

GIH

EFFECTIVE COMMUNITY PROGRAMS TO FIGHT HEALTH DISPARITIES

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FOREWORD

As part of its continuing mission to serve trustees and staff of health foundations and corporate giving programs, Grantmakers In Health (GIH) convened a group of grantmakers and health disparities experts on November 20, 2008, for an informative discussion about community-level efforts to address health disparities. The Issue Dialogue meeting Effective Community Programs to Fight Health Disparities synthesized continuing research on disparities and the progress made in key areas affecting health status or health care inequalities in various minority and underserved populations. Specific illustrative examples of community-level and foundation-driven local initiatives aimed at reducing or eliminating health disparities were also provided. This Issue Brief summarizes background materials compiled for the meeting and highlights key themes and findings that emerged from the day's discussion among participating health funders.

Special thanks are due to those who participated in the Issue Dialogue but especially to the presenters: Anthony Iton, Alameda County Public Health Department; Mildred Thompson, PolicyLink; Grace Caliendo, John Muir/Mt. Diablo Community Health Fund; and Ginger Harrell, The Colorado Trust.

Lauren LeRoy, president and CEO of GIH, moderated the Issue Dialogue. Alicia Thomas, senior program associate at GIH, wrote the background

paper and synthesized key points from the Issue Dialogue into this report. Additional support was provided by Faith Mitchell, vice president at GIH, who helped plan the program, and Leila Polintan, communications manager, who provided editorial assistance to this report.

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EXECUTIVE SUMMARY

EFFECTIVE COMMUNITY PROGRAMS TO FIGHT HEALTH DISPARITIES

Eliminating disparities in health status and health care has been an area of substantial interest and programming among health funders at the national, state, and local levels for well over a decade. As we draw closer to the Healthy People 2010 deadline for eliminating disparities, the latest findings from research and ongoing experience on the ground allow us to assess the progress being made on this critical goal. Engaging with communities in their fight against disparities is also becoming increasingly important to funders. Examples of strategies and interventions provide a framework of practical steps to success that can be used in funders' efforts to eliminate health disparities.

Though U.S. citizens have enjoyed substantial improvements in their health over the last century, not all groups within this country have fared as well. In particular, the health status and outcomes of minority groups and low-income individuals have persistently lagged behind those of whites and higher-income groups. These disparities in health are evidenced by higher rates of illness and mortality and lower life expectancy rates. Research indicates that disparities also have a deleterious effect on the access and quality of health care received by these disadvantaged populations.

The persistence of disparities in this country has been attributed to the lingering effects of racism and discrimination; breakdowns in social, environmental, and community conditions; and ongoing problems

with access and quality of health care. These interwoven factors continue to have major effects on the overall health status and outcomes of communities by limiting or denying a variety of opportunities to disadvantaged and underserved individuals.

In order to enjoy long-term, sustained success, research indicates that disparities-elimination efforts must involve local communities and consider their unique needs. Regrettably, basic infrastructures or service systems are more often lacking or in a state of disrepair in racially or ethnically segregated and lower-income communities. Limitations at these fundamental levels intensify the daily challenges individuals face, further restricting their access and exposure to health-promoting behaviors and services.

Traditional disparities-elimination approaches generally focus on medical intervention models and downstream strategies related to changing individual behaviors and knowledge. Combating health disparities through this lens does not address the underlying conditions—the upstream factors—that lead to disease and mortality. Targeted work to alleviate the complex underlying conditions related to upstream socio-ecological determinants, however, appears much more promising. In essence, until these socio-ecological conditions are addressed, diseases will continue to disproportionately burden underserved communities.

The Issue Dialogue *Effective Community Programs to Fight Health Disparities* provided an opportunity to discuss community-level programs and specific roles health philanthropy can play in addressing the factors contributing to health disparities. Information was provided on a number of opportunities and strategies, as well as challenges, funders may face. The importance of data and tracking disparities at the community level was also noted. These discussions underscored both the value of, and strategies for, directly involving communities in efforts to combat disparities.

Strategies offered to health funders involved in disparities-elimination work included internal organizational capacity-building activities, policy-level approaches to affect change at the highest governmental and institutional levels, and approaches for engaging communities and other relevant stakeholders.

The discussion of these strategies included the following points:

- Ensure strong governing support and participation in efforts to fight health disparities. Boards and organizations must have a willingness to learn new things, take risks when necessary, provide adequate funding, and be patient to stay the course for long-term success.
- Encourage advocacy for public and private policies that address the broader determinants of health, as well as for specific disparities-related issues.

- Consider the creation of a Surgeon General’s report on health equity in the United States. A higher-level declaration of the costs of ignoring health equity among all populations, not just low-income groups, could be an important statement.
- Listen! Funders must realize that they cannot unilaterally make decisions about what is needed in a community or about the strategies that should be employed. Instead, a planning process should be funded with an assessment of the stakeholders to include in designing and implementing initiatives.
- Tackle agency and organizational silos, which can allow for increased communication and mutual goal setting across federal, state, and local agencies. Allowing more flexible spending of current health funding may also help break down silos and increase cross-sectoral collaborations.

Presenters stressed the importance of community capacity building for changing the context and conditions in disadvantaged neighborhoods. Capacity-building efforts strengthen a community’s ability to develop, implement, and maintain effective programs that positively affect the broader conditions responsible for better health and well-being. Specific roles foundations can play in this area are as:

- funders who are willing to support long-term strategies, as well as mandate specific requirements for community involvement;
- catalysts who influence the field, and educate and change policies and organizational practices;
- conveners who bring diverse groups to the table and foster new coalitions and networks; and
- leaders who provide increased knowledge and skills, promote research and evaluation, and frame new and innovative approaches and program practices.

Eliminating health disparities remains a priority in this country and requires a reexamination of underlying

factors. Efforts to alter these factors will require a multi-pronged approach that combines public and private sector expertise and resources. There are many opportunities for health funders to be effective in this arena as they either begin their involvement in disparities-related work or deepen their commitment. This work may be challenging for funders because it is complex, involves systemic changes, and requires fortitude and patience in order to affect lasting change. There is no time like the present, however, to roll up our collective sleeves and step into the battle of a lifetime.

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INTRODUCTION

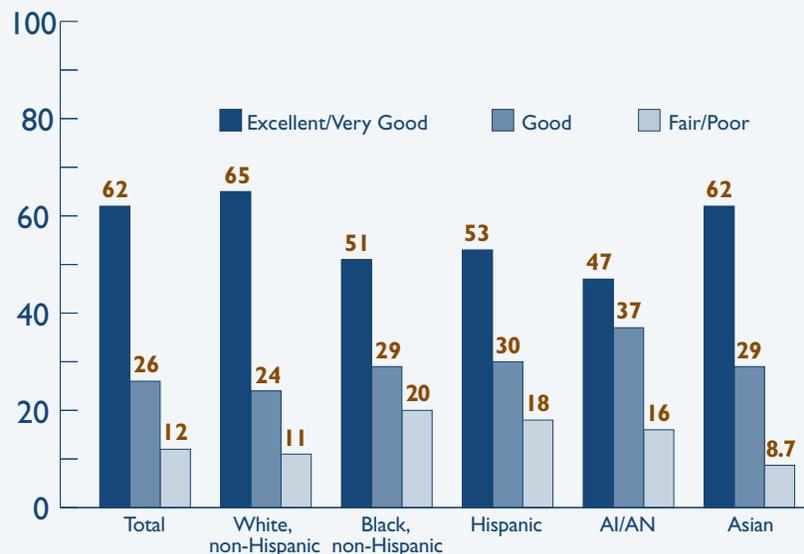
The World Health Organization (WHO) defines health as “a state of complete physical, mental, and social well-being, and not merely the absence of disease or injury” (2006). This definition goes beyond traditional health care to include factors such as individuals’ genetic makeup and personal health and behaviors, as well as social and economic conditions within communities. Despite substantial improvements in the health of U.S. citizens over the last century, the health status and outcomes of minority groups and low-income individuals continue to lag behind those of whites and higher-income groups. These persistent differences are generally referred to as disparities in health or health disparities, used interchangeably throughout this report.

What Causes Health Disparities and Just How Bad Are They?

Health disparities exist within a broader social context in which various health- and nonhealth-related factors interact to influence health outcomes experienced by disadvantaged groups.

In addition to racial and ethnic minority populations, disparities affect groups based on socioeconomic status, geography, gender, age, sexual orientation, and disability. In general, disparities occur in populations that have persistently experienced discrimination, social disadvantage, or other historical trauma and subsequently

Figure 1: **Self-reported Health Status Among Adults Aged 18+, 2005**



Note: Data are age adjusted
Source: Mead et al. 2008

AI/AN = American Indian/Alaska Native

DEFINING DISPARITIES

There are several formal definitions of *health disparities*, all of which agree that disparities are inequitable differences that affect health status and health outcomes for certain social groups.

The Minority Health and Health Disparities Research and Education Act of 2000 describes *disparities* as differences in “the overall rate of disease incidence, prevalence, morbidity, mortality, or survival rates,” noting that several factors contribute to health disparities.

Healthy People 2010 defines *disparities in health status* as the “unequal burden in disease morbidity and mortality rates experienced by ethnic/racial groups as compared to the dominant group.”

The 2002 Institute of Medicine report *Unequal Treatment* defined *disparities in health care* as “differences in the quality of health care that are not due to access-related factors (such as individual insurance status or income level) or clinical needs, preferences or appropriateness of intervention.”

Sources: U.S. Government Printing Office 2000; HHS 2000; Smedley et al. 2002

experience poorer health or greater health risks.

Sources of racial and ethnic disparities in health are “complex, rooted in historic and contemporary inequities, and involve many participants at several levels, including health systems, health professionals, and patients” (Smedley et al. 2002). Thus, disparities can occur as a result of a mixture of factors such as income, education, insurance status, and other features that influence health status and health care access and quality.

