and learning to incorporate their messages into our work.

### WE HAVE A SHARED FATE: DEVELOPING A “CASE FOR EQUITY”

Because these efforts are so crucial to the work of the foundation, last year our board created an equity committee, charged with guiding the efforts of the foundation in this area. The committee began by developing the organization's “case for equity.” In its entirety, our case for equity reads:

We have a shared fate – as individuals within a community and communities within society. All communities need the ability to shape their own present and future. Equity is both the means to healthy communities and an end that benefits us all. Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may, in effect, serve to marginalize some and perpetuate disparities. Working toward equity requires an understanding of historical contexts and the active investment in social structures

over time to ensure that all communities can experience their vision for wellbeing.

► **Priorities for our Equity Work** – We believe that we will improve the health of all communities through deliberate strategies that promote equity and eliminate health inequities. We believe that the following areas represent the greatest opportunities for Northwest Health Foundation's efforts:

- Race/ethnicity, including immigrant and refugee identification
- Geography
- Physical, mental, and developmental disability

### THE PROCESS OF GETTING THERE

For Northwest Health Foundation, any community's approach to achieving health equity can be seen as following an arc that might help any organization to consider, no matter where it is in the overall process:

- Documenting issues of disparities
- Facilitating community-driven paths to solutions
- Identifying and implementing solutions

Each of these activities can become quite complex, and each must reflect the capacity, needs, and population of your community. Just as every community has different population needs and institutional structures, the path to significantly reducing disparities and achieving health equity must match those needs. The following are some highlights of the work that we have conducted in Oregon.

### DOCUMENTING THE ISSUES

The process of documentation is not a simple one, but it is absolutely necessary. How do we know disparities exist in a particular community? How severe are these disparities?

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*Some argue they deliver health services with “equity” because they treat everyone the same. In fact, equity requires treating some patients very differently. An effective health system needs more than interpreters; it requires a bias toward understanding the cultural perspectives in which health care is received.*

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Which populations suffer the most from inequities? What level of philanthropic funding has been applied to these populations? These are the types of questions that must be answered in order to take concrete steps toward



reducing disparities.

As a health-focused grantmaker, one of the techniques we used to address this was community-based participatory research (CBPR). In one case, our foundation partnered with the Portland-based Coalition of Communities of Color and Portland State University to document disparities by race and ethnicity. The report, released in 2010, provided clear data for the period under study (2008), and concluded that for minority populations, the region was “uniquely toxic.” The report, *Communities of Color in Multnomah County: An Unsettling Profile*, explained that for these populations, the rates of inequities with the larger population tended to be worse than in the cities of Seattle and Detroit. (The report can be found at: [www.coalitioncommunitiescolor.org](http://www.coalitioncommunitiescolor.org).)

For example in Portland’s Multnomah County:

- The high school dropout rate for minorities was 30 percent compared to 7 percent for the white population.
- While the child poverty rate for the white population was 12.5 percent, for Native Americans it was 46 percent, for African Americans 41 percent, and for African immigrants 56 percent.
- People of color were earning about half that of white individuals: \$16,500 a year compared with \$33,000.

Also with this study, data became available for the first time on Slavic and African immigrants and refugees in the county.

As is part of most CBPR processes, political and media engagements were an important part of the strategy. Public hearings were held at both the City of Portland and Multnomah County. Because of these efforts, the report received extensive news coverage in broadcast and print media, and led to editorials in several newspapers to declare that more resources must be spent on the problem of disparities by race and ethnicity.

Over the subsequent months, many accomplishments have been achieved as a result of these engagement activities, not the least of which was the creation of the Office of Equity at the City of Portland in 2011.

Another area of documentation – in philanthropy – was conducted by Grantmakers of Oregon and Southwest Washington (GOSW). The project focused on a single

question: How much giving by Oregon foundations is reaching Oregon’s communities of color? To answer that question, GOSW contracted with the Foundation Center to collect and analyze this data. At Northwest Health Foundation, we used this methodology to examine our own institutional practices. In our case, we found that the percentage of grant

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*Equity is not about allocating grantmaking in proportion to racial populations. We must assess the collective needs and assets in our communities and provide a collaborative structure to address these needs. This is part of advancing the common good.*

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dollars reaching communities of color reached 27 percent in 2009 – a slight increase from the previous year. The number of grants reaching communities of color increased from 11 percent to 19 percent.

Were these good results? What levels should we have targeted? What levels should we be targeting in the future? The answers to these questions for your organizations, of course, differ depending on many factors. But what I wish to emphasize here is how important data is to the entire process. Just as important as collecting the data is reporting it – on your website, to your constituents – because this reporting process opens up a conversation that would have otherwise been academic without concrete data.

## SUPPORTING COMMUNITY-DRIVEN SOLUTIONS

One of the fundamental steps toward achieving equity is ensuring that diverse populations are always represented during policymaking processes. This is why our foundation has funded several groups representing communities of color to advocate for health equity-related policy changes. We have not considered it to be our foundation’s role to determine what these solutions may be. Rather, our responsibility has been in such areas as helping identify community leaders, facilitating partnerships between community groups, and arranging for and funding technical assistance programs for nonprofits around lobbying and advocacy.

Here is one example. In 2011 the new advocacy coalition People of Color Health Equity Collaborative formed during the Oregon legislative session. It consisted of 16 organizations, all funded by the foundation. The vision of the collaborative was “an Oregon where all residents have equal health outcomes regardless of color, race, ethnicity, gender, class, sexual orientation, or immigration status.” The groups advocated for a variety of legislative issues, including cultural competency legislation, a health insurance exchange,

expanding health insurance to include children of undocumented immigrants, and increasing the Earned Income Tax Credit. While only the insurance exchange passed, the coalition will certainly be back for future sessions, and it is my expectation that other foundations in our region will add to the support of these types of efforts in the future.

## SOLUTIONS COME IN MANY FORMS

There are many ways to get to equity, and of course, each community defines needs differently. Having said that, I believe it is important to understand some of the possible solutions toward which our advocate partners have been dedicated. At Northwest Health Foundation, we and our grantee partners have been working in each of these areas throughout Oregon and southwest Washington over the past few years. Each of these types of efforts has been cited by organizations such as The Commonwealth Fund as programs that have made demonstrable progress in reducing disparities and achieving equity:

- **Culturally Competent Health and Health Care** – Examples of this include training providers about cultural differences, using professional interpreters, and recognizing how different cultures incorporate family into their health care needs.
- **Primary Care “Homes”** – Ensuring that everyone has access to a patient-centered primary care home, also called a medical home, has been cited as one of the most important changes we can make to our health care system to achieve health equity.
- **Community Health Workers** – Greater use of community health workers has been shown to reduce disparities by race, ethnicity, and income.
- **Improved Workforce Diversity** – Programs such as the Workforce Improvement for Immigrant Nurses project in Oregon are critical to help achieve a workforce that matches our aging and rapidly diversifying society.
- **Parks and Recreation** – Many people still live in neighborhoods without access to a nonviolent and exercise-friendly park, which has a detrimental effect on population health. Policy change can go a long way to ameliorate these disparities.
- **Food Systems** – As health grantmakers have long known, and as the wider public is increasingly learning through research, people who have better access to supermarkets tend to have lower levels of obesity. Lower-income communities often have fewer grocery stores and more convenience stores. Changing this dynamic can help reduce disparities by race, ethnicity, and income.

## COMMUNICATING WHAT WORKS

Our grantee partners live this work every day, and they communicate their needs, their concerns, and their progress on a consistent basis. After all, their constituents expect them to do so. Nevertheless, many of our partners have asked us as a funder to communicate what we do, and why we do it, to lend strength to their own work and their own messages.

In 2011 we took this request about communicating the importance of equity quite seriously. We dedicated the first edition of our on-line magazine *Points of View* to this issue, producing videos, resources, stories, and talking points. These communications pieces all highlighted the importance of focusing on equity, what we do in the area, and how we talk about it. (The equity edition of *Points of View* can be found at [www.nwhf.org/equity](http://www.nwhf.org/equity).)

This last area – the language we use around equity – should not be underestimated. Those who know me know that I am an outspoken champion of “reclaiming our patriotism.” If part of this nation’s patriotic history was to rebel against the British Crown for taxing and policymaking without representation, I believe it is an extension of this patriotic spirit that we continue to push for the truly representative democracy that still eludes us today. As all the social justice leaders who have emerged in this country over the years, from Lillian Wald to Martin Luther King, Jr., have demonstrated, we have much more work to do to achieve the promise of our nation’s egalitarian founding principles.

Indeed, infusing equity into everything you do means working toward a society where there are no second class citizens, and where all our communities can live the message outlined by the 2012 GIH annual meeting – Health and Equity for All!

# THE POWER OF A BELIEF

Gail C. Christopher, DN, Vice President-Program Strategy, W.K. Kellogg Foundation

Program officers at the W.K. Kellogg Foundation (WKKF) come together each month to share insights from their grantmaking experiences. One memorable story came from an education program officer working primarily in the state of Mississippi. She shared a story about trying to get local civic and business leaders to match philanthropic investments in a proven charter school model. The business leaders refused and indicated unanimously that it would be a “waste of money” because those children could not learn. The community turned to other sources to raise the needed dollars, and two years later when these same civic and business leaders saw the test scores and improved educational outcomes, they were “flabbergasted” and voiced shock. They simply had to admit that their “beliefs” about the innate abilities of these children were wrong.

When a new superintendent of a chronically failing public school district boldly altered the curriculum to emphasize literacy, and, as a result, significantly improved student performance and teacher morale, stress was reduced and the life trajectory from diseases caused by stress was altered for these students. Their risks for failure and even incarceration were reduced.

The message from these stories is twofold: children can achieve academically when given a chance and the right tools, and in the process they can reduce their vulnerability to illness and disease.

There is a growing body of evidence that explains how our experiences become our biology. Nancy Krieger of the Harvard School of Public Health was one of the early researchers who advanced the theory of how diverse aspects of people’s social location within their societies are “embodied” and related to disease susceptibility. Bruce McEwen added more to this idea by developing the concept of allostatic load, which elucidates the biochemical and hormonal pathways through which experiences have a cumulative effect. As recently as December 2011, the American Academy of Pediatrics issued the policy statement *Childhood Adversity, Toxic Stress, and the Role of the Pediatrician: Translating Developmental Science into Lifelong Health*. Andrew Garner was the lead author of this report.

When the brain perceives an experience as stressful,

physiologic and biochemical responses are initiated such as blood pressure elevation and hormonal secretions. Over time, with repeated exposure, biochemical stress mediators can have adverse effects on the function of body organ systems. This can lead to chronic diseases such as hypertension and atherosclerosis in adults. Early stress exposures in infancy and childhood can negatively affect brain development.

Public health workers, parents, educators, economic and community developers, land use planners, elected officials, law enforcement officers, and care givers make decisions and take actions every day that may cause increased or decreased allostatic load consequences for our nation’s most vulnerable populations. Grantmakers’ decisions may have similar consequences.

