

GIH

STRIVING FOR
HEALTH EQUITY:

*Opportunities as Identified
by Leaders in the Field*

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A SPECIAL
REPORT FROM
GRANTMAKERS
IN HEALTH

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FOREWORD

At its March 2011 annual meeting, Grantmakers In Health (GIH) convened the inaugural gathering of the National Alliance for Health Equity (NAHE), a funder collaborative focused on issues related to addressing disparities and promoting health equity. NAHE was designed to create a learning community in which funders would explore emerging strategies and engage in frank discussion regarding challenges faced in their work. During this meeting, participants developed the concept for an expert report that would outline strategic solutions and recommendations for funders conducting disparities-related work. This report would also serve as a guideline for future GIH disparities programming.

Strategies explored in this report will provide funders with opportunities for intervening along a continuum of upstream and downstream approaches to address health disparities. Hopefully it will also stimulate collaboration across philanthropy to tackle systems and policies contributing to disparities in health.

Striving for Health Equity: Opportunities as Identified by Leaders in the Field would not have been possible without the generous support of GIH Funding Partners: the Aetna Foundation and the Missouri Foundation for Health. The author is Dr. Brian Smedley, vice president and director of the Health Policy Institute at the Joint Center for Political and Economic Studies. This project was initially managed by Alicia Thomas, former senior program associate at GIH. Additional support was provided by Faith Mitchell, GIH vice president for program and strategy; Cara Chervin, GIH program associate; and Leila Polintan, GIH communications manager.

EXECUTIVE SUMMARY

STRIVING FOR HEALTH EQUITY:

Opportunities as Identified by Leaders in the Field

Health and health care inequities remain deep and persistent. Health inequities literally span from the cradle to the grave in the form of higher rates of infant mortality, chronic disease, disability, and premature death among many racial and ethnic minority groups (CDC 2011). The second decade of the 21st century presents many challenges and opportunities for health funders seeking to advance health equity. Given this landscape, what can health funders do to promote health equity? How can funders harness what is already known about successful practices and bring them “to scale” to benefit larger populations? To address these and other questions, Grantmakers In Health sought the perspectives of leading thinkers in the health equity arena on where the field has been and needs to go.

To identify key opportunities, leaders in government, philanthropy, academia, public health, and other fields were interviewed to seek their recommendations for health funders. What emerged were several areas of strong consensus regarding new directions that health foundations should consider, as well as other promising strategies that are emerging but have yet to garner broad support.

The recommendations that follow fall along various points along the “upstream-downstream” continuum. They include approaches focused “downstream,” on health systems, as well as “mid-stream,” on health behaviors and attitudes. Moving “upstream,” some recommendations are focused on policy and systems change. One recommendation is focused on the issue that fundamentally, political engagement and democratic participation in the policy process are necessary to chip away at the inequitable distribution of power that underlies health inequities.

SUGGESTIONS FOR METHODS AND STRATEGIES

Several suggestions for methods and strategies—ways of doing the work—emerged from the interviews. These suggestions cut across specific policy and program areas and draw upon examples of promising efforts.

► **Foundation Self-Assessment** – Several health foundation staff and executives noted that an important—but sometimes neglected—starting point for foundations engaged in or planning to engage in health equity work is to conduct a rigorous equity self-assessment, and to continually monitor the impacts of grantmaking from an equity perspective. Once the equity elements of the mission statement are clearly identified, foundations should assess how board members, staff, and community members understand the causes and consequences of health inequities, and the foundation’s approach to addressing them. Well-facilitated staff and board conversations and trainings on race and structural racism offer opportunities for self-reflection and sharing of personal experiences.

Foundation self-assessment should also critically examine board and staff diversity, as well as institutional cultural competence. And as foundations make grants, it is important that they evaluate both intended and unintended consequences from an equity perspective.

► **Building Upon Successes** – Health funders have transformed how health care providers and administrators think about cultural and linguistic diversity, and have developed many important and successful programs that have removed barriers to high-quality health care for many underserved populations. Lessons learned from these successful efforts can be applied in the work to address social and economic determinants of health. For example, health care systems are now much more sensitive to the notion that “one size does not fit all” and that different population groups have different needs, values, and expectations regarding care. The same is true for how communities and community leaders respond to efforts to address neighborhood conditions that shape health. Such approaches draw naturally upon the many sources of strength and resiliency in communities and allow these assets to surface as part of strategies to advance health equity.