Health Status

Illustrating disparities in general health status, Figure 1 highlights individual racial groups’ subjective

rating of their health (Mead et al. 2008). It is evident that all minority groups, with the exception of Asian Americans, were more likely to report their health status as “fair” or “poor.” Leading causes of death and health status indicators such as infant mortality rates are also measures used to capture health status disparities across populations (Exhibit 1) (CERD 2008; Mead et al. 2008). Variability exists in trends across causes of death and health status indicators, though many, such as life expectancy rates, appear to be improving over time. Unfortunately improvements in some indicators are inequitably distributed across population groups based on race/ethnicity, income, education, or geographic location. In recent years, some areas have not experienced

All minority groups, with the exception of Asian Americans, were more likely to report their health status as “fair” or “poor.”

progress as rapidly as in earlier years; others have been increasing, as in the case of children's and adults' obesity rates (National Center for Health Statistics 2007).

Health Care

The issue of racial and ethnic disparities in health care was raised to national prominence by the release of the 2002 Institute of Medicine report *Unequal Treatment* (Smedley et al. 2002). In

general, disparities in health care are associated with systems-level barriers that block people's access to quality health care delivery systems. Examples of such barriers include linguistic difficulties, low health literacy levels, mistrust of health care systems based on real or perceived negative experiences, limited access to regular sources of care, scarcity in the availability of diverse health care workforce professionals, and health care financing system barriers.

EXHIBIT 1: DISPARITIES IN KEY HEALTH STATUS INDICATORS, 2008

Cancer: Cancer statistics indicate that African Americans tend to experience higher incidence and mortality rates from many cancers that could be cured through early diagnosis and treatment. African Americans are more likely than whites to suffer and die from colorectal, prostate, and cervical cancer. Also, though white women have the highest incidence of breast cancer, African-American women have the highest mortality rate among all racial groups.

Cardiovascular Disease: Although heart disease was the leading cause of death among all groups in the United States in 2003, mortality rates for African Americans were much higher than for whites. In general there is a higher prevalence of heart failure, coronary heart disease, hypertension, and stroke among African-American women as compared to white women. Heart failure, hypertension, and stroke prevalence are higher for African-American men than white men.

Diabetes: Diabetes is a critical chronic condition that can serve as a major risk factor for many other disorders, including heart and kidney diseases. Diabetes is more likely to affect racial and ethnic minority groups than whites in the United States, with American Indians/Alaska Natives at greatest risk. Nearly 20 percent of this population have diabetes and are twice as likely as whites to have the condition. Nearly 15 percent of African Americans and 14 percent of Hispanics suffer from the condition as compared to 8 percent of whites.

Once individuals are inside the health care delivery system, there may then be issues with the quality of care they receive. As with disparities in health, numerous factors contribute to differences in quality across populations. These factors include difficulties in patient-provider communications due to language barriers or provider cultural competency issues. Individual provider bias or discrimination in providing differential treatment to certain groups also plays a role in outcomes (Smedley et al. 2002).

HIV/AIDS: HIV/AIDS prevalence rates are one of the most striking health disparities in this country and have reached epidemic proportions among many minority populations. African-American and Hispanic women account for 82 percent of reported AIDS cases. In 2005 African-American women comprised 66 percent of new HIV infections, were infected at a rate of 23 times greater than that of white women, and suffered AIDS as the leading cause of death for women aged 25 to 34. The AIDS diagnosis rate is also four times greater for Hispanic women than whites.

Infant Mortality Rates: Infant mortality statistics show African Americans to be the most impacted among all U.S. racial/ethnic groups. Their infant mortality rate is almost 2.5 times higher than that of whites (13.6 vs. 5.66, respectively, per 1,000 live births), followed by American Indians/Alaska Natives at approximately 9.0 per 1,000 live births. A notable finding is that despite higher socioeconomic status, African-American women with college or graduate degrees often experience higher infant mortality rates than white women with less than a high school education.

Life Expectancy: Life expectancy measures are another commonly used measure for gauging the health of populations. Since the beginning of the 20th century, life expectancy at birth in the United States has increased, including a narrowing of the gap between African Americans and whites. Despite these promising trends, disparities still exist: African Americans can expect to live 6-10 fewer years than the 78 years of life expectancy of whites.

Source: CERD 2008; Mead et al. 2008

THE IMPORTANCE OF UNDERSTANDING AND ADDRESSING HEALTH DISPARITIES

With an increasingly diverse U.S. population, persistent health disparities will have a greater impact on the country’s overall health status. Minority groups comprised approximately 34 percent of the population in 2000 (Mead et al. 2008). This figure is projected to rise to 50 percent of the population by 2050, with Hispanics representing the fastest-growing minority group (Figure 2). Beyond the moral and ethical dilemmas posed by inequities in health outcomes, there will likely be an increase in the number of individuals at risk for disease, shorter life expectancies, or poorer quality of life and health care as the proportion of minority populations continues to grow (Mead et al. 2008).

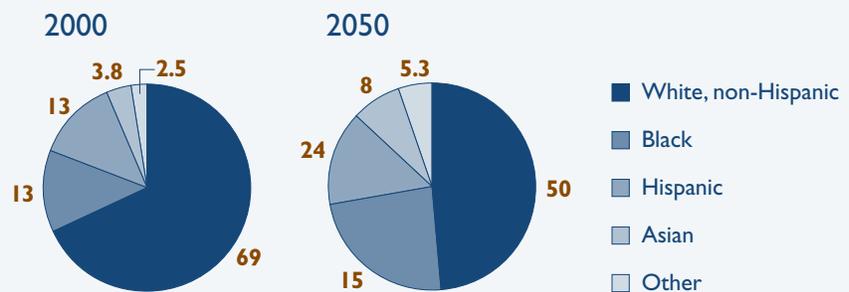
“We can predict who bears a disproportionate burden of [social, economic, and health] shocks. And, with that ability to predict it, we should be courageous enough to try to change the conditions, build resiliency in those communities and those populations so that they can better withstand the inevitable shocks that move through society.”

– Dr. Anthony Iton,
Alameda County Public Health
Department

Disturbingly, the persistence of disparities is attributed to the lingering effects of racism and discrimination; breakdowns in social, environmental, and community conditions; and ongoing problems with access and quality of health care. These interwoven factors often have

major impacts on the overall health status and outcomes of communities. A troubling facet of health disparities is the evidence that, even when overall health trends improve and socioeconomic factors are taken into account, racial and ethnic disparities often persist.

Figure 2: **Projected Percentage Change in Racial/Ethnic Composition of the United States Population, 2000 to 2050**



Note: Numbers add up to more than 100 percent because of rounding and because some categories are not mutually exclusive.
Note: “Other” includes the following categories: American Indian/Alaska Native, Native Hawaiian/other Pacific Islander, and two or more races.

Source: Mead et al. 2008

RACISM AND COMMUNITY HEALTH OUTCOMES

The Cherishing Our Hearts and Souls Coalition (COHS) provides an example of a local community-based collaborative, through the Harvard School of Public Health, aimed at exploring racism's effects and improving the cardiovascular health and wellness of African Americans and underserved residents in Massachusetts neighborhoods. COHS includes stakeholders ranging from community-based organizations, to local residents, to human and social services agencies. The coalition focuses on building social capital within the community, reducing risk factors, addressing racism, and enhancing stress coping skills through community-based problem solving regarding the impact of racism on health and its link to health disparities. Evaluation results indicate that the coalition has been extremely successful in educating the general public and community health care providers about issues of racism and cardiovascular disease (Harvard School of Public Health 2008).

The Lingering Legacy of Racism and Discrimination on Health Outcomes

Although discrimination on the basis of race or ethnicity is now illegal in health care, education, employment, and housing, its legacy and persistence in this country have had powerful effects on the health status of minority groups. Though discussions of race often center on the experiences of African Americans, other racial and ethnic groups such as American Indians, Asians, and Hispanics have also experienced systematic racism (Thomas and Crouse Quinn 2008).

Over the past 50 to 60 years, racial attitudes have improved significantly from the almost universal beliefs in the inferiority of minority groups and the need to have “separate but equal” public

services according to race. Currently there are more egalitarian attitudes regarding integration and equality (PolicyLink 2002). Nonetheless, overt and subtle racial attitudes and discriminatory practices continue to create structural or institutional inequities and facilitate the process of diminishing opportunities for some groups.

Discrimination's effects reach broadly into the health care delivery system, often exacerbating health conditions that can lead to illness or mortality. Understanding the historical and contemporary forces involved in racism, discrimination, and segregation is necessary for engaging in structural and institutional changes to provide quality educational opportunities, increase employment wages, and improve social factors in disadvantaged neighborhoods (CERD 2008).

“If you ignore history in this, you're irrelevant to this whole notion of eliminating health disparities. You've got to understand the history of racism, discriminatory belief systems, and social exclusion; you've got to understand how these patterns were created, enforced, and are still having manifestations today.”

– Dr. Anthony Iton,
Alameda County Public Health
Department

Communities and Disparities

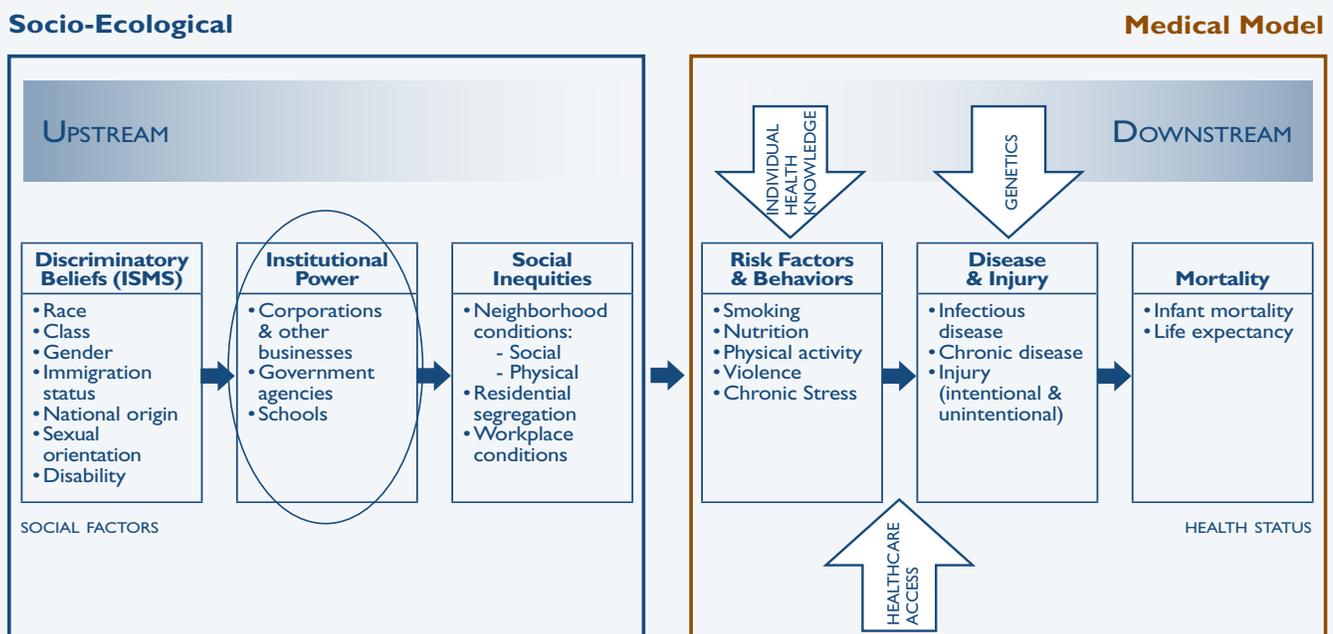
The Centers for Disease Control and Prevention’s (CDC) guiding principle for improving U.S. minority health states that:

[T]he future health of the nation will be determined to a large extent by how effectively we work with communities to reduce and eliminate health disparities between non-minority and minority populations experiencing disproportionate burdens of disease, disability, and premature death. Across the country, communities are often afflicted with risk factors that profoundly impact individual and overall community health. This is especially the case among minority and low-income communities,

which often have the worst social, economic, and health care access/quality conditions, with a correspondingly high level of health problems (CDC 2008).

Efforts to eliminate or reduce disparities must involve local communities and consider their unique needs. Essentially these needs revolve around issues such as adequate housing; high-quality schools, health care providers and facilities, food distributors, and recreational areas; access to transportation and employment opportunities; and limited exposure to environmental toxins, crime, and violence (PolicyLink 2007). Regrettably, basic infrastructures and service systems are more often lacking or in a state of disrepair in racially or ethnically segregated and lower-income communities.

Figure 3: **A Framework for Health Equity**



Source: Iton 2008b

Limitations at these fundamental levels intensify the daily challenges individuals face, further restricting their access and exposure to health-promoting behaviors and services.

Increasing attention is being paid to the influence community factors have on individuals and the overall health of residents and their communities. Across the United States, numerous local-level disparities-elimination initiatives target specific health conditions or underserved populations in geographically diverse areas. These initiatives have focused on issues such as combating the effects of racism, improving educational or economic opportunities, increasing social cohesion, or increasing access to quality health care.

A useful conceptual framework for health equity was presented at the

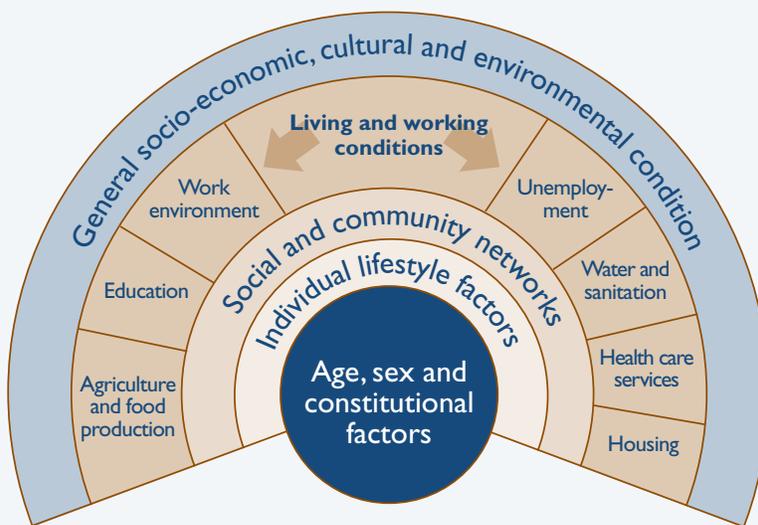
Issue Dialogue (Figure 3). The framework provides an upstream approach that moves from a downstream focus on medical causes of death, common diseases, and risk behaviors to an examination of broader upstream socio-ecological factors. These upstream factors include the social inequities affecting neighborhood conditions, institutional decisions that help create those conditions, and the discriminatory beliefs that shape the priorities of affected institutions.

Social and Economic Determinants of Health

Numerous factors work in concert to influence health (Figure 4) (Dahlgren and Whitehead 1991). Research is increasingly focusing on the roles of social, economic, and environmental

Increasing attention is being paid to the influence community factors have on individuals and the overall health of residents and their communities.

Figure 4: **Social Determinants of Health**



Source: Dahlgren and Whitehead, 1991

conditions (also known as the social and economic determinants of health) as powerful factors influencing health, quality of life, and life expectancy.

Disparities in health status often mirror inequities in the broader social and economic determinants of health (McGinnis et al. 2002). These determinants include social factors (such as income, employment status and working conditions, education, violence/crime, social networks, and community cohesion) and environmental factors related to both the natural environment (such as air, soil, and water quality) and the built environment (which includes housing, transportation, and community design) (BCBSMA 2008; Prevention Institute 2002).

The social and physical conditions people live in can facilitate or constrain their ability to avoid diseases and improve their overall health. Communities that shoulder a disproportionate amount of unequal health outcomes are often more economically challenged, racially and economically segregated, and more likely to have fewer resources (PolicyLink 2002). Overall, the convergence of poverty, social factors, the physical environment, and race/ethnicity in neighborhoods can produce detrimental conditions that directly or indirectly affect health through exposure to environmental toxins or the promotion of unhealthy behaviors that can lead to illnesses (Beyers et al. 2008).

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COMMUNITY SOCIAL FACTORS

Neighborhood or place-based social factors play a role in determining health outcomes that manifest over an individual's life course. A neighborhood or community's "environment" is considered "anything external to individuals shared by members of the community," including established behavioral norms (PolicyLink 2007). The impact of place-based factors varies based on the size, geography, culture, or composition of specific communities. The overall population, however, is often healthier in communities displaying more of the protective factors that influence positive personal behaviors, preventive activities, or disease management (Prevention Institute 2002).

Public health practices do not always incorporate the implications of "place" and other underlying conditions in communities that influence people's behaviors. Institutions such as government agencies, schools, and businesses shape many community policies and may skew resources away from disadvantaged populations. Poor communities are often most affected by exacerbating conditions, such as weather emergencies, and institutional crises, such as housing and mortgage system failures. Within these communities, there should be a greater focus on increasing the resources and resilience of affected groups. Until hazardous social and environmental conditions are changed on the ground, deleterious health outcomes may continue to burden underserved communities.

Socioeconomic Status and Employment

Income and wealth are some of the most significant influences on an individual's health. They provide

the means for meeting basic living and health-related needs, as well as facilitating healthier choices and behaviors. Unemployment can have a major negative impact on health status due to the limitations it places on individuals' access to even the most fundamental needs. Additionally, most people's income and wealth are derived from their employment. Estimates indicate that approximately 40 to 50 percent of American adults' waking hours are spent at work (MacArthur Foundation 2008). Therefore, working conditions and physical and psychological demands of jobs can play a key role in influencing an individual's overall health.

Lower socioeconomic status (SES) is associated with negative health impacts that tend to accumulate over time and persist throughout the lifespan. Individuals with lower median family incomes, another indicator of economic status, often display poorer overall health (CERD 2008). Many minority groups have significantly lower income levels than whites, and therefore face more

"Whatever we do in terms of designing interventions, we have to improve the health status of people at the lowest end of the socioeconomic spectrum because that will help everyone."

– Dr. Anthony Iton,
Alameda County Public Health
Department

INCREASING HEALTH, EMPLOYMENT SKILLS, AND OPPORTUNITIES IN DISADVANTAGED COMMUNITIES

Los Angeles' Pico Union/MacArthur Park community is predominately low-income and minority (approximately 77 percent Latino population). The community received a grant through the Los Angeles Economic Development Zone to provide educational and work skills training and employment services to its unemployed and underemployed community residents. The program also provided a licensed vending program that opened a restaurant offering more nutritious, culturally appropriate foods to the community.

Results achieved by the program included increased job preparation and training for individuals with limited job skills and income opportunities, as well as an increased availability of affordable, nutritious food options (Prevention Institute 2003).

“If we keep the [American school] system as it is, millions of children will never get a chance to fulfill their promise because of their zip code... their skin color... or the income of their parents. That is offensive to our values and an insult to who we are.”

– Bill Gates, as quoted by Dr. Anthony Iton, Alameda County Public Health Department

exposures to health risks (Figure 5) (Mead et al. 2008). As individuals ascend the socioeconomic ladder, health status generally improves. Higher SES buffers many health risk exposures, with an accumulation of health protection benefits the longer a person remains at higher levels on the scale (MacArthur Foundation 2008).

Education

Linking the impact of education and SES to health outcomes, children born into lower SES families with fewer resources are more prone to develop health problems earlier in life. They may also suffer from chronic illnesses, such as asthma, which contribute to more missed school days and fewer years of completed schooling (MacArthur Foundation 2008). This educational deficit, in turn, limits individuals to lower-paid

positions that are often associated with poorer, more stressful physical working conditions. After years of cumulative risks and exposures, adults at the lower end of the employment scale are more likely to experience high levels of stress; chronic pain and diseases such as cancer, diabetes, or heart disease; and premature death (PolicyLink 2007).

The level of education a person achieves influences health outcomes by either facilitating or limiting their ability to earn income and improve occupational and social status. By race, research indicates that minority populations are much less likely than whites to have advanced degrees, with Hispanics being least likely to attain bachelor's degree or higher (Figure 6) (Mead et al. 2008). Higher education levels also increase the likelihood that individuals will obtain and understand health-related prevention and health promotion information

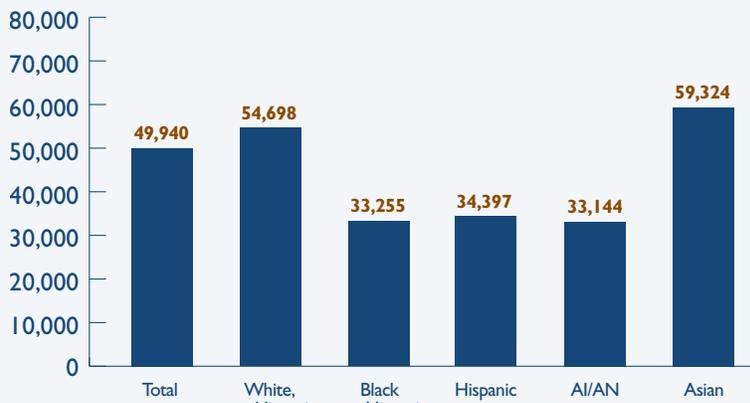
(PolicyLink 2007). Advanced education may improve perceptions of individual social standing and contribute to better health through boosts in the levels of respect, power, and treatment enjoyed by individuals with higher community social standings, regardless of income levels (Mead et al. 2008).