Archived at WKKF is the original resolution document with 55 signatures from the April 2000 foundation-funded Salzburg Seminar (#437) *The Social and Economic Determinants of the Public’s Health*. This groundbreaking gathering of health and policy leaders from around the world served as a backdrop for subsequent WKKF social determinants of health funding strategies. Efforts to accelerate the application of knowledge about the social determinants of health became the hallmark of WKKF health funding through the decade of 2000-2010, and continues today. At the Salzburg Seminar, there was considerable tension between calls for what was then termed “scientific problem solving” as opposed to “calls for complex, caring creative relationships.” As is often the case when paradigms are shifting and deeply held beliefs are challenged, false dichotomies were created and used to distract or impede progress. One such dichotomy that persists in the minds of many health funders yet today is the belief that access to quality, affordable health care is somehow juxtaposed to social determinants of health. This dichotomy is clearly wrong-headed. Timely access to quality, affordable care is one of many social (or contextually based) determinants of health and well-being. The Affordable Care Act, with its primary prevention, health promotion, and “health in all policies” sections can serve as an unprecedented resource for propelling the nation toward more equitable health outcomes and greater health equity. Its inherent opportunities must be leveraged,

however. That will require “the will and the skill” of an energized public. The Salzburg convening heralded a shift in thinking for the attendees who collectively asserted that “community involvement must be underpinned by a value system of social justice, fairness, and equality” (WKKF 2000). They called for efforts to transcend the limits of the biomedical model for defining and resolving public health threats.

Fast forward to 2012. A global movement for health equity exists. The principles of this movement are embodied in the final report of the World Health Organization’s (WHO) Commission on the Social Determinants of Health entitled, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinates of Health*. The commission was created in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it. The commission’s final report boldly asserts:

Social justice is a matter of life and death...Inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness...The conditions in which people live and die are in turn, shaped by political, social, and economic forces.

I would add that, as the Mississippi school story reveals, the conditions are also shaped by the force of beliefs.

Several countries and agencies have become partners with WHO and the commission by working to frame policies and programs across the whole of society that influence the social determinants of health and improve health equity. The United States is not one of the partnering nations. However, when the framework for our nation’s public health goals, Healthy People 2020, was announced in 2011, it included a focus on understanding and addressing the social determinants of health. This marked a sea of change in U.S. government health policy and can be attributed (in part) to persistent, yet innovative work by many philanthropies such as the MacArthur Foundation, the Robert Wood Johnson Foundation, and WKKF, and to bold leadership by many city and county health officials in the National Association of City and County Health Officials (NACCHO).

It was not easy to slice through the broad list of social indicators in the social determinants of health paradigm and select the “one” for inclusion as a Healthy People 2020 goal. Some in the field were disappointed that only one indicator was selected. This one had to be measurable and have data systems in place in states and counties across the country that could be compared over time. The data would have to be aggregated and disaggregated. Issues of correlation versus

cause would need to be clarified and supported. The committee honed in on education as *the* social determinants of health indicator for 2020. Specifically they chose on-time graduation or high school completion within four years. In so doing, they have challenged health grantmakers to show the way and cross our own boundaries in related understanding and action. Of course our primary action as funders is “grantmaking.” What is our role, if any, in helping realize this pivotal social determinants of health Healthy People 2020 goal? In the comments that follow, I will share some insights gleaned during WKKF’s decades-long journey into the complex world of social determinants of health and health equity.

WKKF is not an exclusively “health or health care” foundation. Our other focus areas are education and family economic security, both “social determinants of health.” Two overarching approaches guide all of the program areas at the foundation: community/civic engagement and racial equity. We recognize that geographic boundaries are determinants of social, economic, and policy forces that converge within local communities where people live, work, and develop. We have supported “place-based” initiatives over the years and recently identified several priority places – “geographic areas for long-term focused funding and investments to improve lives of vulnerable children.” These are New Mexico, Mississippi, Michigan, and New Orleans in the United States. The foundation continues to carry an international portfolio, as well.

Perhaps I should pause here to assert a core principle that since 2007 has undergirded the funding approach of WKKF. This principle is that our funder’s mandate and our subsequent mission of helping communities create the conditions that “propel vulnerable children to success,” cannot be fully realized without an explicit focus on achieving racial equity through racial healing and addressing structural racism. It follows that our work on health inequities (often framed as health disparities) necessitates addressing the effects of our nation’s deeply held unconscious biases. Our country’s collective unconscious and implicit biases were wrought through more than three centuries of building and sustaining stratified social, economic, legal, medical, governance, and religious institutions to protect the mythological belief in racial hierarchy.

While great strides were made to abolish slavery, to legislate freedom, and to end discrimination through the civil war and the era of reconstruction, as well as in the civil rights movement of the 1960s, neither the former nor the latter dealt with the fundamental *belief* in racial differences and racial hierarchy. These beliefs shaped and defined the social order and dictated behaviors and resource distribution

for a time period that exceeds the life of this nation as a “nation.” Indeed, the denial of the humanity of millions of enslaved and free Africans and native people in the Americas and much of the world (coupled with annihilation, exploitation, and exclusion of brown, yellow, red, or black races) was an institutionalized government and church-sanctioned way of believing and behaving for more than four centuries. As of 2012, the United States is only 236 years old.

In short, the preformative, formative, developmental, and most recent history of this young nation was shaped by the belief in superiority based on physical characteristics and inferiority (actually less than human status) based on skin color, hair texture, and the contour of facial features. To view persistent inequality in wealth, education, health, and social indicators without dealing with this fact is to practice and reinforce our national malaise of “denial” about our racialized history and its consequences.

In my years of clinical practice as a licensed holistic health provider, naprapath (a healer specializing in connective tissue, pain relief, and wellness), naturopath, and nutritionist, I learned that getting people to embrace new ideas and subsequently to change their actions or behaviors often requires overcoming denial. I observed that denial, as a psychological tool, has four stages. The most obvious is denial of the facts of a situation (some patients deny smoking for example). Once the facts are accepted, the next level of resistance is denial of consequences. When consequences are finally acknowledged, then the mind or psyche may refuse to see the myriad implications of a difficult or painful truth that threatens it. But the ultimate level of denial that must be overcome is the most difficult. We must face the “feelings” that are uncovered when denial is no longer blinding us. I learned that people will release denial when (and only when) at some level *they* believe *they have the resources* for coping with the threat or *loss*. When it comes to facing and addressing this nation’s racialized culture and structured realities of racialized exclusion and hierarchy, the facts have yet to be widely asserted or understood, the consequences are euphemistically disguised as disparities or intractable social dislocations at best, and the implications are far too complicated for most beneficiaries or subjects of the hierarchy to acknowledge. Finally, emotions – the raw feelings that range from fear, shame, guilt, anger, rage, and hate to love – constitute the seemingly insurmountable mountain that has to be scaled before we can hope to achieve racial healing.

America must come to grips with the meaning and effects of its racialized societal structure. Some ask how it is possible to address these issues and the legacy in their communities. At WKKF we were surprised and inspired when we were

overrun with responses to our modest request for proposals from communities that were willing to apply innovative approaches to healing the legacy of racism and its consequences in their communities. Our scan of the nascent field in 2008 showed that most racial healing work was either voluntary or minimally funded. While we have committed \$75 million to the first phase of the work, our resources only scratch the surface of need and, we believe, good will that is latent within communities across America.

In response to a clear mandate by the WKKF board of directors, we designed and are implementing a comprehensive strategy to “jump start” a long overdue healing process in this country. The goal is to uproot the remnants of the most pervasive set of beliefs that gave rise to existing systems of privilege and stratification of opportunity. Racial bias, particularly unconscious or implicit bias, is a social determinant of health. And since residential segregation, school funding, access to quality medical care, job opportunity, and even air quality are driven by these patterns of belief, racial bias is perhaps the most fundamental social determinants of health in the United States.

Did those civic and business leaders in Mississippi really change their core beliefs about the innate capacity of innocent black and Latino preschoolers to learn? A realistic response is that their assumptions were challenged. And some of them actually changed their decision about funding the charter school. But real healing would require engaging these same “leaders” in experiential processes designed to help them peel back years of layers of denial. They would need to participate, voluntarily, in experiences that brought them into a set of facts, historical and contemporary. We have found that “story is a powerful tool” in this work. They would need to be guided through experiences that generate a deeper understanding of consequences and implications. Finally, with the help of skilled facilitators, they might connect with and diffuse the emotional barriers to expand their conscious circle of human concern and empathy. This is the work of racial healing for individuals.

These leaders are often quite powerful and have lived their lives at the top of the extant racial hierarchy. In his 2010 book, *Fire in the Heart: How White Activists Embrace Social Justice*, author Mark R. Warren documents the stories of white activists who became aware of the dynamics of racial inequality and injustice and were no longer willing to participate in the passive acceptance of this as part of the American social fabric. Warren quotes one of the more than 50 white activists he interviewed:

Oh hell, I’ve been working at this stuff for a long, long time. I’m clear that I benefit from notions of white

superiority that have been inculcated in this culture from the founding of the nation, and I don't feel good about that. But I don't think hand wringing and feeling guilt personally about that is very helpful. What I have to do is to be real clear about that and then say, "What can I do in a day-to-day way that allows people to cross racial barriers in ways that are meaningful at a personal level and that are meaningful at a communal and political level?"

What can we as health grantmakers do in a day-to-day way that allows people to cross racial barriers in ways that are meaningful in achieving health equity?

The journey at WKKF continues after having begun more than 20 years ago. We can offer some lessons:

- An engaged and committed board of directors emerged after it was diversified and involved in shared experiences of racial healing. External facilitators helped in this process.
- Decisions and actions to diversify staff required coaching to help individuals understand and cope with subsequent conscious and unconscious biases that began to play out more openly in the work place.
- Objective data tracking systems are both required and useful in sustaining the work. Implementing them requires redesigning data systems for soliciting and processing applications, contracts, reports.
- Once the "ism" of racism is lifted, calls for addressing all "isms" are made. We were clear that, while we understood and respected the injustice of sexism, homophobia, and classism, our mission to help vulnerable children compelled us, at this time, to prioritize the longstanding issue of racism. The rapidly changing demographics of the country revealed that most children born today and in the foreseeable future are children of color. Most of these children are being born into low-income or impoverished communities. Failure to address the racial divide portends only widening gaps of inequality in America and limited opportunity for the majority of our children, as well as increased exposure to chronic stress, high allostatic loads, and disease susceptibility.

Health grantmakers can help communities achieve the Healthy People 2020 social determinants of health goal related to education success in many creative ways. Funding local collaborations working to address issues such as school funding inequities, residential segregation, housing discrimination, environmental justice, or food justice is one possibility. Foundations may also support local coalitions

working on living wage campaigns or employment opportunities. Funders may partner with private and public sector leaders to help reframe the debate about health and health care to include a focus on social determinants. NACCHO has developed a related web-based curriculum and toolkit (with support from the National Institutes of Health), available at [www.naccho.org](http://www.naccho.org).

It is our contention at WKKF that while all such efforts are warranted and may be effective in the short run, they will not have long-term impact until the underlying issues of racial bias and the racialized opportunity structures of this nation are exposed and healed. These residual beliefs along with the confusion, anxiety, and paralysis that they produce are barriers to true community coalescing for the greater good of humanity and this nation.