- ▶ **Leveraging Public-Private Partnerships** – Because resources are scarce and political resistance to new government initiatives is strong, several interviewees recommended that funders look for opportunities to “broker” public-private partnerships that can strengthen investments toward equity. In such arrangements, for example, government and philanthropic organizations can offer incentives to businesses and private investors to increase access to health products and services.
- ▶ **Reaching Outside the Health Sector** – Most interviewees expressed a belief that the health equity community—including public health, health funders, community-based organizations, and others—has not done enough to engage and partner with individuals and organizations working to effect change in other sectors such as education, housing, transportation, criminal justice, and the like. They argue that efforts to address the root causes of health inequities must address policies and systems in these sectors and that health and equity considerations must be infused in all policies.
- ▶ **Communications** – Interviewees expressed frustration with the lack of communications tools and strategies available to scholars, public health practitioners, grassroots organizers, and others working to advance health equity. In particular, interviewees noted, communications strategies need to address the challenges of race and racism head on. New communications approaches are also needed to help engage with non-health groups that are also working to advance racial equity, to connect with and open opportunities for dialogue.
- ▶ **Democratic Participation** – Some interviewees noted that many of the core themes above—such as the importance of influencing policy and building multisector alliances—fundamentally depend upon active civic participation. One interviewee observed that “21st century public health practice needs to be muscular, optimizing democratic participation and facilitating the ability of parents to fight for their children.”

KEY PROGRAM RECOMMENDATIONS

Leaders interviewed for this project saw several opportunities for health funders to advance equity work at many stages along the “upstream-downstream” continuum. Their suggestions are summarized below, beginning with strategies aimed “downstream” at health systems and individual behavior change, and progressing “upstream” to societal and systems changes.

- ▶ **Data Collection** – More consistent and robust data collection—in health care settings and communities—provides a key opportunity to advance health equity policies, programs, and strategies. Provisions of the Affordable Care Act (ACA) require all federal grantees to collect consistent data on race, ethnicity, and primary language, presenting an important opportunity to advance knowledge in the field. Several interviewees argued that health funders can help hospitals and health systems train staff at the frontlines of data collection; educate patients to help them understand how data are used; and support research projects that help understand how, when, and under what circumstances health and health care disparities exist, and, conversely, where they are not found.
- ▶ **Health Care and Public Health Workforce** – Some interviewees noted that despite the coverage expansions and health care workforce programs authorized under the ACA, many communities will likely continue to face severe shortages of health care and public health professionals, problems exacerbated by cuts in state and local health programs. There is a significant need to understand how a variety of other health workers can fill these gaps, such as nurses operating in primary care settings, dental assistants addressing oral health needs in underserved communities, and community health workers promoting prevention. Funders could help assess how these health workers are meeting community needs and fund demonstration or seed projects to fill gaps.
- ▶ **Behavioral Economics** – Some interviewees commented on the range of demonstration projects, both domestically and internationally, seeking to provide economic incentives to individuals to help them adopt positive health behaviors. Funders could help support and evaluate such programs, and, where successful, encourage efforts to bring them to scale.

- ▶ ***Early Childhood Interventions for At-Risk Youth*** – Several interviewees pointed to the strong and growing evidence that high-quality early childhood education programs can “inoculate” children living in challenging conditions and help them achieve better educational and vocational outcomes, and in some instances, better health as adults. While not explicitly a “health” intervention, health funders can collaborate with other public and private funders and partners to support expansion and enrollment of eligible children in early childhood intervention and enrichment programs, and promote program fidelity so that such programs provide consistently high-quality services.
- ▶ ***Place-Based Investments*** – Several interviewees commented on what they saw as a positive trend among funders to adopt a “place-based” frame in their work, which generally seeks to reduce exposure to health risks and increase access to health-enhancing resources at the community level. Such strategies promote safe neighborhoods, access to fresh and healthy food, clean and safe environments, and access to recreational and exercise spaces.
- ▶ ***Housing Mobility*** – Neighborhoods with high concentrations of poverty can impair the health and human development of their residents. Health funders have an important opportunity in the coming years to advance housing mobility as a public health intervention, which entails the use of housing assistance to help families in high-risk neighborhoods move to communities with better opportunity structures and, therefore, better conditions for health.