Neighborhood Conditions

Individuals located in impoverished

social and physical environments are at greater risk of exposure to numerous stressors and avenues by which they can become ill or suffer an injury. At the neighborhood level, these stressors are linked to segregation, the unavailability of community resources, the marketing of unhealthy products and limited access to healthy foods, increased exposure to crime and violence, and deficiencies in the cohesion and support among community social networks.

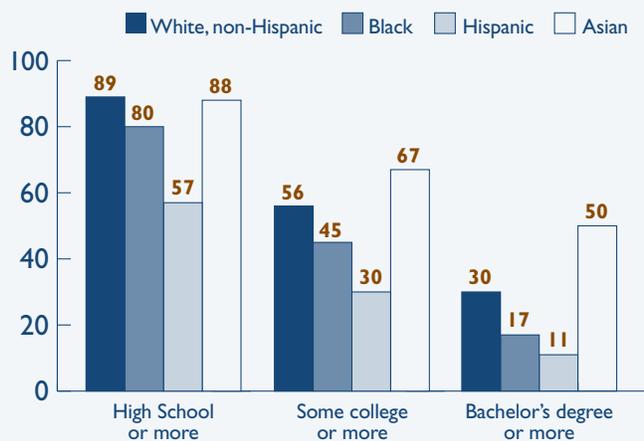
Figure 5: Median Family Income in U.S. Dollars, 1999



Source: Mead et al. 2008

AI/AN = American Indian/Alaska Native

Figure 6: Percentage of Population Age 25 and Older by Education Level Achieved, 2003



Source: Mead et al. 2008

Note: "Some college" includes respondents who had completed some college but had not completed a degree and those who had completed an associate's degree.

Disadvantaged communities are frequently exposed to heavily targeted marketing and easily accessible outlets for unhealthy products such as fast food, alcohol, and cigarettes.

Segregation

People are at higher risk for poorer health outcomes when segregated into culturally or geographically isolated communities where they are unable to access services and opportunities. Discrimination in U.S. housing sales and rentals became illegal with the passage of the Civil Rights Act of 1968, but subtle and blatant discrimination can still be seen in housing practices (Thomas and Crouse Quinn 2008). These practices include limiting the availability and affordability of suburban housing properties; promoting “redlining” or racially skewed mortgage or insurance programs in poor, predominately minority areas of cities; and real estate agent biases in the types and locations of properties advertised to clients. Residential segregation has deleterious effects such as concentrated poverty, increased crime and violence, lower levels of educational achievement, and limitations in access to neighborhood resources such as quality housing and food (Smedley et al. 2002).

Neighborhood Resources

Particularly in disadvantaged, low-income, and racial or ethnic minority communities, there is often inadequate exposure to, or inability to afford, health-facilitating resources such as living-wage employment; high-quality school systems; safe and accessible locations to play and exercise; effective, reliable transportation systems; and commercial services such as banks, grocery stores, or restaurants (PolicyLink 2007). The presence of

such resources increases the collective wealth of a community and, in turn, improves the health of its residents (Prevention Institute 2002).

Marketing/Product Accessibility

Disadvantaged communities are frequently exposed to heavily targeted marketing and easily accessible outlets for unhealthy products such as fast food, alcohol, and cigarettes. Within these communities, there are often a limited number of supermarkets, recreational facilities, or full-service dining establishments to offset the unhealthy product offerings. Typically available healthy food options may be expensive, further limiting access for some individuals (MacArthur Foundation 2008).

Violence/Crime

Criminal activities and violence can jeopardize physical safety within poor communities; increase psychological stress; or impede community development when businesses are unwilling to be located in the community or outsiders are afraid to patronize local establishments, events, or activities (MacArthur Foundation 2008). Depending on the level of crime and violence, residents may be afraid to leave their homes even to seek necessary or emergency services. The presence of effective neighborhood-level public safety services, such as police and fire protection, may improve residents’ confidence about moving freely within their communities and getting a timely response during a crisis, as well as lowering crime incidence (PolicyLink 2007).

Social Networks

Neighborhood social networks help promote connections and a sense of ownership, support, empowerment, and protective health behaviors among residents; these networks are frequently lacking in disadvantaged communities. Social capital achieved through deepening the bonds within immediate communities and through bridging and strengthening linkages between these groups and the larger community also shapes overall community health (PolicyLink 2007). The presence of positive role models and social learning opportunities can also aid individual efforts to adopt health-promoting behaviors (Prevention Institute 2002). Mortality rates and reports of poor or fair health status are often lower among communities with a greater degree of social capital (PolicyLink 2007).

Environmental Exposures and the Built Environment

Environmental conditions can also play a role in influencing individual and overall community health and long-term outcomes. Health effects can arise from exposure to natural environmental factors present in the air, water, and soil, as well as from “built” environmental components, including physical structures themselves.

Natural Environments

Negative health outcomes often manifest over time within residential areas and work environments where individuals are exposed to pollutants and toxins in

surrounding air, water, or soil. Residents may suffer from cognitive delays from lead-based paint exposures; or asthma, other respiratory conditions, or skin ailments resulting from mold, dust, or insect infestations (Prevention Institute 2002). Studies often reveal that sources of pollution, such as freeways and airports, are more likely to be located near lower-income, minority communities (PolicyLink 2007).

Built Environment

The “built environment” refers to physical structures, such as houses, schools, parks, businesses, sanitation systems, and streets/roadways, throughout communities (PolicyLink 2007). Poor urban design or inadequate or poorly maintained structural components for meeting the needs of communities can contribute to chronic health conditions arising from poor exercise or nutrition, physical injuries/accidents, or toxic exposures. Reliable, convenient transportation options within a community also ensure residents’ access to external facilities such as employment opportunities and educational institutions. A balance, however, is critical so that transportation is available but disruptive traffic conditions that increase air pollution levels are minimized.

Stress

Stress, especially when extreme or prolonged, has a powerful influence on physical and psychological health outcomes and behaviors (Altschuler et al. 2004). As previously discussed, individuals at lower SES often live and

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Mortality rates and reports of poor or fair health status are often lower among communities with a greater degree of social capital.

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work in more stressful environments where there may be less control over work functions; insecure employment; higher economic strain; and adverse life events, such as interpersonal conflicts or violence or loss of one's home or job. These individuals may have little to no resources available to buffer or avoid the effects of these stressors. Exposure to neighborhood-level factors, such as violence and criminal activities, overcrowded or dilapidated housing conditions, and noisy environments, can increase individuals' stress levels and take a toll on health. For racial and ethnic minorities, the effects of these conditions may be exacerbated by exposure to racism and discrimination (MacArthur Foundation 2008).

Some individuals engage in health-damaging behaviors, such as smoking, drinking, physical inactivity, or risky sexual activities, to relieve high levels of stress and find a temporary outlet from stressful conditions (MacArthur Foundation 2008). The short-term release of stress puts longer-term health at risk for conditions, including addiction, depression, increased incidence of diseases and illnesses, or early death. As people become more economically successful over time, exposure to toxic stress levels, and their subsequent psychological and physiological consequences, diminishes (Altschuler et al. 2004; MacArthur Foundation 2008).

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As people become more economically successful over time, exposure to toxic stress levels, and their subsequent psychological and physiological consequences, diminishes.

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UTILIZING SOCIAL NETWORKS FOR HEALTH SERVICES ACCESS IN LOCAL COMMUNITIES

CareFirst Blue Cross Blue Shield's Hair, Heart and Health program is a community-based initiative in select African-American communities in Baltimore, Maryland, and Washington, DC, that has utilized established minority community social networks to reach disadvantaged populations. This initiative, operating through local barbershops and beauty salons, provides health care screenings to patrons ages 18 or older to identify those at risk for stroke, heart disease, or end-stage kidney disease. Hair care professionals have been trained to conduct basic health screenings and to encourage patrons to seek professional medical attention.

Findings from the Baltimore site, which includes 13 participating facilities, indicate that over 1,800 individuals have been screened for high blood pressure. At least one cardiovascular risk factor was found in approximately 80 percent of all individuals screened (CareFirst Blue Cross Blue Shield 2008).

HEALTH CARE SYSTEM ACCESS AND QUALITY

Accessible, affordable, equitable, and culturally appropriate health care services are vitally important to ensure the overall positive health of communities. When individuals are able to access high-quality routine and emergency health care services, they are more likely to seek timely medical care and lessen the risk of undiagnosed or untreated health conditions.

As discussed during the Issue Dialogue, public health efforts to improve health equity have typically focused on interventions centered on the “medical model,” which emphasizes treating people after they have gotten sick. The model generally does not address the underlying conditions that lead to disease; instead it focuses on changing individual knowledge and health behaviors. Research to date does not indicate a sustained benefit from the medical model’s approach to combat health disparities. In fact, research notes that

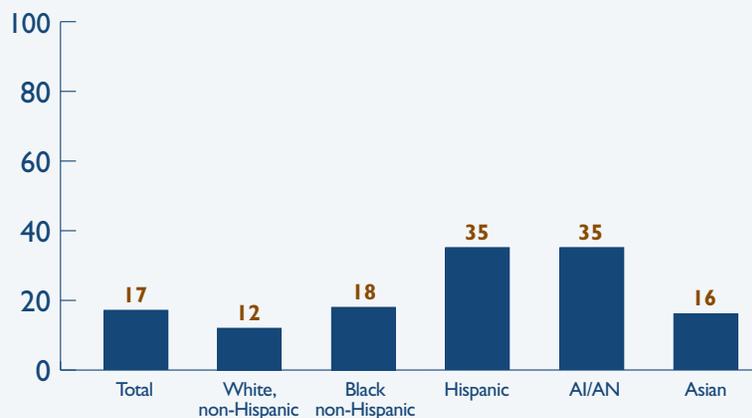
health care access and quality account for only 15 to 20 percent of differences in morbidity and mortality (Beyers et al. 2008; PolicyLink 2007).