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# Charting a Path Toward HEALTH EQUITY

Margaret O'Bryon, President and CEO, and Rachel Wick, Director of Policy, Planning and Special Projects, Consumer Health Foundation

**H***Health in an Unequal World.* This is the title of a lecture given by Sir Michael Marmot five years ago at the Royal College of Physicians in London. In it, he sets forth a framework for explaining inequalities in health within and between countries. It is premised on an understanding of poverty that goes beyond income level to a broader understanding that is based on people's sense of social control and their social engagement. He posits that in addressing health inequalities we need to focus not only on the extremes of income poverty, but also on the fundamental human needs of autonomy, empowerment, and human freedom that are the result of social conditions and are potent causes of ill health.

This broader framework of addressing health inequalities challenges us as funders to understand the complexities inherent in this work, as we decide where and how to deploy our resources and our capacities to their highest and best use. Deeply embedded in addressing the root causes of poor health are the realities of structural racism and the fact that inequities in employment, housing, education, and health care contribute to poorer health outcomes among people of color, and particularly among those with low and moderate incomes.

From a policy perspective, we also know that health inequities and inequalities are avoidable. As Sir Marmot noted in his plenary speech at the 2009 Grantmakers In Health (GIH) annual meeting, "Social injustice is killing people on a grand scale. A toxic combination of poor social policies, unfair economic arrangements, and bad politics is responsible for most of the inequities we see in the world today, within and between countries." He exhorts, "To be clear, those are the causes, and we need to address the fundamental causes."

So the tough question becomes: how do we as health funders develop a deeper understanding of these fundamental causes and address them within the context of the communities we serve, while at the same time remaining true to our core mission of health? Finding a niche in the complex world of health equity can be challenging. Forces like poverty and racism are deeply historical and multidimensional.

This essay focuses on how the board and staff of the Consumer Health Foundation, a small local foundation,

charted its path toward health equity. The process has been creative, adaptive, and iterative, and we hope it can offer resources and tools to others on their journey.

## DEEPENING OUR UNDERSTANDING OF HEALTH EQUITY

For the Consumer Health Foundation, deepening our understanding of the fundamental causes of health inequity has required that we develop new ways of learning that could connect us more deeply and directly with communities and the people who live and work in them.

One of the new models we adopted was that of a *learning journey*. The idea of the learning journey was developed by the Presencing Institute at the Massachusetts Institute of Technology, which develops tools for social change with the goal of creating societies that are "more sustainable, inclusive, and aware." Its website is rich with resources, including steps for learning journeys like ours, which involve inquiry, deep listening, and dialogue with a range of people and organizations. The method is ideal for learning more about a community as a dynamic system, rather than the work of a particular initiative or organization (which is more characteristic of a site visit).

Our foundation's first learning journey was to Langley Park, a community that sits at the crossroads of Montgomery and Prince George's counties in Maryland and the District of Columbia. Much of Langley Park's richness is in its diversity: its residents represent more than 40 countries and speak dozens of languages. Nearly 80 percent of residents are Latino, and about one in five residents live below the poverty level (U.S. Census Bureau 2011). CASA de Maryland, one of our grantee partners, served as the host for our learning journey. CASA has a strong presence in Langley Park through its direct service programs, as well as its community organizing and public policy advocacy work in housing, employment, immigration rights, fair development, and access to health care.

CASA arranged for the foundation's board and staff to tour the community – both by van and on foot. We talked with residents and community leaders in their homes, places of business, in a parking lot, and on the street. We returned

to CASA's Multicultural Center and, over dinner prepared by a local restaurant owner, had a moving conversation with residents of all ages about the opportunities and challenges affecting Langley Park. We listened to stories about the entrepreneurial spirit of the community, coupled by fears of displacement for many small business owners due to a proposed development for a new transit line in the area. We heard from a young woman who was active in advocating for the successful passage of the DREAM Act in Maryland, and what the opportunity to go to college meant to her. We heard stories about tenuous relationships with law enforcement, including racial and ethnic profiling, and felt the fear that permeated the community because of immigration issues, including deportation.

The learning journey provided us with a clear and strong sense of neighborhood, place, and community. It also helped us see and experience the interconnected forces and conditions that affect community health.

The foundation has also drawn upon the arts to deepen its understanding of health equity and to engage the broader community in the learning process. The arts have been a particularly powerful tool for starting conversations about tough topics like structural racism. For example, the foundation sponsored a performance of *A Right to Care* by Tony Award-winning actress Sarah Jones, followed by a Q&A session that resulted in a fascinating dialogue between actress and audience, focused on issues of race and identity. We also developed a partnership with Arena Stage to sponsor the attendance of 200 of our local partners at Anna Deavere Smith's performance of *Let Me Down Easy*. This event was also followed by a Q&A session with the audience, this time led by Dr. Vanessa Northington Gamble, professor of medical humanities at The George Washington University. Dr. Gamble offered her insights to the audience, making the link between health equity and health care clear in her observation: "Many of the things that happen to us in the health care system happen to us before we get there."

More traditional convenings have also served as a means of advancing our understanding of health equity, and for bringing thought leaders in the field into conversation with practitioners in local communities. For the last several years the foundation has used its annual meeting as a forum to bring in key leaders from the public health field such as Dr. Camara Jones, Dr. Adewale Troutman, and Dr. Tony Iton. We also partnered with GIH in 2009 to convene *Changing the Conversation: Taking a Social Determinants of Health Approach to Addressing HIV/AIDS among Women of Color*, with the purpose of understanding HIV/AIDS prevention among African-American women through a social

determinants lens.

In reflecting on our own learning and community education process overall, it became very important to raise, share, and discuss the tough and complex issues around structural racism, race, and health equity through a variety of means and "intelligences." This enabled us to more fully engage with multiple community partners, which is critical to this work.

## NEW WAYS OF WORKING TO ADDRESS HEALTH EQUITY

Local funders, in many ways, are uniquely situated to work at the intersections of health and other factors in communities. We are often "place-based" ourselves; many health conversion foundations have very defined geographic footprints. Many of us are designed to exist in perpetuity so our connection to the community is long-term. We have helped seed nonprofit organizations and seen them through many life cycles. We are also deeply attuned to local politics, yet we are able to take the long view.

There are a number of steps our foundation has taken – often incrementally – to shift its own practice to reflect its understanding and commitment to health equity.

► **Leading with Values** – One of the critical steps we have taken with the board and staff is clarifying our values. In this process we reaffirmed many of our longstanding values such as consumer voice. We added new values like innovation and risk taking to demonstrate our willingness to test new approaches. This is particularly critical when it comes to the complexities inherent in health equity. We also became much more explicit about our commitment to equity and social justice, including the impact of structural racism on health. As one of our board members noted, "You can call it whatever you want – health equity, health justice, or the social determinants of health – but it's still about racism."

The foundation worked with the Applied Research Center and the Philanthropy Initiative on Racial Equity on an external assessment of our commitment to racial justice. We also created safe spaces to talk about the impact of structural racism on health, working with seasoned technical assistance providers who guided us through staff, board, and grantee trainings. Racial equity training was the cornerstone of our most recent board and staff retreat.

Another critical shift has been to broaden our foundation's theory of change to reflect that good health is determined by *both* access to health care and other social and economic factors. We are continuing our longstanding



commitment to improving access to health care for our region's uninsured and underserved residents; however, we have added a new stream of work that focuses on the intersections between health and other social determinants. We have also dedicated a much larger proportion of our grantmaking to advocacy funding.

This values and strategy work has been critical in that it created alignment between our board and staff and between the foundation and the community. The board has taken on strong leadership in this area.

Health equity has become the broader context for all of our work. We have referenced our core values in our request for proposals, in our speaking engagements, and in our publications. We dedicated our 2009 annual report, *Health Justice: A Conversation*, to discussing our health equity strategy with the broader community. One of our nonprofit partners noted that the report helped the community really understand and embrace the philosophy and intent behind our health equity work.

► ***Developing a Systems-Based Approach to Grantmaking*** –

The strengthening of our values and shift in our strategy prompted changes in our approach to grantmaking. It has evolved to look much more like a multidimensional campaign than a focused initiative. We believed that grants should be used to respond to multiple issues facing local communities, not just one issue. This multifaceted approach also respects the diversity of communities, their needs, and their autonomy in deciding what is important. We also shifted a big part of our capacity building work to supporting and building a variety of community capacities, including community organizing, service delivery, systems change, budget and policy analysis, and policy implementation. We are committed to supporting groups over time, and to building new relationships and providing nonmonetary support to a range of nonprofits beyond our grantee pool. This has enabled us to understand multiple aspects of the community “system” and the way these forces interplay within a community.

► ***Being Open to Unforeseen Alliances*** – For small health foundations like ours, forming strategic alliances with peers has been extremely critical for our health care access work, but it is *essential* for work on the other social determinants of health. We simply cannot do it all – intellectually or financially. When we began to open ourselves up to working on the other social determinants, we actually began to see ourselves in new partnerships, places, and initiatives. In many instances we found cross-cutting opportunities to address health care access alongside other determinants. Workforce development is one area that is

ripe with opportunity for health funders interested in health equity. Several years ago we joined a funders collaborative housed at our community foundation that focuses on workforce development. Being part of a collaborative did not require that we lead this new area, but we could bring knowledge and relationships from our health care access work. We could also learn a lot from our peers who were focused on workforce. Another critical collaboration has been with health and other funders (generalist, housing, education, employment, and environmental) at our local regional association of grantmakers who share a vision and passion for working together to address inequities in our region. We can organize ourselves into cross-disciplinary teams to work on issues like aging using an equity lens and a systems perspective. This is exciting new work that continues to evolve.

Federal place-based grant opportunities such as the Promise Neighborhoods initiative and the Sustainable Communities initiative have opened doors for us. The Convergence Partnership's work to support “regional convergence” efforts is a great example of new national and local funding partnerships that are designed to advance equity. The strong focus of these initiatives on place has us thinking more intentionally about how to work with multisector funders and multisector nonprofits. It has also helped us see gaps at the neighborhood level in terms of the new kinds of infrastructure needed for true community building. At a regional level, we are seeing an opportunity for the foundation to play a role in ensuring that health and equity are part of a framework for thinking about long-term growth in our region. The Metropolitan Washington Council of Governments recently developed a blueprint for how our region will grow over the next 30 years called *Region Forward*. We are looking to the impressive work of groups like PolicyLink to help us lead in this area.

► ***Searching for “Out-of-the-Box” Models*** – Seeing ourselves as catalysts for health equity has also prompted us to look at innovative models that blend for-profit and nonprofit strategies, among other approaches. Over the last year, through our local association of grantmakers, we engaged with regional philanthropic colleagues in an inquiry to gauge interest in the Evergreen Cooperative model that was started in Cleveland, Ohio (through the leadership of The Cleveland Foundation). Catalyzing cooperative businesses may seem like an unusual approach for philanthropy and especially for a health foundation; however, from an equity lens, addressing issues related to jobs, income, and neighborhood development has direct effects on community and individual health.

## ONGOING CHALLENGES AND OPPORTUNITIES

As the foundation becomes more intentional about addressing health equity, we have seen our work become much more relational and complex. Areas of work that often existed within their own spheres within the foundation – grantmaking, capacity building, alliance building, communications – are becoming much more integrated. This requires that we adopt new approaches to evaluation, which cannot simply be about monitoring and tracking the performance of grantees. We need to take a systems-level approach that will account for the dynamic interactions between and among all foundation activities.

