# 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):

> 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.

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

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

***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).***

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.

> ***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).***

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 leadership, 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.

***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).***

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 professionals 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;
- 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 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 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 risks and work differently. The country can ill afford another "lost decade" of stagnating and declining health among its most vulnerable populations.

> ***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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