Access to Health Care

Disparities in health care access can result from both individual- and systems-level issues. These include a lack of health insurance coverage, not having a regular source of medical care, limited availability of health care resources, as well as health financing constraints.

Health care access and quality account for only 15 to 20 percent of differences in morbidity and mortality.

Figure 7: **Percentage of People Under Age 65 Without Health Insurance Coverage, 2004**



Note: Data are age adjusted to the 2000 U.S. standard population.
 Note: The category “uninsured” includes persons who had no coverage as well as those who had only Indian Health Service coverage or only a private plan that paid for one type of service, such as accidents or dental care.

Source: Mead et al. 2008

AI/AN = American Indian/Alaska Native

Insurance Coverage

In the United States, approximately 47 million Americans (17 percent) under age 65 did not have health insurance coverage in 2004 (Mead et al. 2008). More than half of this population was composed of minorities (Figure 7). Hispanics and American Indians/Alaska Natives were the most disadvantaged minority groups, with approximately 35 percent of their populations not having coverage (Mead et al. 2008).

It is notable that even under conditions of equal insurance coverage and access to care, studies indicate that African Americans and other minority groups are less likely than whites to receive preventive services and life-saving treatments (MacArthur Foundation 2008). Regardless of race, lack of health insurance coverage directly affects access to medical care. For example, individuals without insurance are more likely to postpone or forgo needed medical

care, as well as not obtain prescribed medications (CERD 2008).

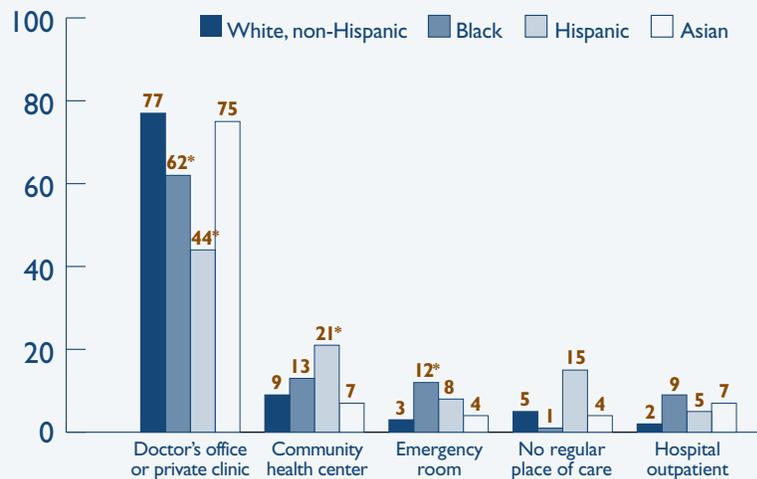
Health insurance coverage in this country is largely linked to employment. With rising health care costs, many employers are cutting back on health insurance benefits or are providing coverage that requires larger employee contributions (MacArthur Foundation 2008). As a consequence, many individuals are dropping their health care coverage. This is particularly true among low-income working adults (Mead et al. 2008).

Regular Source of Care

Access to medical care is also limited by the lack of a usual source of care, including local physicians, health centers, or hospitals (CERD 2008). Among individuals who have or are at risk for chronic illnesses, not having a regular source of care makes it more difficult to obtain usual or preventive care, gain access to

In the United States, approximately 47 million Americans (17 percent) under age 65 did not have health insurance coverage in 2004. More than half of this population was composed of minorities.

Figure 8: **Percentage of Adults Ages 18 to 64 by Usual Place of Care, 2006**



* Compared with whites, differences remain statistically significant after adjusting for insurance or income. Source: Mead et al. 2008

prescription drugs, or get referrals for specialty services (Mead et al. 2008). By comparison, individuals with a regular source of care are more likely to receive preventive services (such as immunizations and screenings), build trusting relationships with providers, and receive and understand the health information provided during visits.

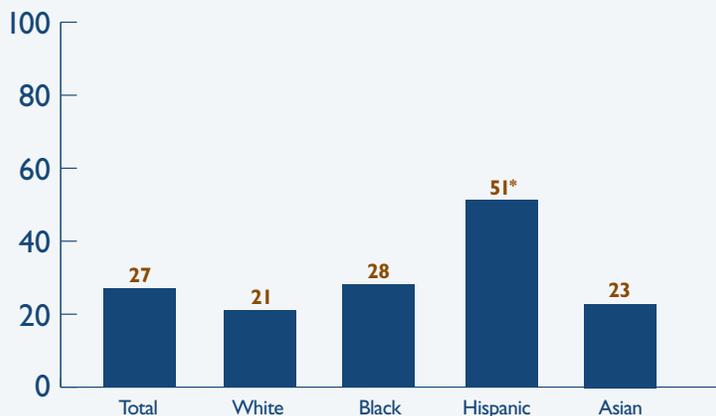
Racial and ethnic minorities, the poor, uninsured and underinsured populations, geographically isolated persons in rural areas, and limited or non-English speaking groups are more likely to report not having a usual source of care. Minority groups in particular are less likely to have a regular doctor, using hospital emergency departments or outpatient facilities, health clinics, or “no place” as their regular source of care instead (Figure 8) (Mead et al. 2008). Lack of access to a regular source of care is particularly acute for Hispanics, who are nearly three times as likely as whites to report having no regular provider (Figure 9).

Availability of Health Care Resources

Inequitable distributions of health care resources, such as health care facilities, pose a barrier to access for many individuals. In a 2006 survey, approximately 54 percent of Hispanics and 52 percent of Asian Americans reported that they did not always get care when needed, as compared to 41 percent of whites (Beal et al. 2007). A shortage of health care resources in many rural areas also leaves individuals vulnerable to traveling long distances to obtain necessary services, enduring long waiting times for appointments, and having inadequate access to timely emergency care. The availability of health care resources in communities can be further minimized by challenges such as low health literacy, linguistic barriers, and limited or restrictive health care financing resources. Lack of diversity among health care professionals also acts as a constraint to health care resources (National Center for Health Statistics 2007).

Minority groups are less likely to have a regular doctor, using hospital emergency departments or outpatient facilities, health clinics, or “no place” as their regular source of care instead.

Figure 9: **Percentage of Adults Ages 18 to 64 Reporting No Regular Doctor, 2006**



* Compared with whites, differences remain statistically significant after adjusting for age, income, and insurance.

Source: Mead et al. 2008

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Estimates indicate that as many as 90 million U.S. citizens have difficulty understanding and acting upon health information, with nearly half of this group (40 million) reading below the fifth-grade level.

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Health Literacy. Health literacy is a fundamental component of reducing health disparities and avoidable health care costs. Healthy People 2010 defines it as “the degree to which an individual has the capacity to obtain, process, and understand basic information and services needed to make appropriate decisions regarding his or her health” (IOM 2004). Limited health literacy can make it difficult for people to complete intake forms, enroll in insurance programs, and understand how to navigate the health care system. Individuals with limited health literacy also may not understand when it is necessary to seek care for certain symptoms. Moreover, low literacy has been linked to less frequent use of preventive services and poor health outcomes (such as higher rates of hospitalization), both of which are associated with higher health care costs (Kutner et al. 2005).

Estimates indicate that as many as 90 million U.S. citizens have difficulty understanding and acting upon health information, with nearly half of this group (40 million) reading below the fifth-grade level (Kutner et al. 2005). Additionally nearly 60 million (29 percent) adults in the United States have only basic literacy skills in either English or Spanish (IOM 2004). Though health literacy deficits touch all populations and subgroups, racial and ethnic minority groups have been most affected. Approximately 50 percent of Hispanics, 40 percent of African Americans, and 33 percent of Asian Americans report challenges related to health literacy (Institute for Healthcare Advancement 2008).

Linguistic Barriers. Language barriers between individuals and health care providers can lead to decreased access to quality care, limited consumer comprehension, decreased satisfaction, and increased cost due to system inefficiencies (Administration on Aging 2001). This is notable because roughly one-sixth (46 million) of the U.S. population speaks a language other than English at home, with nearly 10 million of these individuals reporting that they speak English “not very well” or “not at all” (Mead et al. 2008). Non-English-speaking patients are also less likely to use preventive care services and are more likely to rely on care through emergency rooms (CERD 2008).

In many instances health care organizations do not offer sufficient interpretation services. Research indicates that over 20 percent of Hispanics have completely forgone seeking medical advice because of language difficulty or inability to communicate with health care providers (CERD 2008). Other critical issues for people with limited proficiency in the English language include not receiving all necessary preventive services, not understanding directions for prescription medications, or not seeking follow-up care as indicated (Smedley et al. 2002).

Financial Resources and the Health Care Financing System. A disproportionate number of minorities and poor individuals are in publicly funded health insurance programs or private health plans with limited benefits.

These programs and plans may have differences in the intensity and quality of care provided, as compared to clients at the higher end of the income scale. Capitation and health plan incentives to encourage the most efficient, cost-saving care for patients can create barriers for some populations. Racial and ethnic minorities may be particularly disadvantaged if additional time is required due to communication or cultural preferences. Lower reimbursement rates under public programs may reduce the supply of health care professionals willing to serve low-income populations, further diminishing access and quality of care (Smedley et al. 2008).

Poor health, limited education, low-income status, and high levels of functional impairment are associated with higher out-of-pocket health care costs and overall medical expenses (Mead et al. 2008). Medical costs in lower-income populations can account for approximately 31.5 percent of income. Moreover, 45 percent of Hispanic adults, 41 percent of Asian-American adults, and 35 percent of African-American adults report difficulty paying for medical care, as compared to approximately one-quarter (26 percent) of white adults (Administration on Aging 2001).

Provider Scarcity. In areas with highly concentrated minority and low-income populations, critical shortages of health care providers, specialists, and facilities further limit access to health care (Smedley et al. 2002). These shortages give people little or no choice in where

they can obtain care. If access to a regular source of care is not possible, emergency rooms are often used for treatment for acute symptoms (American College of Emergency Physicians 2008). Further restrictions in disadvantaged groups' health care access have occurred when local hospitals have closed.