Our health equity work has also opened up opportunities to participate in a broad range of coalitions, alliances, and partnerships. Given our limited staff and funding resources, however, we struggle with determining the highest and best uses of our limited time and resources. We also are constantly challenged to clearly articulate our health equity lens within the framework of our work around improving access to health care. The fact that we have a clear mission, vision, and set of shared values that are put into practice through the foundation's theory of change and logic model has been enormously helpful in guiding program and related decisions.

## MOVING FORWARD

As we look to the future, we see a number of opportunities for growing and strengthening our health equity work:

- Engaging in more place-based learning journeys in partnership with host nonprofits in communities across the region.
- Discovering new approaches and testing new methods to support grassroots community building and organizing.
- Identifying if and how we could work at the intersections to address the multiple determinants of health.
- Looking for additional opportunities to “walk our talk” in the equity arena, including mission consistent investing, hiring practices, and board composition.
- Speaking out more as a foundation about our commitment to health equity and initiating difficult conversations about race and racism.
- Continuing to offer racial equity trainings for our board, staff, and grantee partners.
- Forging new relationships with local and regional colleagues in government, business, academia, philanthropy, and the nonprofit sector to catalyze new partnerships and conversations about addressing health equity across our

region – suburban Maryland, Northern Virginia, and the District of Columbia.

- Working to institute a more intentional check-in process for the board and staff to reflect on our health equity work on an ongoing basis. What are we learning? Are there internal and/or external adjustments that need to be made in our work and/or the way we operate? Are we being effective? Self-reflection and self-awareness, as well as critical thinking, are essential qualities for working in this arena.

As one of our board members noted at recent retreat, “This is a journey for the Consumer Health Foundation.” We have had fits and starts but have attempted to learn as we stumble, pick ourselves up, and move forward. We have benefited greatly from the research and experiences of our funding colleagues both locally and across the country and have translated that into our work.

Most importantly, as captured so beautifully by Sir Marmot, we have come to realize more and more deeply how the equity work in which we are all involved is at its heart work around justice, fairness, and creating communities where prosperity is shared among all. It is also the work of connection and opens up for funders exciting opportunities to work in different ways and to forge new relationships within our respective communities.

***Transforming the world is possible because the very complex forces of interconnection that make systems resistant to change are the same ones that can be harnessed to propel change.***

– From *Getting to Maybe: How the World Is Changed*

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# Health + Equity: FINDING SOLUTIONS UPSTREAM

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In the documentary *Living Downstream* (2010), biologist and cancer survivor Sandra Steingraber eloquently describes a cautionary tale:

There was once a village along a river. The people who lived here were very kind. These residents, according to parable, began noticing increasing numbers of drowning people caught in the river's swift current. And so they went to work, devising ever-more elaborate technologies to resuscitate them. So preoccupied were these heroic villagers with rescue and treatment that they never thought to look upstream to see who was pushing the victims in.

As health advocates and funders, this tale is familiar to many of us. Often we are torn between meeting the immediate and critical needs of our communities, and focusing our attention upstream on root causes of problems. Twelve years ago, a group of funders interested in what was happening at the intersection of health and the environment pulled on our wading boots to journey upstream together.<sup>1</sup>

Along the way, we have found solid evidence that many health and equity problems being treated with health care downstream are triggered – and can be remediated – upstream.

We also have learned that some of the most creative and effective outcomes arise out of collaboration across a diversity of efforts, from service of immediate needs to strategic work on root causes. If we are truly rooted in caring for people, families, and communities, “upstream and downstream” are all parts of one river.

## MAPPING ROOT CAUSES UPSTREAM

In the parable above, the implication is that the answer is simple: someone is pushing the victims into the river. We know, however, that the root causes of poor and inequitable health outcomes are myriad and complex. Fortunately, thanks to over a decade of research in several disciplines, we

know far more today about what is happening upstream.

One key finding of research is that **a range of social and environmental conditions may lead to or exacerbate poor health outcomes.** The World Health Organization Commission on the Social Determinants of Health flagged these conditions of daily life – the environments in which people are born, grow up, live, work, and age – as the factors most likely to put them at risk of disease.

Researchers have demonstrated adverse health impacts from stressors such as poverty, lack of education, and violence (Woolf and Braveman 2011; Raphael 2011; Galobardes et al. 2006). For example, researchers have estimated that over 400 million quality-adjusted life years were lost in the United States between 1997-2002 because of families living on incomes of less than 200 percent of the federal poverty level. This translates into a greater impact on health from poverty than that of tobacco use and obesity (Muennig et al. 2010).

People's exposures to environmental hazards, such as air or water pollution, likewise have been linked to poor health. Numerous studies have found that living near pollution sources – such as hazardous wastes sites, industrial facilities, farms using pesticides, major transportation corridors, nuclear power plants, gas stations, and car repair shops – is related to an increased risk of poor health outcomes (Brender et al. 2011). Regarding the health costs of air pollution in California alone, the RAND Corporation estimated that “failing to meet air quality standards resulted in overall spending on hospital care in California of slightly more than \$193 million over the period 2005-2007. To put this number in perspective, the annual costs would be sufficient to pay for pediatric influenza vaccinations for 85 percent of California's under-15 population” (Romley et al. 2010).

Research linking environmental exposures to chronic diseases is a major and growing concern. In the United States and other industrialized countries, chronic diseases (such as cancer, heart disease, and diabetes) are the primary cause of

<sup>1</sup> In 1999 a group of funders from environmental and health grantmaking communities formed the Health and Environmental Funders Network (HEFN). For over a decade, HEFN and its funder participants have worked closely with Grantmakers In Health to deepen understanding of and strengthen investment in issues at the intersection of health and the environment.

death. By the year 2030, the mortality rate for these chronic diseases is projected to increase by as much as 20 percent globally (Mathers and Loncar 2006).

In May 2010 the President's Cancer Panel released its first-ever report on environmental contaminants and cancer: *Reducing Environmental Cancer Risk: What We Can Do Now*. The report concluded that environmental contributors to cancer have been grossly underestimated and urged action on toxic chemicals as part of an effective cancer prevention strategy. It called upon the President "to use the power of your office to remove the carcinogens and other toxins from our food, water, and air that needlessly increase health care costs, cripple our nation's productivity, and devastate American lives" (Reuben 2010).

Other chronic diseases have been the subject of this increased attention to environmental factors as well, and the evidence continues to grow. For example, a number of studies in recent years have examined the relationship between endocrine disrupting chemicals and diabetes, with startling results. One study conducted by the Centers for Disease Control and Prevention found that people with the highest levels of polychlorinated biphenyls (PCBs), pesticides, and dioxins were 38 times more likely to have diabetes than those with the lowest levels (Lee et al. 2006).

There is growing research interest in the fetal origins of disease (looking at lifelong health impacts of exposures *in utero* and in early childhood), with studies uncovering a trove of relationships among social and environmental factors and chronic diseases. One can find numerous references in the literature to fetal origins of cancer, asthma, heart disease, obesity, and diabetes (Paul 2010). Take obesity, for example. In the first prospective study of fetal exposures and obesity, scientists analyzed newborn babies' cord blood for hexachlorobenzene (HCB), a byproduct of chemical manufacturing processes that use chlorine. By age six, the children with the highest blood levels of HCB were significantly more likely to be overweight and obese (Smink et al. 2008).

An understanding of exactly how disease is related to environmental conditions is evolving along with studies of determinants, exposures, impacts, and outcomes. A 2006 World Health Organization study concluded that a quarter of all diseases globally and a third of children's diseases were environmentally attributable. In the global context, determinants driving high rates of disease and inequity include conditions such as poor sanitation and lack of access to safe drinking water, as well as poverty.

A second key finding of the burgeoning research on social stressors and environmental exposures is that **these different factors may interact to produce a cumulatively greater**

**health impact**. The combined impacts of stress and pollution are a growing concern in children's health research (Cooney 2011). For instance, a recently published study from Southern California reported that traffic pollutants had more adverse impact on the lung function of children living in high-stress households than those living in lower-stress households (Islam et al. 2011). To anyone who has lived with several simultaneous challenges, this idea of greater vulnerability under stress probably makes intuitive sense.

Research is finding an array of synergistic effects, including an interplay of toxins and genetics, such as findings that people have increased risk of Parkinson's Disease if they have both a certain genetic variant and pesticide exposures (Ritz et al. 2009).

A third key finding is that, taken together, **the cumulative impacts of these health determinants are creating health disparities** (Morello-Frosch et al. 2011). People of color and poor people experience much higher rates of exposure to unhealthy environments *and* to social and economic stressors – from poverty, to violence, to discrimination. The accumulated risk factors may have additive or synergistic effects, turning some differences in several areas of life experience into significant differences in health outcomes. For instance, a recent synthesis of studies related to African Americans' higher mortality rates from hypertension points toward a combined impact of environmental lead exposures and stress (Hicken et al. 2011).

Putting these puzzle pieces together, a map emerges of socioeconomic stressors and environmental hazards that affect everyone's health, and that have a disproportionately high impact on the health of vulnerable populations and communities of color.

These health determinants and resulting inequities are costing us dearly. In addition to an immeasurable human and societal toll, they levy a hefty financial price. The cost of certain environmentally induced diseases in children alone was recently estimated at nearly \$77 billion annually (Trasande and Yinghua 2011). The more effective our efforts to eliminate health disparities and inequities, the greater our societal savings will be in the long term.

## INTERVENTION AND PREVENTION

In parallel with providing an evidence base about social and environmental determinants and related health outcomes, the past decade's research also has demonstrated great potential for improving health outcomes by addressing upstream factors. The fact that a significant share of today's major diseases and disorders is not genetically predetermined, but rather caused by conditions of daily life, means we have

opportunities to intervene and reduce or prevent death, suffering, and injustice.

A good demonstration of this is in the work of the Columbia Center for Children's Environmental Health (CCCEH). The Mothers and Newborns Study at CCCEH follows a cohort of 725 African-American and Latino pregnant women and their children in low-income neighborhoods of New York from birth through 11 years of age. In their communities, these women and children are exposed to multiple common pollutants (including air pollution, pesticides, and second-hand smoke) that the study links to low birth weight, respiratory effects, neurodevelopmental disorders, and potentially increased cancer risk (CCCEH 2011).

The good news – yes, there is good news – is that this research already has played a key role in achieving positive policy change for health in New York City. Findings have helped inspire shifts away from diesel buses, extended bus and truck idling, and excessive congestion, and toward cleaner transit technology and policies. One result of this has been reduced personal prenatal exposures in the cohort of this study (Perera 2009). Another important aspect of this study is the role played by community partners in its design and execution. For over a decade, CCCEH has partnered with West Harlem Environmental Action for Environmental Justice on community-based participatory research, and this collaboration has engaged and empowered residents, enriched the science, and increased partners' capacity (Shepard 2009).

Recognizing such potential benefit for families and communities is powerful motivation for those of us working on environmental health and environmental justice. The societal incentives also include possibilities for reducing costs and strain on the health care system. A recent economic analysis published in *Health Affairs* assessed three strategies for addressing poor health outcomes: expanding health insurance coverage, delivering better preventive and chronic care, and enabling healthier behavior while improving environmental conditions. It concluded that only environmental protection slows the growth in the prevalence of disease and injury. In fact, when combined with the other two strategies, the study projected that in the first 10 years alone, environmental protection could save 90 percent more lives and reduce costs by 30 percent (Milstein et al. 2011).