CONCLUSION

There is a sense of optimism about the potential for health funders to significantly advance the health equity movement over the coming years and decades by utilizing the kinds of strategies explored here. These strategies, however, will require greater collaboration among funders and with public and private entities both within and outside the traditional health sector. These partnerships should ultimately help stakeholders understand how health and health inequities are shaped by policies across a range of issues and sectors, and serve to promote the goal of assuring optimal conditions for health for all people.

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INTRODUCTION

Health foundations have historically been at the forefront of efforts to eliminate health and health care inequities. They have sought to increase public awareness of inequities and have successfully contributed to Americans' growing knowledge of the issue (Benz et al. 2011). They have helped shape a strong federal health disparities elimination agenda, as reflected in documents such as Healthy People 2020 (HHS 2011a). They have funded and evaluated dozens of promising intervention strategies that have great potential to help reduce and ultimately eliminate health inequities. And they have raised awareness of the need for strong collaborative efforts across a range of sectors in order to confront this challenge.

Yet health and health care inequities remain deep and persistent. Health inequities literally span from the cradle to the grave in the form of higher rates of infant mortality, chronic disease, disability, and premature death among many racial and ethnic minority groups (CDC 2011). A large volume of research demonstrates that these inequities persist even after socioeconomic factors—such as income and education levels—are considered. For example, babies born to African-American college graduates are more likely to die in infancy than babies whose mothers are white high school dropouts (MacArthur Foundation 2008). Many affected populations also face barriers to high-quality health care, which further exacerbate risks brought about by social and economic inequality (IOM 2003). These health inequities have their roots in historical and contemporary forces such as discrimination, segregation, and poverty concentration (WHO 2008).

The second decade of the 21st century presents many challenges and opportunities for health funders seeking to advance health equity. Given this landscape, what can health funders do to promote health equity? What are among the key challenges and opportunities? And how can funders harness what is already known about successful practices and bring them “to scale” to benefit larger populations? To address these and other questions, Grantmakers In Health (GIH) sought the perspectives of leading thinkers in the health equity arena on where the field has been and needs to go. Specifically, the purpose of this paper is to:

- highlight the “state of play” in the health disparities arena;
- identify key opportunities for reduction/elimination strategies, including areas of opportunity arising from key health reform provisions; and
- offer a set of recommendations and a menu of options for funders considering taking more actionable steps to support health disparities elimination/reduction efforts.

To identify key opportunities, leaders in government, philanthropy, academia, public health, and other fields were interviewed to seek their recommendations for health funders. A select literature review was also conducted to supplement the recommendations provided by interviewees. A draft of this report was shared with over 30 health foundation staff and executives at a meeting convened by GIH with members of the National Alliance for Health Equity. Comments and feedback received at this meeting were integrated into the report.

What emerged were several areas of strong consensus regarding new directions that health foundations should consider, as well as other promising strategies that are emerging but have yet to garner broad support.

This paper will begin by offering definitions for key terms that are increasingly being used by health funders and practitioners, with the goal of seeking conceptual clarity. It will then offer an assessment of some of the leading challenges and opportunities for health foundations seeking to advance health equity. Next, a health equity framework originally offered by Anthony Iton of The California Endowment, that has since been adapted by other public and private entities seeking guidance on where and how to best intervene to eliminate health inequities, is summarized. This framework helps identify intervention points, and places them in the context of an array of health determinants. Finally, key themes and recommendations from

leaders interviewed for this paper are summarized. These leaders are identified in the Appendix, but they are not identified by name (with two exceptions), nor are their quotations sourced in this paper to ensure that they could freely offer advice without specific attribution.