Lack of Diversity in the Health Care

Workforce. Lack of diversity in the health care workforce can also create barriers between providers and minority patients. Roughly 15 percent of U.S. doctors, 9 percent of registered nurses, and 12 percent of dentists are minorities. Similar low percentages are found among other health professions (Association of American Medical Colleges 2008; U.S. Census Bureau 2000). The severe under-representation of minorities pursuing careers in health professions is especially notable because minority providers are more likely to practice in underserved or minority communities and be more adept at tailoring programs and preventive health services for their patients (Smedley et al. 2002).

Quality of Health Care

Even with access to the health care system, individuals can experience challenges in the quality of health care services and treatments they receive. Quality of care issues and differences in treatments can arise as a result of communication problems between patients and providers. Providers' discriminatory attitudes and behaviors, which can influence

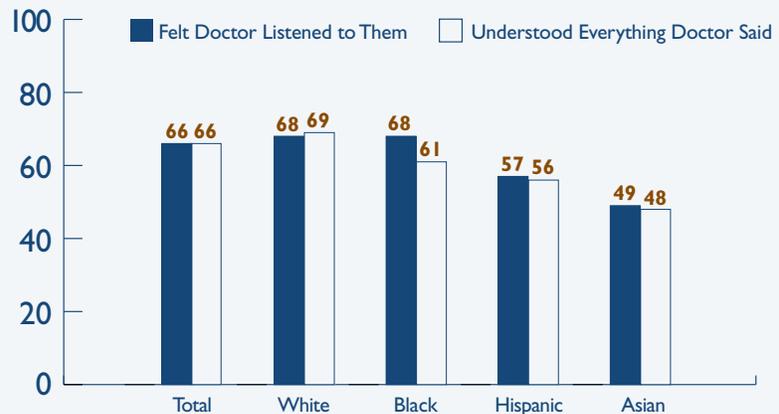
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Poor health, limited education, low-income status, and high levels of functional impairment are associated with higher out-of-pocket health care costs and overall medical expenses.

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To deliver appropriate, sensitive, and high-quality care, providers must understand that beliefs, values, and concerns about health and illness are often culturally based, vary across groups and within families, and may be influenced by generational differences and acculturation.

Figure 10: **Percentage of Adults Ages 18 to 64 Reporting Ease of Communication During Doctor Visits, 2001**



Note: Population includes adults with health care visits in the past two years.

Source: Mead et al. 2008

the treatments they provide, also negatively affect health care quality (Smedley et al. 2008). Six critical domains have been deemed necessary for health care to be high-quality: 1) safety, 2) timeliness, 3) effectiveness, 4) efficiency, 5) patient-centeredness and 6) equitableness. Significant disparities, however, exist across each of these domains (Mead et al. 2008).

Patient-Provider Communication Problems

Effective communication between patients and their health care providers is critical to the delivery of high-quality, effective, and timely treatment and care. Negative experiences during these interactions can contribute to inequalities in health care delivery (CERD 2008). Disparities in the ease of communication are particularly more likely to be reported by Hispanic and Asian-American populations (Figure 10) (Mead et al. 2008).

Providers' limited cultural sensitivity and understanding may also affect the care given to patients. To deliver appropriate, sensitive, and high-quality care, providers must understand that beliefs, values, and concerns about health and illness are often culturally based, vary across groups and within families, and may be influenced by generational differences and acculturation. Culturally competent providers may be more aware of the realities in their patients' daily lives, including understanding whether instructions (such as exercise regularity or healthier eating) can be reasonably accomplished. This is especially important if the patient's neighborhood is vulnerable to violence, nearby markets or stores do not offer nutritious food options, or finances are limited to purchase such items (PolicyLink 2007).

Provider Discrimination

Despite the illegality of legalized and de facto segregation in U.S. healthcare

facilities, discriminatory attitudes, beliefs, and actions among some providers still contribute to biased clinical encounters or administration of inequitable and inferior treatments (CERD 2008). Providers may make negative, sometimes unconscious, assumptions about patients' education levels, compliance ability, access to health-protective social supports, or the likelihood of abusing alcohol or drugs. This can lead to low expectations that these patients care about their health or will follow prescribed instructions. These perceptions could influence providers' decisions about offering treatment to patients, thereby limiting patients from receiving the

most beneficial, cutting-edge therapies or treatment alternatives or from having an opportunity to participate in clinical trials (Smedley et al. 2002).

Additionally, patient perceptions about discrimination in clinical encounters can frame their expectations, behaviors, and attitudes toward providers or the health system at large (CERD 2008). For example, some minority populations have reported a belief that they are treated disrespectfully relative to whites and that they would be more likely to receive better health care if they were of a different race or ethnicity (Smedley et al. 2002).

IMPROVING ACCESS AND QUALITY OF DIABETES CARE

North Carolina's Project DIRECT (Diabetes Intervention Reaching and Educating Communities Together) targets African-American communities in southeast Raleigh to decrease disparities in diabetes prevention and care. The project is the largest community-based intervention for diabetes ever funded to date and includes collaborations between the Centers for Disease Control and Prevention, North Carolina Department of Health, and various county and community organizations. Project activities focus on primary, secondary, and tertiary prevention through improving the diagnosis of diabetes, access to care for diabetics, quality of care provided, and patient self-management, as well as reducing risk factors to prevent the initial onset of diabetes (North Carolina Diabetes Prevention and Control Branch 2008).

STRATEGIES FOR ENGAGING FOUNDATIONS

Discussions during the Issue Dialogue highlighted a number of strategies health funders can use to get involved in work to eliminate health disparities. These strategies include internal organizational capacity-building activities, policy-level approaches to affect change at the highest governmental and institutional levels, and approaches to reaching out to and engaging communities and other relevant stakeholders.

Internal Philanthropic Organizational-Improvement Strategies

A number of suggestions were offered on ways funders can shore up their internal organizational practices, evaluation processes, and management structures. These improvements may help promote increased philanthropic involvement and success in eliminating disparities. For example, it was noted that funders should:

- Conduct their own internal capacity-building activities to understand hiring practices, how funding decisions are made, and what their organizational staff believes and how they behave.
- Ensure strong governing support and participation in funders' efforts to fight health disparities. Boards and organizations must be willing to learn new things, take risks when necessary, provide adequate funding, and have the patience to stay the course for long-term success.
- Understand that achieving small

steps is progress. Foundation should match resources to organizational and initiative goals, address interpersonal and institutional “isms,” recognize that conflicts will inevitably occur, and build staff capacity around health equity and the social determinants of health.

Effective Policy-Related Discussions

Additional suggestions focused on strategies for deepening policy-related discussions around improving disparities and poor health outcomes not ameliorated by medical models of care. There are many roles funders may play in the policy arena:

- Encourage advocacy for public and private policies that address the broader determinants of health, as well as specific disparities-related issues.
- Increase chronic disease prevention at the community level. Efforts to achieve this critical goal could pave the way for funding prevention through Medicare and Medicaid,

reducing the prevalence of diseases, and reducing consumers' utilization of expensive medical treatment services. Research indicates that uniform funding of chronic disease and community-based prevention at the local level would make a huge difference in health care expenditures.

- Establish chronic disease management in the clinical setting, including utilizing peer-based models to more effectively reach patients. Employing these models would provide a more cost-effective use of resources that reduces health care utilization. Peer-based models that bring individuals together and incentivize their participation often show more of a health benefit than found in traditional provider-patient interactions.
- Support continued development of a productive, accountable, and culturally-competent workforce, including providing opportunities for leadership development and succession planning.
- Consider the creation of a Surgeon General's report on health equity in the United States. Similar reports have been written in other Western, industrialized countries to raise awareness of the issue's urgency. A higher-level declaration of the costs of ignoring health equity among all populations, not just low-income groups, could be effective. The report could emphasize the development of a longitudinal data tracking system for life expectancy

and mortality rates at the census level for better monitoring progress and failures.

Partnership Strengthening Strategies

Suggestions were also offered regarding roles philanthropy can play in developing and maintaining partnerships at the community level. To ensure that key and nontraditional entities are present during program decisionmaking and implementation processes, funders should consider the following actions:

- Listen! Funders must realize that they cannot unilaterally make decisions about what is needed in a community or about the strategies that should be employed. Instead, a planning process can be funded, with an assessment of the stakeholders that need to be included in designing and implementing the initiative.
- Require a multisectoral approach that cultivates and expands innovative, community-driven partnerships. A diverse array of stakeholders should be involved and clearly see the role they play in the initiative.
- Secure champions for advocacy purposes and for developing collaborations that strengthen the depth, reach, and potential of initiatives.
- Tackle agency and organizational silos, which can allow for increased

communication and mutual goal-setting across federal, state, and local agencies. This is particularly important for work around determinants of health, especially those experienced by low-income populations in highly segregated communities. Allowing more flexible spending of current health funding may also help break down silos and increase cross-sectoral collaborations.

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The effectiveness of initiatives is increased when residents representing community interests are able to engage in higher-level program participation.

- Provide direct funding of community engagement activities. This should be a deliberate, intentional focus of grants that also allows for meaningful incentives such as child care, transportation, or food coupons.
- Underscore the importance of program evaluations. Funders should seek ways to collaborate with researchers and data experts to measure the impact of community engagement on both programs and their clients. It is important to document how people’s lives have been meaningfully changed as a result of a specific program or initiative.

Issue Dialogue discussions underscored the need for adequate understanding and documentation of health disparities in one’s own community, region, or state. This information helps make the case for policy and programmatic investments. It can also direct a funder’s focus to the most salient community issues. Documenting the disparity from the beginning is important, as is funders providing a vision of what success in

tackling the disparity will look like. This includes establishing how to measure success and the anticipated time it may take to see signs of improvement.

Community Engagement Strategies

Greater community involvement may be beneficial to all parties involved in disparities reduction efforts. In particular, community-based participatory research (CBPR) utilizes collaborative approaches where all participants are involved equitably. CBPR also recognizes the unique strengths each individual can offer. In addition to improving an individual’s sense of self, tangible community-level improvements and benefits to infrastructures and processes also arise. Increased civic participation and promotion of democracy can also empower individuals and communities to push for necessary changes and improvements in their environments. The Issue Dialogue identified insights associated with engaging communities, including:

- The effectiveness of initiatives is increased when residents representing community interests are able to engage in higher-level program participation.
- Residents gain self-sufficiency through opportunities for leadership development and skill-building, which, in turn, enhances both individual and community capacity.