When we first began traveling upstream, there was enough evidence to encourage that exploration. Today, environmental health science has progressed much further, strengthening the case for including upstream work in tackling health and equity concerns. Improved understanding of root causes,

together with better data and models, is helping funders evaluate, prioritize, and take action. As an example, the health team at The Kresge Foundation has launched a major initiative to improve health through improvements in housing conditions. They have identified benchmarks of progress (such as decreased lead exposure and reductions in asthma incidence and hospitalizations), along with return on investment indicators (such as costs for mitigation measures in a home in relation to lifetime benefits from reduced lead exposure and reduced health care costs related to asthma treatment) (The Kresge Foundation 2011).

## PHILANTHROPY UPSTREAM...AND DOWN

So what does this mean for grantmakers? Philanthropic approaches in this space are nearly as varied as the root causes and health outcomes of concern. But a few common themes emerge that offer potential lessons for others.

► ***Putting Communities at the Center*** – As we work to eliminate health disparities and inequities, we have few better allies than the organizations and community leaders seated in the neighborhoods most heavily affected. Capitalizing on local knowledge, expertise, and passion improves the effectiveness of our efforts, as well as building community capacity and resilience.

This lesson surfaced in a collaborative research project in California's San Joaquin Valley, initiated by community groups and involving a research team at the University of California-Davis (UC-Davis), with support from the Ford Foundation and The William and Flora Hewlett Foundation. The project compiled data on poverty, environmental conditions, and other factors to assess their cumulative impact on health outcomes. The UC-Davis researchers reported that community participants, given maps of federal and state data about local environmental hazards, documented and were able to fill in serious data gaps (London et al. 2011).

Cumulative impact assessment work in greater Los Angeles has similarly underscored the value of combining the knowledge base of a university consortium, community groups, funders, and public officials. The Los Angeles Collaborative for Environmental Health and Justice began with a review of environmental hazards in proximity to vulnerable populations, and has catalyzed a "clean up and green up" strategy to improve public health in particularly challenged neighborhoods through a mix of policies and actions (Los Angeles Collaborative for Environmental Health and Justice 2010).

With communities facing multiple stressors and

hazards, creating healthier daily conditions is a multifaceted, long-term effort. Philanthropic investment to strengthen local capacity can really help. So, too, can providing some flexibility of resources, especially to address problems or opportunities unforeseen at the outset.

The Gulf Coast Fund for Community Renewal and Ecological Health provides an acute illustration of this lesson. The fund, housed at Rockefeller Philanthropy Advisors, was born in the aftermath of Hurricanes Katrina and Rita. From its inception, it was designed in partnership with community leaders and crafted explicitly as a model of community-driven philanthropy, embedding local expertise in the fund allocation process. The fund also was designed with enough flexibility to deal with a wide array of problems, ranging from disaster relief services, to hazard monitoring, to long-term advocacy.

Grants from the fund address immediate health needs in communities across the region, such as support for local medical clinics, relief supplies, and safety equipment for residents cleaning out their homes and neighborhoods of toxic debris. It also has supported emergency housing for displaced residents, organizing and advocacy training, farm cooperatives and farmers markets, cultural programs, environmental health monitoring, and workforce development. The fund has increased support to a historically under-resourced region of the United States, as well as built capacity and relationships across the region that proved critical when the Deepwater Horizon drilling disaster occurred. (More information can be found at [www.gulfcoastfund.org](http://www.gulfcoastfund.org).)

Investing in community leadership and capacity can empower more effective responses to factors adversely affecting local health. It also tends to build resilience for addressing the next sets of challenges, whether from an economic downturn or an extreme weather event.

- ▶ ***Your “Health and Equity” Is Their “Environmental Justice”*** – One of our most encouraging discoveries in upstream work is that many potential allies and partners are out there. The communities that share health grantmakers’ core values extend far beyond health philanthropy. The landscape of work addressing determinants is surprisingly broad, crossing geographies, disciplines, and sectors. Such diversity and fragmentation expand possibilities but make it challenging to see the whole.

This positive reality also tends to be obscured by language. The ways foundations frame and describe their work are meaningful, but they also make it harder to see actual or potential connections across portfolio issues.

Quite often a project receiving support from a health funder focused on children’s health or health disparities may also attract grants (using a different proposal and vocabulary) from an environmental justice funder, a food systems funder, a community development or a social justice funder (and the list goes on).

Recognizing this dynamic, some funders focus more on shared concerns and objectives, and less on the words typically used to frame their work. They find grantmaking partners across traditional portfolio silos and new grantees across funding pools. These cross-cutting collaborations can bring critical resources to bear and improve the information base for decisions.

Work to improve health in communities of color and low-income communities provides a great example. For decades, community residents have organized around concerns about their families’ poor health and the dangerous and unjust concentration of environmental hazards around them. This “environmental justice” movement initially attracted funding mostly from environmental grantmakers. Still, the funding was disproportionately low: a study concluded that the environmental justice movement was seriously underfunded, receiving less than 5 percent of environmental grantmaking (Faber and McCarthy 2001).

Several funders seeking to broaden the pool of funding for environmental work recognized its public health value and worked to expand funding within health philanthropy, including in portfolios aimed at health disparities, vulnerable populations, and children’s health. Aided by collaboration between Grantmakers In Health and the Health and Environmental Funders Network, today the funding base for environmental justice is, while still far less than optimal, significantly diversified, with more support and leadership from health philanthropy (Bullard et al. 2011).

Many of health philanthropy’s contemporary concerns lend themselves to similar broadening of partnerships, whether around an intervention area (such as healthy eating and active living) or in efforts to mobilize civic engagement and political support for health care reform and implementation.

- ▶ ***Big Strategies for Big Problems*** – Some conditions worsening health and equity outcomes cannot be tackled by one sector or one local community. Many root causes of poor health have their own upstream story, whether it is economic forces or policy decisions at higher levels of political jurisdiction.

No single foundation can tackle these complex societal drivers in isolation. Health philanthropy, with its traditional orientation toward service and prevalence of geographic constraints, has been comparatively inhibited in seeing its place in strategic work around regional, national, or international systems change efforts. More and more health funders, however, are recognizing potential long-term health payoffs in broader systemic efforts.

For example, health funders now play active roles in multistakeholder collaborations and campaigns tackling specific determinants such as food access or substandard housing. Environmental health funders, drawing from both health and environmental interests, have partnered for years in a multifaceted strategy to tackle toxic threats to health from chemicals. This strategic collaboration has helped underwrite policy work from local to global jurisdictions, broad-based public engagement and consumer pressure, market shifts ahead of regulatory action, and innovative development of safer chemicals and materials.

We see similar potential for greater combined philanthropic impact on many major health issues. Strategies to address the alarming rates of asthma in communities of color, for example, could include work to improve access to care, treatment options, care giving, and impacted community capacity. This work would be complemented by efforts to reduce exposures to contaminants that trigger or exacerbate asthma, whether mold in housing, or particulate pollutants from diesel buses, or transportation corridors near homes and schools. Learning across these intervention areas could also identify new gaps or opportunities. Kids struggling to breathe do not care whether effective interventions fall into a “health,” “environmental,” or other portfolio. They want to breathe easily throughout their daily lives, which extend from home, to neighborhood, to school environments.

Likewise, philanthropic strategies to diminish the toll of breast cancer would include more and better screening for breast cancer, especially among communities of women experiencing higher rates of disease and mortality. It also should include more research and intervention on the preventable causes and support for campaigns to eliminate known carcinogens from our food, air, water, and personal care products. We cannot ignore the needs that exist downstream for early detection and better care. We also, however, need to focus upstream to stop preventable cases of breast cancer.

The point is that many discrete funding interventions alone can – and do – make a difference. But in combination and through collaboration, their cumulative impact

comes closer to matching the scale and complexity of the problem. Philanthropy can draw on – and needs to keep improving – the evidence base about both determinants and interventions. It also could be learning and working much more regularly in partnerships inside and outside philanthropy, toward more effective and strategic solutions.

### GRAB A PAIR OF BOOTS...

We know firsthand how overwhelming it can be to view health and equity in a broad social context. The forces constraining good health for all are numerous, complex, and powerful. The array of determinants can be daunting, and they often appear to be in arenas too far afield of a foundation’s mission and focus. Many health grantmakers seeking to follow an evidence base in guiding investments have, until recently, been on firmest ground staying within the familiar territory of access to care, quality of care, and service delivery.

For health philanthropy in particular, the urgency of meeting immediate needs has been a compelling preoccupation. It remains an essential focus. In fact, we often have found ourselves encouraging environmental grantmakers to extend their upstream focus on determinants to include downstream help for communities living in distress.

Recent progress toward more comprehensive health care coverage, however, may create space for additional health philanthropy upstream. The increasingly robust evidence base on health determinants has improved the case for doing so, and the landscape of new funding partners offers support and the chance for systemic impact.

So grab a pair of boots and look for us upstream. The water’s not bad, and together we can make it a lot healthier for everyone.

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# A ROADMAP FOR HEALTH EQUITY

Dolores E. Roybal, Executive Director, Con Alma Health Foundation

Con Alma Health Foundation (CAHF) was founded 10 years ago based on a health equity framework before the term “health equity” became “cool.” Our founders knew: “There is more to good health than lifestyle choices, genes, and access to health care. Individual health is often seen as a person’s own responsibility to make the right choices to stay healthy. But...the choices we make are limited by the choices we have” (NMSHEWG 2010a).

Although we are small as foundations go (assets between \$20-25 million depending on the market), CAHF is the largest foundation in New Mexico dedicated solely to health. We were established with the mission:

To be aware of and respond to the health rights and needs of the culturally and demographically diverse peoples and communities of New Mexico. The Foundation seeks to improve health status and access to health care services, and advocates for a health policy, which will address the unmet health needs of all New Mexicans.

Diversity of experience, talent, and viewpoints was incorporated into our structure from the beginning. Our board of trustees represents the racial/ethnic, gender, age, geographic, socioeconomic, and other factors that represent the diversity of the state. We also rely on a similarly diverse community advisory committee (CAC) to provide advice and recommendations concerning the performance of the foundation in achieving its charitable purpose and mission and in identifying and assessing the health needs of all New Mexicans.

## OPERATING FROM A HEALTH EQUITY FRAMEWORK

Promoting health and equity for all does not require major resources, but simply the desire to reframe the conversation about health (NMSHEWG 2010b). This commentary shares how one small foundation makes a difference, and how what we have learned can be applied to further improve the health of New Mexicans and the nation consistent with the Healthy People 2020 goals. Lessons learned, although specific to New Mexico, can be generalized to other locations.

## CORE VALUES

A key responsibility for foundation leadership is to maintain

awareness of CAHF’s core values and ensure that they are integrated into our work. The board, CAC, grantees, community partners, and other stakeholders, along with a talented and committed staff, are all involved in the fulfillment of the foundation’s mission and promotion of health equity. Although funding priorities and the environment might change, the core values and mission do not.