DEFINITIONS

Historically, many different terms have been used to describe health inequities. Beginning with the 1985 Secretary's Task Force on Black and Minority Health (the so-called "Heckler Report"), many scholars and policymakers began using the term "health disparity" to indicate differences in the health status of population groups. Some years later, the Institute of Medicine report *Unequal Treatment* (2003) attempted to define "differences," "disparities," and "discrimination" to describe health care quality gaps between racial and ethnic groups, and the culpability of policies, health systems, and individuals within systems that contribute to these gaps. In recent years a consensus for these terms is emerging in the field, although some authors use them interchangeably. This section will define some key terms as identified by interviewees that are used in the field, and will discuss the importance of language to convey the problem and needed solutions.

Historically, health disparities, as defined by many in academia and public health, refer to differences in the health status of population groups. Healthy People 2010, for example, defined health disparities as "differences that occur by gender, race or ethnicity, education or income, disability, living in rural localities, or sexual orientation" (HHS 2000). Similarly, the National Institutes of Health defined health disparities as "differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States" (NLM 2011). These definitions, however, do not offer a rationale or criteria for identifying disparities, and therefore fail to provide guidance regarding which population groups should be identified as disparity populations. The definitions also fail to address when and whether health differences may be the result of modifiable factors, such as policies or practices that disadvantage some groups or advantage others. In such cases, health disparities could be considered unjust or unacceptable, and therefore must be addressed through concerted policy action.

To provide greater conceptual clarity, the Secretary's Advisory Committee for Healthy People 2020 proposed an operational definition of health disparities that may be used to develop targets and objectives, guide resource allocation, and assess progress. Chaired by Paula Braveman and composed of distinguished researchers and practitioners, the committee proposed that a definition of health disparities must be grounded in ethical and human rights principles, should focus attention on disparities emerging from social injustice, and must distinguish health disparities from other differences that also require policy attention but do not necessarily result from injustice. They concluded that disparities are an "issue of justice" and note that "it is time to be explicit that the heart of a commitment to addressing health disparities is a commitment to achieving a more just society" (Braveman et al. 2011).

Reflecting this growing consensus, the National Partnership for Action to End Health Disparities (2011) defines health disparities as:

A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.

Some of the leaders interviewed for this paper, however, submitted that health disparities are merely differences in health and health care between population groups. They assert that the term *health inequities* is more appropriate to describe most health disparities. Health inequities, as first defined by Whitehead and described in recent literature, refer to health differences that are rooted in social disadvantage and are therefore unjust or avoidable (Braveman and Gruskin 2003; Kawachi et al. 2002). Braveman, Kawachi, and others have argued that these semantic distinctions are important because definitions "guide measurement, and hence, accountability." Health inequities, some interviewees noted, are the outcomes of inequities across an array of determinants.

More recently, the term health equity has been used to refer to the “attainment of the highest level of health for all people” (Braveman and Gruskin 2003; Kawachi et al. 2002). Camara Jones (2011) of the Centers for Disease Control and Prevention, however, suggests that this definition is limiting; she argues that:

Health equity is *assurance* of the conditions for optimal health for all people. Achieving health equity requires *valuing all individuals and populations equally*, recognizing and *rectifying historical injustices*, and addressing contemporary injustices by providing resources according to need. Health and health care disparities will be eliminated when health equity is achieved.

In summary, she argues that “health equity is a process, not an outcome.” This is the viewpoint that many of the leaders interviewed for this paper hold and is the definition used for this paper.

These definitions are important for understanding and conceptualizing intervention strategies, as well as for understanding the framework for health equity offered in this

Health equity is a process, not an outcome.

report. But the array of researchers, practitioners, policymakers, community organizers, and others involved in health equity work does not necessarily share a lexicon. The field could benefit from common understanding of these terms, some interviewees noted.

ON RACISM

At the same time, some interviewees noted that fostering broader understanding of—and defining—racism is key to advancing health equity efforts. As one leader of a health foundation observed, “Racism is the core issue. If we don’t address it, we won’t advance equity.”

Racism is a term that carries strong emotional significance for many Americans but is at the same time poorly understood. Camara Jones (2003) again offers a comprehensive and, among our interviewees, broadly accepted definition:

Racism is a system of structuring opportunity and assigning value based on phenotypic properties (i.e., skin color and hair texture associated with “race” in the United States) that unfairly disadvantages some individuals and communities, unfairly advantages other individuals and communities, and ultimately undermines the full potential of the whole society through the waste of human resources.