- Community involvement can lend a positive impact to short- and long-term health outcomes.

The Issue Dialogue emphasized the importance of community capacity building for changing conditions in disadvantaged neighborhoods. Capacity-building efforts strengthen a community's ability to develop, implement, and maintain effective programs that affect the broader conditions responsible for better health and well-being. As with CBPR, building the capacity of communities equips residents with skills to speak and act effectively on their own behalf. These individuals may also be more engaged in influencing decisions that directly affect them. In addition, participating in building strong neighborhood groups may mobilize communities into action. Conversations arising during the Issue Dialogue identified a few roles foundations can play in efforts to engage communities. These roles call for foundations to function as:

- funders who are willing to support long-term strategies, as well as mandate specific requirements for community involvement;
- catalysts who influence the field and educate and change policies and organizational practices;
- conveners who bring diverse groups to the table and foster new coalitions and networks; and
- leaders who provide increased knowledge and skills; promote research and evaluation; and frame

innovative, new approaches and program practices.

Discussions also identified a number of “keys to success” for working with community-level initiatives that may help guide funders’ efforts, including the need to:

- bring attention to the work of fighting disparities;
- actively engage and partner with others;
- provide incentives to promote consumer involvement (such as child care or transportation stipends, or educational or training development opportunities);
- regularly evaluate and document the program’s progress;
- acknowledge successes, small and large, as they come along;
- reflect and learn from failures; and
- publish program results for the benefit of communities and other funders.

In addition to the benefits derived from engaging with communities, funders and others working with these groups should understand that challenges to sustaining community engagement will inevitably arise. Examples of some of these challenges include:

- racial or class-based tensions undermining the effectiveness of community leaders,

Capacity-building efforts strengthen a community's ability to develop, implement, and maintain effective programs that affect the broader conditions responsible for better health and well-being.

- difficulties reaching new populations that may arise because of demographic shifts or contextual changes in programs or organizations,
 - internal power struggles or control issues within groups or collaboratives,
 - limitations in consumer involvement due to competing priorities
- such as work or participation in other activities or programs,
- inadequate funding and other resources to support long-term efforts, and
 - struggles to meet unfamiliar cultural needs for some consumers participating in the initiative.

ADDITIONAL PHILANTHROPIC INITIATIVES

Efforts to tackle health disparities will require a multipronged approach that combines federal, state, and local level expertise and resources with those of other contributors, including foundations. Potential foundation roles could include both striving to address specific health care issues and engaging in efforts to combat the institutional roots that cause disparities. Numerous funders have adopted programs to reduce or eliminate health disparities. A few examples are provided below to highlight strategies that have been, and can be, used to address disparities at the local level in communities around the country.

Improving Social and Environmental Determinants of Health

The California Endowment's overall organizational endeavors aim to expand access to quality health care for the underserved and improve the health of all Californians—this includes a focus on the broader determinants of health. Its Community Health and Elimination of Health Disparities Program funds initiatives that focus on building healthy communities by improving social and physical environments that shape health behaviors and outcomes. The Community Action to Fight Asthma (CAFA) initiative, funded under the program, includes 12 community-based asthma coalitions across the state. The coalitions are focused on developing local and state programs and policies to reduce environmental triggers for asthma among school-age children in housing, schools, recreational centers, and outdoors. CAFA has used educational and programmatic activities to advocate for improvements in these issue areas.

Significant results were achieved, including: 1) creation of CAFA's cohesive statewide network through the coalitions; 2) expansion of the coalitions' activities and skills to encompass higher-level advocacy, policy, and community efforts; and 3) increases in policymakers' knowledge of environmental triggers affecting asthma through the coalitions' efforts. By raising awareness of asthma's environmental triggers, CAFA has shifted discussions from traditional medical treatments for childhood asthma to more community-based, preventive solutions. These efforts have also helped address key health disparities and social and economic costs associated with asthma (The California Endowment 2007).

Improving Health Care Access and Quality

In the early 2000s, health disparities in cancer rates and mortality were documented among Latinas in Central and East Contra Costa County, California. In response, the John Muir/Mt. Diablo

The California Endowment's Community Health and Elimination of Health Disparities Program funds initiatives that focus on building healthy communities by improving social and physical environments that shape health behaviors and outcomes.

Community Health Fund and The California Endowment provided \$1.6 million from 2001 to 2004 to build a multiagency local collaborative. This collaborative and its Spanish-Speaking Women's Cancer initiative focused on helping Latinas get earlier detection and treatment for breast and cervical cancer. A continuum of services was provided to affected monolingual Spanish-speaking women, including community outreach and education, navigation through the health care system, and emotional and practical support to help them through their experience.

Findings from the initiative's evaluation indicated the development of 1) a successful, culturally relevant model promoting early detection and treatment of breast cancer; 2) a strong public/private partnership that integrates services and maximizes use of resources to provide a continuum of cancer-related care and services; and 3) improved responsiveness and enhanced capabilities among health care systems meeting the needs of women in this population (John Muir/Mt. Diablo Community Health Fund 2008).

Though formal funding has expired, the initiative has sustained itself and continues to support affected Spanish-speaking Latinas and their families. This is largely because participating organizations have integrated many of the initiative's key expenses into their own operating budgets. These groups have also worked diligently to secure funding from other sources to pay for activities that crossed organizational boundaries.

The Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA)

also engages in programmatic grant-making to expand access to health care for underserved populations in the commonwealth. BCBSMA's Closing the Gap on Health Care Disparities initiative provides three-year support to local nonprofit organizations addressing health care disparities in local communities. Support is provided for improving access, reducing barriers to quality health care, and supporting services for groups experiencing specific health disparities. The initiative's first phase recently concluded, and the outcomes and lessons learned will be gathered and shared with program grantees and the broader practitioner and policy community. The report will highlight the most successful strategies and partnerships between providers and community stakeholders. It will also illustrate specific areas where changes occurred, including provider practice changes and increased community education and awareness of disparities (BCBSMA 2008).

Increasing Organizational Cultural Competency

Beginning in 2005, The Colorado Trust committed \$13.1 million to an ongoing, seven-year initiative aimed at reducing racial and ethnic health care disparities in the state. The initiative emphasizes engaging local community leaders to assess their opinions of the biggest disparities affecting residents. This includes gaining a deeper understanding of community members' experiences, beliefs, and values around seeking health care and why they believe disparities exist. The

Beginning in 2005, The Colorado Trust committed \$13.1 million to an ongoing, seven-year initiative aimed at reducing racial and ethnic health care disparities in the state.

driving force for the initiative is the notion that increasing individual and organizational cultural competency will place organizations in better positions to reduce health disparity issues (The Colorado Trust 2008).

Following development of the initiative's approach, the first five-year cycle of Equity in Health grantees began in 2005, followed by a second cycle of grantees in 2007. These nonprofit organizations and educational institutions are addressing a variety of issues ranging from increasing the provision of culturally competent health care, school-based health, and mental and dental health care, to stronger translation and interpretation programs to help improve services for diverse populations. Technical assistance is provided through cultural competency dialogues, networking and learning circles, statewide and regional trainings, and organized cross-site visits, as well as tailored, one-on-one assistance.

Program evaluation has been considered critical for providing documentation of successes, challenges, and key lessons learned. An ongoing evaluation is in progress, utilizing a cultural competency assessment instrument for surveys and telephone interviews. The evaluation examines whether grantees' cultural competency changes over time and the conditions necessary for bringing about positive changes in organizational capacity to serve diverse populations. It is hoped that cultural competency becomes so ingrained and interwoven into organizational processes that it becomes daily standard operating procedure.

Cultural competence, however, is an ongoing process that requires regular "check-ups" to respond to ever-changing community demographics, needs, and priorities.

The MetroWest Community Health Care Foundation also works to improve cultural competency in local community organizations. The foundation's health disparities grant-making includes promoting greater cultural competency among health care organizations and conducting racially and culturally relevant health outreach and screenings.

One example is the KidsCare Connection program, which uses a case management model to reduce barriers to health care for underserved minority children in the area. One hundred sixty-two children have been referred to the program, many of whom have serious chronic and acute illnesses. These children and their families have also been connected to a variety of health care services, including primary care, mental health, dental, orthodontics, vision, nutrition, and fitness. The program provides additional services such as translation, setting medical appointments, enrolling children in health insurance, negotiating medical bills, and providing or arranging transportation. It also collaborates closely with local organizations that provide a variety of social, health, and legal services so that clients can fully access programs for which they are eligible (MetroWest Community Health Care Foundation 2007).

OPPORTUNITIES AND CHALLENGES

Eliminating or reducing racial and ethnic disparities in health must combine efforts of the public and private sectors, including governments, foundations, providers, community organizations, advocacy groups, and individuals.

“Our work is not about pointing the finger at anyone. It’s about bringing people together to find out exactly how we can decrease the health disparities that exist in all of our communities.”

– Ginger Harrell,
The Colorado Trust

Drawing on lessons learned from efforts over the past decade to reduce disparities, we can move forward with a greater understanding of the factors that are likely to achieve success and critical obstacles to overcome. Foundations may find these themes useful in charting a course as they either begin their involvement in disparities-related work or deepen their commitment.

Key points include:

- developing partnerships with a range of nontraditional organizations;
- ensuring strong community involvement in all initiative processes;
- conducting program evaluations and collecting data stratified by race, ethnicity, socioeconomic status, or other demographic characteristics;
- considering specific population subgroups or topic areas to achieve focused results;
- creating public will through reframing the disparities discussion; and
- beginning to address fundamental, systemic issues related to health

disparities to affect long-lasting, meaningful change across all populations.

Partnership Development and Community Involvement

Because of the multifaceted nature of disparities and their antecedents, efforts to combat them will require engaging and partnering with sectors and disciplines beyond those typically utilized in the public health arena such as environmental, poverty, and housing organizations (PolicyLink 2007). New, cross-sectoral interagency collaborations can create unique synergies to better address efforts to eliminate disparities on a broader scale. Partnerships should benefit all parties involved; reflect joint goals, objectives, and resources; and foster strong communication and realistic expectations about constraints and other areas of weakness (Thomas and Crouse Quinn 2008).