To fulfill the foundation’s mission, CAHF adheres to six core values to guide policies, operations, and grantmaking:

- **Improve the health status of all New Mexicans.** The foundation focuses on the needs of the uninsured and the medically underserved, and works to reduce health disparities by promoting greater access to health care and improved quality of health care (with a special emphasis on people of color and rural and tribal communities) in order to protect the rights of all New Mexicans to adequate health care. The foundation makes grants that emphasize the importance of education, prevention, and personal responsibility.
- **Maintain the public trust.** The foundation remains true to its corporate and charitable mission. It adheres to the highest standards of accountability by providing accurate financial and programmatic reporting and public disclosure, by adhering to a strong conflict of interest policy and code of conduct, by evaluating and reporting outcomes of grantmaking activities, and by engaging communities in dialogue and problem solving.
- **Involve, collaborate, and partner with New Mexico communities.** The foundation involves local and indigenous communities in its decisionmaking by appointing and electing members of these communities to policymaking and advisory positions. It engages all communities in health care needs assessments and evaluation processes, which facilitate community self-definition and self-determination, and which strengthen and develop their local community health infrastructure and institutions. The foundation makes grants to build the capacity of grantees to more effectively accomplish their health missions.
- **Innovate and lead.** Health is defined broadly to include components of environmental, psychological, emotional,

behavioral, oral, social, economic, and spiritual health and well-being, and searches for new solutions to old problems. It has the courage to risk failure in order to succeed. The foundation supports the identification, preservation, and communication of traditional practices that maintain, foster, and improve health.

- **Teach and learn.** The foundation develops partnerships with educational and health care institutions and grassroots community organizations to improve cultural and linguistic competencies. The foundation supports the development of health care professionals who reflect the cultural and linguistic diversity of New Mexico, resulting in greater opportunities for those under-represented in the health care fields, and supports the creation of new knowledge that broadens the understanding of health issues.
- **Be an effective advocate for health policy that supports the foundation’s charitable purpose and mission.** The foundation encourages consumer participation in health policy formation and individual health decisions to develop their skills and capacities so that consumers may become advocates in their own communities. It supports programs that provide analysis of health data and health policy issues and programs, which advocate health policy positions that foster the foundation’s mission. And it seeks to shape health policy and implementation consistent with the foundation’s mission and core values.

These values are incorporated into CAHF’s bylaws and featured at [www.conalma.org](http://www.conalma.org). They form a matrix not only for grantmaking and program activities, but also

for strategic planning and evaluation. They underpin everything we do, and we have evolved an ongoing internal culture of assessing our work based on the core values.

### HEALTH EQUITY IN NEW MEXICO: A ROADMAP FOR GRANTMAKING AND BEYOND

Relevant, accurate health care information is critical to addressing the complex health-related issues we face. In 2006 the board of trustees committed resources to a research project designed to help guide the foundation’s future grantmaking. The report, *Closing the Health Disparities Gap in New Mexico: A Roadmap for Grantmaking*, became the touchstone for the foundation’s grantmaking priorities and program initiatives.

The commitment to working from core values and relevant, community-based information is an ongoing effort. Based on our rapidly changing environment, we are currently updating the report to focus more explicitly on health equity and to incorporate primary data through community focus groups. The insights gained will bring a deeper understanding of issues and solutions to our work.

### HEALTH EQUITY

Health equity concerns “those differences in health that can be traced to unequal economic and social conditions and are systemic and avoidable – and so essentially unjust and unfair” (Unnatural Causes 2008). The terms “health disparity” and “health equity” are sometimes used interchangeably. Although related, there are specific differences

HEALTH DISPARITY	HEALTH EQUITY
Any difference in health between groups of people (based on geographic location, gender, socioeconomic status, or ethnicity).	The term is based on the belief that everyone is entitled to a healthy life.
Some health disparities are NOT unjust or inequitable (such as innate biological differences resulting in different mortality rates between males and females).	Health equity pursues the elimination of health disparities.
However, most health disparities are avoidable, often the result of social or economic conditions or policies (such as obesity and smoking rates or the incidence of cancer between lower- and upper-income families).	Good health requires not only the traditional approach, but must also focus attention to “address the broad policy and systems environment that influences health.”
Public health has traditionally attempted to reduce health disparities by targeting its interventions at individuals within vulnerable populations.	Health equity considers the status of the individual within a series of expanding contexts: family, religious/ethnic and other communities, geography, and the larger culture.

Source: Andress & Associates 2011

between the two concepts.

Achieving health equity depends on a broad policy focus; recognizing the role of government and social policy; collaboration to address social determinants; a multistakeholder and sector approach; public/government, nonprofits/philanthropy, and private/business; community understanding and participation; and support for civic capacity of the community, which is essential to understanding and changing policies and systems.

## FOCUS GROUPS: COMMUNITIES IN ACTION

As part of the process in completing CAHF's report *Health Equity in New Mexico: A Roadmap for Grantmaking and Beyond* (an update to the 2006 report), 15 focus groups were held, incorporating communities based on geography and on racial/ethnic background. The focus groups were structured to protect confidentiality.

The participants were public health consumers, health providers, policymakers, nonprofits, and other community leaders. The groups met at locations convenient for participants, and a detailed facilitation guide was prepared and distributed to facilitators and note takers to maintain consistency in approach and responses. CAC members and CAHF staff volunteered as either facilitators or note takers for each focus group. The CAC took the lead in recruiting local participants who were representative of their community.

State and local data profiles were provided, and participants were asked to respond to the "community snapshots" as a starting discussion point and to comment on their reactions to the descriptive data. The snapshots included indicators related to socioeconomic determinants of health, health outcomes, health status, health determinants, and health systems issues.

Focus Group Questions:

- Does this "snapshot" accurately describe your community?
- What are the priorities for health in your community?
- What do you want for the future of health in your community?
- What are the resources, strengths, and opportunities that promote health equity in your community?
- What are your ideas/solutions to promote health equity?
- Beyond funding, what role(s) should CAHF play in addressing health equity?

The responses were integrated into an overall answer to the question: What do New Mexicans want for health equity?

- Improved socioeconomic conditions
- Policies that advance health equity, especially for racially/ethnically diverse populations
- Bigger, more diverse health workforce, and more culturally competent providers
- Preservation and enhancement of cultural and spiritual assets
- Prevention, health promotion, and holistic health
- Increased access to quality and affordable health care

## SECONDARY DATA (NEW MEXICO DEMOGRAPHICS)

New Mexico is a very diverse state. The nation's population is also increasingly diverse: people of color are projected to comprise 54 percent of the country's population by 2050 (U.S. Census Bureau 2008). New Mexico is already a "majority-minority" state, defined as one in which the combined population of minorities exceeds the majority population. There are two large minorities: Hispanics (46.3 percent) and Native Americans (9.4 percent); African Americans comprise 2.1 percent.

The Hispanic population in New Mexico is an old one, descending from Spanish-speaking peoples who lived in the region before the territory was annexed by the United States. New Mexico is ranked first by percentage of Hispanics and fourth by population of Hispanics in the United States. New Mexico also has the second-highest percentage of Native Americans of any state, comprised of 22 Indian Tribes – 19 Pueblos, two Apache Tribes, and the Navajo Nation.

- The total New Mexico population is close to 2 million. New Mexico is the fifth largest state in the country, though it is ranked only 36<sup>th</sup> in population. It is a largely rural state with only three large urban areas.
- In 2011 New Mexico ranked 34 in health rankings overall out of 50 states, and has the second highest percentage of uninsured (21.6), behind Texas (24.6) (America's Health Rankings 2011).
- Although considered a young state, New Mexico will experience a large growth in the aging population in the coming years, moving from one of the lowest percentages of elders to one of the highest: from 39<sup>th</sup> in the nation to fourth in the percentage of people over the age of 65 by 2030.
- The overall percentage of the total population under the age of 10 is decreasing, moving from 31.1 percent in

2000 to 28.2 percent in 2010, but the proportion of the Hispanic population that is under 18 years of age is 58 percent, the largest in the United States.

Findings from the focus groups and updated secondary data were highly consistent with the foundation's mission, core values, and health equity framework. They were also consistent with the Affordable Care Act's (ACA) focus on prevention and on improving access and quality and with the goals of Healthy People 2020.

## ORGANIZATIONAL PRIORITIES AND STRATEGIC PLAN

Based on this information, the foundation will apply these priorities to grantmaking and program activity for the next few years:

- Health care access, especially in rural New Mexico
- Policies that address social determinants of health
- Prevention, nutrition, health promotion, and holistic health
- Needs of the increasing elderly and immigrant populations in New Mexico
- Linguistic and culturally appropriate services and workforce
- Behavioral health and health care reform

CAHF is in the process of updating its strategic plan for the next one to three years. The board, CAC, and staff identified these preliminary organizational goals:

### ➤ Continue to focus on health policy and advocacy.

- Operate from a framework of systemic change that includes issues of the economy, workforce development, health equity, diversity, racism, and cultural competence.
- Build strategies and demonstrate outcomes that have an impact on policy (such as health care reform and the growing needs of the aging population).
- Articulate to partners and stakeholders how we see our role in improving health in New Mexico and be specific about how we might do this.
- Focus on improving access to care and prevention.
- Support policy development through research, evaluation, and advocacy.
- Educate legislators, policymakers, and other

stakeholders on health policy.

- Prioritize and advocate for health policies that are consistent with the foundation's mission, core values, and funding priorities.

### ➤ Serve as a resource to New Mexico communities.

- Increase knowledge about CAHF statewide, and market CAHF as a resource.
- Serve as a clearinghouse for sharing data and information.
- Use CAHF resources to address systemic issues faced by the underserved, rural, and "below-the-radar" populations (elderly, rural, immigrants, uninsured).
- Strengthen outreach to Tribes, Pueblos, and the Navajo Nation.
- Support and facilitate cross-community communication and collaboration.
- Continue to participate in, convene, and facilitate community collaborations.

### ➤ Continue to build the capacity of the nonprofit sector, organizations, and communities.

- Provide information, support, and opportunities for nonprofit collaboration to assist in leveraging state and national funding opportunities.
- Provide education and technical assistance to communities, leaders, and grantees.

### ➤ Continue to strengthen the internal capacity of CAHF.

- Clearly articulate the mission, goals, and core values to grantees and other constituencies, emphasizing broad definitions of health and social determinants.
- Develop human and financial resources through leveraging state and national funding, and building the endowment.

## HEALTH EQUITY AND HEALTH CARE REFORM

The correlation between poverty, educational attainment, and good health is evident when comparing health outcomes for children and families and others in the United States. Developing solutions to these complex problems and ensuring that children, families, and communities benefit from the many opportunities that exist within the ACA will require the capacity to successfully implement federal health care reform across the state and advance health equity for racially and ethnically diverse populations (CAHF 2011).

Successful implementation of the ACA could directly improve the health of children and families across New Mexico and the country. The expansion of Medicaid eligibility to include all adults up to 133 percent of the federal poverty level, and the establishment of a health insurance exchange will increase access to affordable, high-quality health coverage for those who are currently uninsured. The emphasis on accountability for quality and effectiveness could result in a health care system that is responsive to the needs of children and families, eliminates health disparities, and promotes health equity. The new law also provides many opportunities to develop and implement health promotion, prevention, and wellness programs.