Specific strategies for reducing disparities should be crafted by and for the specific needs of communities. Strategies and interventions should take into account community demographics, social and economic composition, politics, cultural values, health beliefs,

and preexisting infrastructures and supports. Ensuring participation of community groups, leaders, and residents also increases the likelihood of correctly identifying critical neighborhood factors affecting health, as well as assuring buy-in regarding the perceived quality, value, and reach of efforts. Inclusion efforts further strengthen the community by improving the leadership and advocacy skills of groups working toward the establishment of critical community services or changes in policies and regulations (IOM 2008).

Data Collection and Program Evaluation

To develop effective public health policy and programming solutions to reduce disparities, standardized data about health status and health care access and quality are needed (IOM 2008). Limitations in the availability of accurate, relevant, and timely data make it difficult to justify funding expenditures and developing targeted, effective disparities programs (Smedley et al. 2002).

In particular, collecting appropriate data stratified by race, ethnicity, socioeconomic status, and primary language can provide useful information about such things as differences in processes, structures, and outcomes of health care for various groups. These are key areas where discriminatory practices, patterns of care, and outcomes of intervention programs may still occur. Results derived from conducting assessments and evaluations of disparities programs can

inform efforts to improve service delivery for underserved populations. The results can also address health system cost issues through the provision of more adequate and equitable care (Smedley et al. 2002).

Expanding the Focus to Other Populations and Issue Areas

As previously discussed, historical racism and discrimination have created power differentials, institutional behaviors, and patterns that separate people according to race and class. Race and ethnicity, however, may not always be the most important factors contributing to health disparities. Instead, we should take a closer look at issues that arise from a person's class and poverty level. In particular, the poorer a person is, the shorter her life expectancy. Class, however, is often still closely linked to race and ethnicity. Therefore in designing interventions, a focus on improving the health status of people at the lowest end of the socioeconomic spectrum can be effective. It is expected that this will ultimately have more of an impact and benefit for everyone.

Strategies and interventions aimed at reducing health disparities may also be more successful if targeted at specific populations, stages of life, or health care conditions. For example, early childhood is often the period in the life course when effects of health inequities are first manifested. Additionally, social disadvantages are considered especially detrimental to

“We have focused most of our [disparities] discussion on the issue of race and ethnicity, with some sprinkling of class. But, we’re now viewing the whole question of diversity and reducing the gaps in disparities by also looking at other factors – geography, age, class, sexual orientation – and other issues where we find gaps because of special conditions and needs of communities. It is important that as we think about the gaps in disparities, we don’t exclusively focus on race and ethnicity.”

– Mario Gutierrez,
The California Endowment

long-term health outcomes when they are experienced early in life.

Creating Public Will and Reframing the Disparities Discussion

Creating public will to end racial and ethnic health disparities is another important step in fostering positive changes in areas such as policies, funding sources, and individual attitudes and perceptions. Creating public will involves an agenda-building process that capitalizes on events, both planned and chance, to influence public and media perceptions of the legitimacy and visibility of social problems (GIH 2008).

Increasing the awareness of specific issues among the broader public is an important catalyst for change among decisionmakers such as politicians and initiative planners (Salmon et al. 2003). The phrase “health disparities,” however, may not capture or motivate the public as resoundingly as terms such as “institutional racism” or “health inequities.” The terminology used to discuss these important issues needs to capture the attention of a broad audience, yet be sensitive enough to not cause people to disconnect themselves. Urgency must be conveyed regarding the ongoing need to tackle many of these persistent challenges to the health of numerous populations in this country. It is also important to address the underlying and fundamental questions of class and race and their contributions to disparities.

Highlighting local-level success stories around creating healthy communities also strengthens the disparities discussion. These stories can connect population health improvements to applicable social and economic determinants of health or issues related to access and quality of health care services. More discussion is needed around successful, evidence-based community strategies or replication models that have been used to mitigate risk factors, promote health-protective behaviors, and improve myriad conditions affecting communities (Salmon et al. 2003; Prevention Institute 2002). Ultimately movement building is important, but public will must be galvanized into action. At that point, tangible examples of local-level solutions can help generate greater change and long-term investment in reducing health disparities across communities and initiatives (Salmon et al. 2003).

Addressing Fundamental, Systemic Issues

Disparities have many antecedents and ultimately require systems-level prevention efforts to eliminate them. As noted by the *Unequal Treatment* report, “Interventions to improve access to medical care and reduce behavioral risk have only limited potential for success if the larger societal and economic context in which people live is not improved” (Smedley et al. 2002). This makes it clear that although addressing health care issues is important, a narrow focus on medical services alone will not be effective in eliminating

“We [the foundation] do not consider ourselves experts, so expertise has not gotten in the way. We instead learn from the communities we serve.”

– Grace Caliendo,
John Muir/Mt. Diablo
Community Health Fund

“We need to work on changing the local policies that are creating the detrimental conditions in communities. We also have to work on ourselves as an institution, how we behave and how we operate, especially around what our responsibilities are to and within our communities.”

– Mildred Thompson, PolicyLink

disparities. Looking beyond health and medical components to the root causes of poor health will allow a greater ability to address how and why illnesses occur from the start.

Efforts to improve physical and social environments are a critical next step in reducing health disparities and improving overall population health.

Addressing issues related to economic and educational opportunities, exposure to poor environmental conditions, and community and public services within and around communities will go a long way toward diminishing inequities that jeopardize the health and well-being of underserved communities.

“Because of the cumulative impact of multiple stressors, our overall approach must shift toward changing community conditions and away from blaming individuals or groups for their disadvantaged status. Eliminating health disparities in our country is a huge opportunity to invest in critical areas where we know it will make a difference in our communities.”

– Issue Dialogue participant

CONCLUSION

Eliminating health disparities remains a priority in this country and requires a reexamination of the factors that most affect them. It is important to understand what strategies and interventions have worked in the past, where ongoing gaps may exist, and the strengths and resources a diverse array of stakeholders and collaborators can bring to this effort. Numerous lessons have been learned that can serve as a roadmap for moving forward with a greater understanding of the factors that are most likely to achieve success or skew progress toward failure.

Shifting from the medical model framework to one focused more on the social determinants of health will require funders to think differently about accountability, metrics, and securing reliable data to monitor population outcomes. This work is

challenging for funders because it is multigenerational, involves systemic changes, and requires fortitude and patience in order to assess true changes. There is no time like the present to roll up our collective sleeves and step into the battle of a lifetime.

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ABOUT GIH

With a mission to help grantmakers improve the health of all people, Grantmakers In Health (GIH) seeks to build the knowledge and skills of health funders, strengthen organizational effectiveness, and connect grantmakers with peers and potential partners. We help funders learn about contemporary health issues, the implications of changes in the health sector and health policy, and how grantmakers can make a difference. We generate and disseminate information through meetings, publications, and on-line; provide training and technical assistance; offer strategic advice on programmatic and operational issues; and conduct studies of the field. As the professional home for health grantmakers, GIH looks at health issues through a philanthropic lens and takes on operational issues in ways that are meaningful to those in the health field.

Expertise on Health Issues

GIH's Resource Center on Health Philanthropy maintains descriptive data about foundations and corporate giving programs that fund in health and information on their grants and initiatives. Drawing on their expertise

in health and philanthropy, GIH staff advise grantmakers on key health issues and synthesizes lessons learned from their work. The Resource Center database, which contains information on thousands of grants and initiatives, is available on-line on a password-protected basis to GIH Funding Partners (health grantmaking organizations that provide annual financial support to the organization).

Advice on Foundation Operations

GIH focuses on operational issues confronting both new and established foundations through the work of its Support Center for Health Foundations. The Support Center offers an annual two-day meeting, The Art & Science of Health Grantmaking, with introductory and advanced courses on board development, grantmaking, evaluation, communications, and finance and investments. It also provides sessions focusing on operational issues at the GIH annual meeting, individualized technical assistance, and a frequently asked questions (FAQ) feature on the GIH Web site.

Connecting Health Funders

GIH creates opportunities to connect colleagues, experts, and practitioners to one another through its Annual Meeting on Health Philanthropy, the Fall Forum (which focuses on policy issues), and day-long Issue Dialogues, as well as several audioconference series for grantmakers working on issues such as access to care, obesity, public policy, racial and ethnic health disparities, and health care quality.

Fostering Partnerships

Grantmakers recognize both the value of collaboration and the challenges of working effectively with colleagues. Although successful collaborations cannot be forced, GIH works to facilitate those relationships where we see mutual interest. We bring together national funders with those working at the state and local levels, link with other affinity groups within philanthropy, and connect grantmakers to organizations that can help further their goals.

To bridge the worlds of health philanthropy and health policy, we help grantmakers understand the

importance of public policy to their work and the roles they can play in informing and shaping policy. We also work to help policymakers become more aware of the contributions made by health philanthropy. When there is synergy, we work to strengthen collaborative relationships between philanthropy and government.

Educating and Informing the Field

GIH publications inform funders through both in-depth reports and quick reads. Issue Briefs delve into a single health topic, providing the most recent data and sketching out roles funders can and do play. The GIH Bulletin, published 22 times each year, keeps funders up to date on new grants, studies, and people. GIH's Web site, www.gih.org, is a one-stop information resource for health grantmakers and those interested in the field. The site includes all of GIH's publications, the Resource Center database (available only to GIH Funding Partners), and the Support Center's FAQs. Key health issue pages provide grantmakers with quick access to new studies, GIH publications, information on audioconferences, and the work of their peers.

DIVERSITY STATEMENT

GIH is committed to promoting diversity and cultural competency in its programming, personnel and employment practices, and governance. It views diversity as a fundamental element of social justice and integral to its mission of helping grantmakers improve the health of all people. Diverse voices and viewpoints deepen our understanding of differences in health outcomes and health care

delivery, and strengthen our ability to fashion just solutions. GIH uses the term, diversity, broadly to encompass differences in the attributes of both individuals (such as race, ethnicity, age, gender, sexual orientation, physical ability, religion, and socioeconomic status) and organizations (foundations and giving programs of differing sizes, missions, geographic locations, and approaches to grantmaking).



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