In order to promote health equity and support health care reform, CAHF engaged multisector participation through an advisory network charged with developing a comprehensive plan for implementing health care reform in New Mexico (with funding support from the W.K. Kellogg Foundation). CAHF also applied for support through the Grantmakers In Health State Grant Writing Assistance Fund, designed to offer grant writing assistance support to state government agencies to implement the ACA. As a result, the New Mexico Human Services Department was awarded \$34,279,483 for a Level One Establishment grant to develop and establish a health insurance exchange over the next 12 months. A Level Two Establishment grant application will be submitted in March 2012.

## SUMMARY AND RECOMMENDATIONS

Philanthropy, regardless of size or assets, can promote health and equity for all through a number of strategies and recommendations:

- Define health broadly to include components of environmental, psychological, emotional, behavioral, oral, social, economic, and spiritual health and well-being.
- Focus on the needs of the uninsured and the medically underserved.
- Respect and respond to the values and experiences of all peoples and communities.
- Make grants that promote systemic change and are outcome-oriented.
- Evaluate and report outcomes of grantmaking activities.
- Work to reduce health disparities by promoting greater access to health care and improved quality of health care (with a special emphasis on people of color, and rural and tribal communities) in order to protect the rights of all to adequate health care.
- Engage communities in meaningful dialogue and problem solving. Involve local and indigenous communities in decisionmaking by appointing and electing members of these communities to policymaking and advisory positions.
- Engage multiple sectors in promoting health equity.
- Engage all communities in health care needs assessments and evaluation.
- Support community self-definition and self-determination to strengthen and develop local community health infrastructure and institutions.
- Make grants to build the capacity of nonprofits to accomplish their health missions.
- Support the identification, preservation, and communication of traditional practices that maintain, foster, and improve health status.
- Search for new solutions to old problems.
- Support programs that provide analysis of health data and health policy issues/programs.
- Encourage consumer participation in health policy formation and advocate health policy positions that foster health equity.

CAHF is one example of health equity in action and how philanthropy can help move the nation's health agenda forward. Assets go beyond the dollars used for grantmaking. We also serve as a convener and a catalyst for positive, systemic change. Health equity is not simply a strategy; it is a requirement in order to improve health in our state and nation. As the saying goes, it's not how big you are; it's what you do with it.

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# Confronting the Health Determinants of School Success in the Early Grades: A Commentary from the Campaign for Grade-Level Reading

Ralph R. Smith, Vice President, The Annie E. Casey Foundation

The escalating concern about whether the United States will have a healthy workforce with 21<sup>st</sup> century skills prepared to compete in the global economy has fueled a reinvigorated push by many to reduce the number of students who leave school before graduating from high school. We know from abundant evidence that high school graduation leads to lower rates of health problems (HealthyPeople.gov 2011). In addition, the voices of retired military officers who crisscross the country remind us that we need both “military readiness” and technological know-how to ensure national security. Because high school graduates make up the pool from which the nation recruits its workforce, its military, and its college-goers, producing a generation of “college- and career-ready” high school graduates has become a cross-sector, bipartisan goal.

This growing consensus is mostly good news to those of us who also care about disrupting, reversing, and then ending intergenerational poverty. Haskins and Sawhill’s (2009) extensive review of the research confirms the common sense conclusion many of us reached long ago:

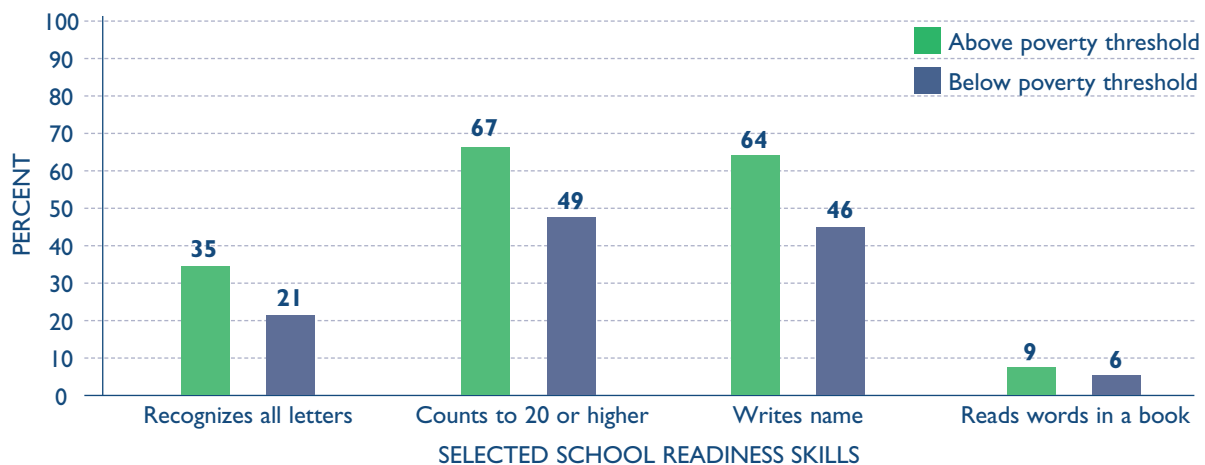
... if you want to avoid poverty and join the middle class in the United States, you need to complete high

school (at a minimum), work full time, and marry before you have children. If you do all three, your chances of being poor fall from 12 percent to 2 percent, and your chances of joining the middle class or above rise from 56 to 74 percent.

At first blush, the clarity and straightforwardness of this dramatic conclusion seem to cut against the increasingly vocal concern about declining social mobility. Then comes the realization that for many children of families in poverty, completing high school is *the* formidable hurdle. A recent study confirms that over 22 percent of children who live in poverty do not graduate from high school (Hernandez 2011). This figure rises to 32 percent for those children spending more than half of their childhood in poverty. These numbers reveal an ironic twist. The road out of poverty often is obstructed by the circumstances, conditions, and consequences of poverty.

This conundrum is one of the major challenges confronting the recently organized Campaign for Grade-Level Reading (GLR Campaign), organized and led by The Annie E. Casey Foundation on behalf of more 80 funders and two dozen sector-leading organizations across the country. A new

PERCENTAGE OF CHILDREN AGES 3-6 WITH SELECTED SCHOOL READINESS SKILLS, BY POVERTY STATUS



Source: O'Donnell 2008

front in the battle to improve high school graduation, the GLR Campaign is fueled by the research showing that reading proficiency at the end of third grade is a critical predictor of high school graduation. A recent longitudinal study to calculate high school graduation rates for children at differing reading skill levels by sociologist Donald J. Hernandez reports that children who are not reading proficiently by the end of third grade fail to graduate from high school at a rate four times greater than that for proficient readers. Other research findings suggest that 74 percent of those who miss this milestone never catch up (AECF 2010).

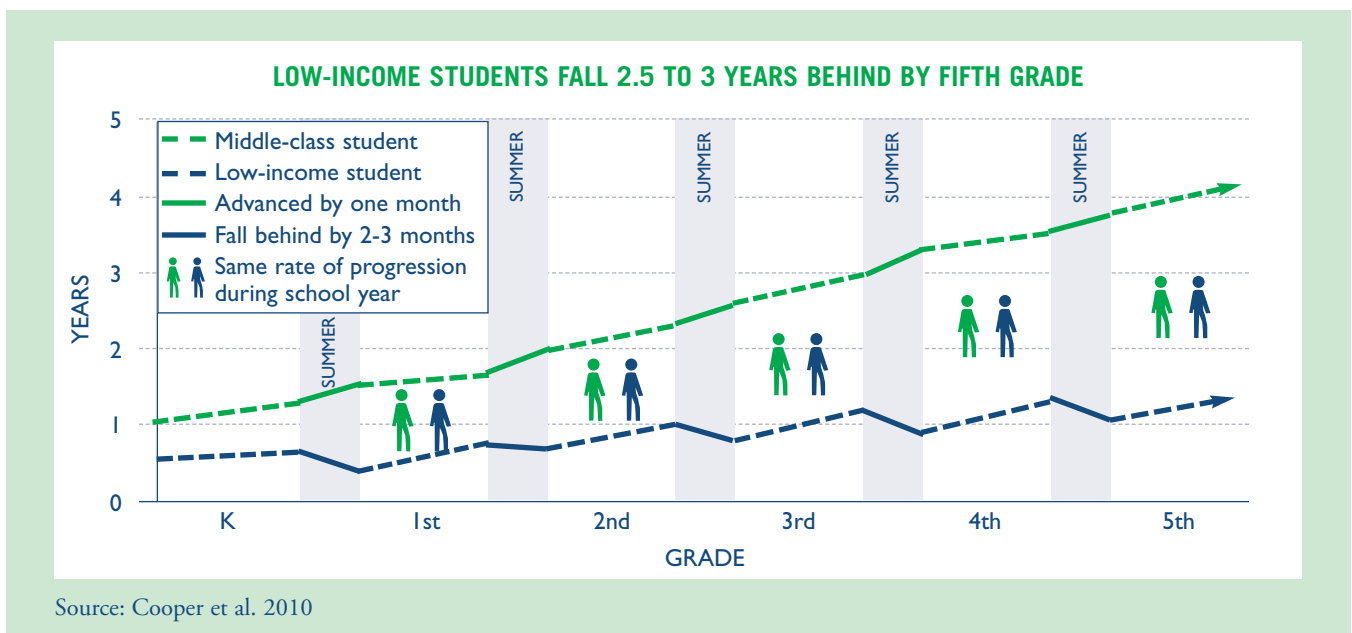
What ignited the GLR Campaign, however, is the reality, according to the National Assessment of Educational Progress, that over 80 percent, or four out of every five children of low-income families, miss this critical milestone (AECF 2010). They are not proficient readers at this pivotal juncture between learning to read and reading to learn. Translation: the children whose parents are poor are significantly less likely to attain the first rung on the ladder out of poverty – high school graduation.

Convinced that these alarming statistics could not be reversed by schools alone, the GLR Campaign launched a “call to action” to mobilize entire communities around ensuring the “on-track development” of vulnerable children. The campaign acknowledges that, over the long term, the key drivers of sustainable and scalable student outcomes are quality teaching for every child in every setting every day, and a less fragmented system of care, services, and family supports for children from birth through third grade. As important, however, is its call for communities to find locally-owned solutions for three of the major brakes on student

success in the early grades: 1) too many children are not ready for school and are so far behind that they simply cannot catch up by the end of third grade, 2) too many children miss too many school days and too much “time on task” instruction to keep pace, and 3) too many children lose too much ground over the summer and return to school in September having fallen behind where they were in June.

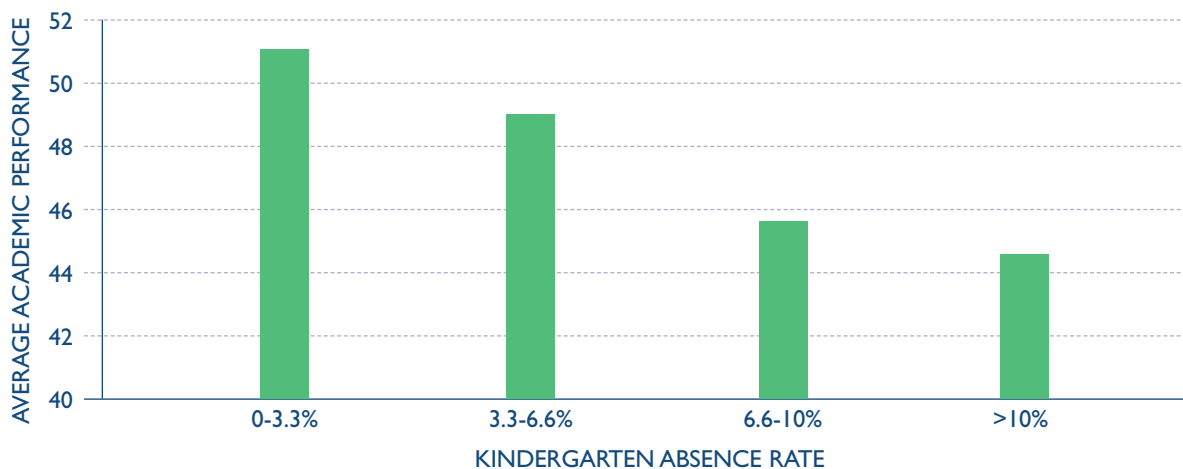
Poverty-related disparities in health care, health services, and health outcomes are deeply implicated in all three of these challenges – starting too far back, not keeping pace, and losing ground. There now is compelling evidence that the instability, trauma, and toxic stress that are hallmarks of poverty affect the architecture of the brain and thus the cognitive, social, and even physical development of young children. So does parental depression. The triggers and health hazards that come with unhealthy homes make asthma the top medical cause of school absence and elevated blood lead levels a major deterrent to on-track development. And the subpar nutrition that attends enhanced food insecurity over the summer months undermines even the best-intended efforts to address childhood obesity and to turn summer learning loss into summer learning gain.

In many respects, what is emerging is the realization that the grade-level-reading-by-the-end-of-third-grade predicate for high school graduation has a predicate of its own – confronting and ameliorating the poverty-related health determinants of “on-track development” and student success. That realization is prompting responses in significant quarters. Particularly notable is the recent policy statement of the American Academy of Pediatrics (2011) that calls on the entire pediatric community “to catalyze fundamental change





### CHRONIC KINDERGARTEN ABSENCE LOWERS 5TH GRADE READING SUCCESS FOR LOW INCOME STUDENTS



Source: Chang and Romero 2008

in early childhood policy and services...to reduce the precipitants of toxic stress in young children and to mitigate their negative effects on the course of development and health across the life span.”

A less fragmented system of care, services, and family supports would improve the likelihood of better prenatal care, periodic developmental screenings, early intervention, health insurance, and a medical home. And these, in turn, would allow considerably more confidence about achieving the

milestones for on-track development set by the campaign: children born healthy, thriving at three, ready for school at five, and present and engaged during the early grades. And yet, it seems unlikely that even a more robust and comprehensive combination of current reforms would aggregate up to the “fundamental change” the American Academy of Pediatrics urges. The interplay between the social determinants of health and the health determinants of school success commands urgent attention to persistent poverty itself.

*In the following exchange with Grantmakers In Health (GIH), Ralph Smith elaborates on both the ways in which children and families become trapped in poverty and how education and health can provide a way out. He notes that whether health funders work with the GLR Campaign specifically, or support the healthy development of young children more generally, they are in a position to provide important leadership. Their willingness to partner with educators and other sectors whose work involves children, like the housing community, is an essential part of this work.*

*Related to the focus of the GLR Campaign, GIH has reviewed the evidence linking poverty and health, explored how health foundations are working across sectors to improve health, and examined what philanthropy has learned about how best to design place-based strategies and comprehensive community change initiatives. This body of work is listed in the reference section.*

#### **1. You say that poverty itself poses obstacles to the path out of poverty. Can you elaborate?**

Success in school is essential to successful participation in today’s economy. High school dropouts are far more likely to be unemployed and, when employed, have incomes substantially below those of their more educated peers. They also will be less able to adapt to the new needs of a fast-changing global marketplace.

The irony is that, for many children of families in poverty, that first major step on the road to economic security and a productive adulthood – completing high school – is in itself a formidable hurdle. The ability

of these kids to learn – and learn at high levels – is impaired by a host of factors that come with being poor and living in tough neighborhoods where poverty is the norm.

Some of these factors are expected ones associated with education. Unlike many children in low-income families, more affluent children grow up in literacy-rich environments, with learning stimulated from an early age by parents who themselves have a solid education and by the ready availability of books and opportunities.

At least as important are the health-related factors. Low-birth weight is more frequent in poor communities, putting babies at high risk for developmental problems and attention deficit hyperactivity disorder (ADHD). Children in low-income communities have a higher incidence of health problems, ranging from the need for eyeglasses to developmental delays that interfere with learning. Moreover, poor children receive less, and lower quality, medical care than wealthier children with the same health problems. Indeed, many problems may go undiagnosed and therefore untreated altogether, because these children may not get regular checkups and screenings to identify developmental delays that can affect learning. Finally, constant exposure to toxic stress like instability, trauma, and violence affects both the individual child and the overall learning environment in a school full of poor children.

Today, we are fortunate to have – but also should be disquieted by – dramatic insights into how young brains develop. This knowledge shines a spotlight on what is missing for poor kids and why they start out in jeopardy and continue to fall behind. Yet, the work of folks like Jack Shonkoff and his colleagues at the Center on the Developing Child and Ruby Takanishi at the Foundation for Child Development continues to provide powerful evidence that reducing preventable disparities in well-being, while difficult, is no mission impossible. It is, as we say about many things worth doing, “an ambitious but achievable” goal.

## **2. Moving the needle on grade-level reading would seem a major educational challenge. Are schools up to the task?**

What happens in school makes an enormous difference. But with all of the challenges posed by poverty, we also know that the job of teaching is much harder and the risks that children won't succeed are much greater if the whole burden falls on the schools.

There is no doubt that schools can and must do better. Every child should experience quality teaching every day from teachers who are knowledgeable, skilled, and using an engaging curriculum set to high standards. Schools also need strong leadership to create a culture of high expectations and a climate conducive to effective teaching and learning. Dr. Pamela Cantor and her colleagues at Turnaround for Children are doing some intriguing work on what it takes to create that climate in high-poverty schools. Turnaround's whole-child model, now being used in 20 schools in New York City and Washington, DC, focuses on children's emotional and psychological well-being, as well as academics, acknowledging and addressing the stressful realities of life for children growing up in poverty. Teachers are trained in strategies to manage and curb behavior problems in the classroom, and in-school social workers are available to help students who need more extensive help. Principals in Turnaround schools report that they are seeing a dramatic improvement in their schools' atmosphere.

While schools must be held accountable, the truth is that they cannot succeed if forced to go at it alone. Families and communities have a critical part to play in creating the conditions that will enable a quality teacher to be effective. Children's cognitive, physical, social, and emotional development must be nurtured from birth and throughout their early years, so that when they begin school, they are ready for what schools have to offer. As students, they need to be present, healthy, well-nourished, and engaged in the learning process. Parents need to be prepared and supported to become partners in the development and education of

their children. And learning cannot stop at the end of the school day and school year. Children need access to opportunities that promote out-of-school learning and prevent learning loss over the summer months, which today takes a particular toll on those in low-income families.

The challenges of children not ready for school, too many missing too much school, and losing ground over the summer are both consequential and amenable to community solutions. That's why the campaign has made these the opening salvo in our effort to organize the civic space around schools and to mobilize communities to assure the success of all their children. We believe that, working together, effective schools, empowered parents, and mobilized communities combine to make the difference.

### 3. How can health funders help?

There is a short and direct answer to that question. Over 100 communities across the country have agreed to take on the GLR Campaign's "call to action." Health funders can join and support local coalitions in putting a stake in the ground around grade-level reading by the end of third grade. They can help by leading efforts to improve the "health determinants" of readiness, attendance, and summer learning. And they can help by continuing to support important work like the Green and Healthy Homes Initiative that now, across the country, is improving families' health and economic stability by simultaneously increasing their homes' energy efficiency and dealing with problems that lead to asthma, lead poisoning, and injury.

There is a longer answer, as well. The campaign needs the advice, guidance, and good counsel of health funders. We need to benefit from their experience and lessons learned about each of the developmental milestones. Moreover, health funders can be important contributors to each of the campaign's overarching strategies – building a big tent, promoting more effective philanthropy, and investing to accelerate change in promising places and to scale the most promising programs.

For any number of reasons, health funders already seem to be tilting more of their dollars toward two changes in prevailing philanthropic practice encouraged by the campaign – more investment in what works, and better alignment and sequencing of investments to yield better outcomes and greater impact. By lifting exemplars of these practices within their own sector, health funders can inspire others to follow suit and thereby promote more effective philanthropy.

Notably important is the leadership that health funders can provide to advance the more integrated system of care, services, and family supports from birth through third grade to which the campaign aspires. This system must rely on significantly more cooperation and collaboration between the two "systems" that have contact with every child from prenatal on – family and health. Unless and until these ubiquitous systems each do better and do better together, the rest of us are unlikely to succeed with the larger systems reform and integration agenda.

The good news is that we already have some wonderful examples of families and the many systems that serve them joining forces to improve child outcomes. One of my favorites is Reach Out and Read in which pediatricians "prescribe" reading and give children a new book at each well-child visit through age five. Another favorite of mine is the B'more for Healthy Babies Campaign that is mobilizing the local medical community and a host of public, philanthropic, and nonprofit partners to provide essential services and guidance to pregnant women and young parents. The early results around infant mortality are quite promising.

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## GIH SELECTED RESOURCES ON POVERTY AND HEALTH:

*Pathways Out of Poverty: Exploring New Directions for Health Funders*  
Grantmakers In Health, November 2007

*Social Policy Is Health Policy: Addressing the Economic and Social Determinants of Health*  
Grantmakers In Health, October 2008

*Expanding the Circle of Allies*  
Risa Lavizzo-Mourey, President and CEO, Robert Wood Johnson Foundation, June 2009

*Initiatives in Education, Economic Development Present Challenges, Yield Big Rewards*  
Joseph Rosier, Jr., Rapides Foundation, June 2009

*Tackling the Tough Work of Community Change*  
Grantmakers In Health, March 2010

*What’s in a Name? Untangling Health Disparities, the Social Determinants of Health, and Health Equity*  
Grantmakers In Health, March 2010

*Health and Justice: Health Care for People Involved in the Justice System*  
Grantmakers In Health, March 2010

*Healthy and Safe Housing: A Foundation for Healthy Futures*  
David Fukuzawa, Program Director for Health, The Kresge Foundation, and Rebecca Morley, Executive Director, National Center for Healthy Housing, September 2010

*Supporting Children’s Healthy Development: Place DOES Matter*  
Grantmakers In Health, March 2011

*Race to the Top: Is Children’s Health in the Running?*  
Judith C. Meyers, President and CEO, Children’s Fund of Connecticut, September 2011

*Healthy Places NC: Better Results through Place-Based Philanthropy*  
Karen McNeil-Miller, President, and Allen J. Smart, Director-Health Care Division, The Kate B. Reynolds Charitable Trust, January 2012

*Too Few Choices, Too Much Junk: Connecting Food and Health*  
Grantmakers In Health, March 2012

These resources can be accessed at [www.gih.org](http://www.gih.org).