Most Americans understand racism, however, as a “bad apple” problem: an individual with racial bias treating individuals from other racial groups poorly and/or in a discriminatory manner. Indeed, the research literature is replete with studies of the noxious effects of perceived racially motivated animus for the health of people of color. For example, perceived race-based discrimination is positively associated with smoking among African Americans, and smokers find the experience of discrimination more stressful. Repeated subjection to race-based discrimination is associated with higher blood pressure levels and more frequent diagnoses of hypertension (Mays et al. 2007). In another study, black women who reported that they had been victims of racial discrimination were 31 percent more likely to develop breast cancer than those who did not (Taylor et al. 2007). Experiences of racial discrimination also are associated with poor health among Asian Americans. A recent national survey of Asian Americans found that everyday discrimination was associated with a variety of health conditions, such as chronic cardiovascular, respiratory, and pain-related health issues. Filipinos reported the highest level of discrimination, followed by Chinese Americans and Vietnamese Americans (Gee et al. 2007).

A significant body of research also demonstrates how racism operates at *institutional* and *structural* levels. Institutional racism results from policies, practices, and procedures of institutions that have a disproportionately negative effect on racial minorities’ access to and quality of goods, services, and opportunities (Randall 2011). For example, health care systems that fail to offer culturally appropriate, professional interpretation and translation services may present barriers to care for linguistic minorities. Importantly, these institutional barriers may not be intentionally erected, but they must be challenged through awareness and action. Structural racism results from a system of social structures that produces cumulative, durable, race-based inequalities (Kirwan Institute 2011). One of the most significant examples of a form of structural racism that harms the health of people of color is residential segregation: many racial and ethnic minorities live in majority-minority communities that, on average, suffer from a disproportionate concentration of health risks (such as environmental degradation; an abundance of unhealthy foods, tobacco, and alcohol products) and a relative lack of health-enhancing resources (such as geographic access to health care providers, full-service grocery stores, safe parks, and recreational facilities) (Williams and Collins 2001). These neighborhood factors influence health in several ways. They exert effects on both physical and mental health through conditions such as levels of crime and violence, overcrowding, and environmental exposures. Neighborhood conditions also influence health in that they can either support or discourage healthy behaviors, such as exercise, proper nutrition, and the development of strong social supports. While some forms of segregation, such as ethnic enclaves among new immigrants, can foster positive mental health through social support, much of the residential segregation in the United States is reliant on both institutional discrimination in the real estate and housing finance market and individual interpersonal discrimination (Massey and Denton 1993).

Health foundations are increasingly engaging in efforts to dismantle structural racism, while at the same time exploring how the experience of race shapes all American's lives. The W.K. Kellogg Foundation, for example, has made an historic investment in undoing racism, examples of which are provided in Box 1 below.

BOX 1: TACKLING RACE AND RACISM

The W.K. Kellogg Foundation has launched an unprecedented effort to promote racial healing and address racial inequities. The America Healing initiative, launched in 2010, supports programs and initiatives that tackle structural factors that maintain racial inequality and help Americans recover from the wounds of racism. This five-year, \$75 million initiative seeks to help promote racial understanding and equitable policies and practices in the areas of education, health, juvenile justice, economic advancement, the media, and other sectors. This work focuses on issues at the core of structural racism—those policies and practices that continue to create barriers for the health and well-being of children of color.

Among the initiative's strategies and programs are efforts to:

- build a sustainable and accountable media and communications infrastructure that promotes positive racial dialogue and support for more equitable policies;
- build the capacity of grassroots organizations focused on racial healing and equity, while also supporting “anchor institutions” that work on racial justice issues;
- strengthen and expand partnerships among racial justice organizations and their stakeholders to promote cross-sector collaboration; and
- support legal research, policy analysis, and advocacy to dismantle racialized policies and systems, while also communicating the results of this research more effectively with target audiences.

The initiative seeks to open opportunities for Americans to have constructive dialogues on race and racism, and to explore how racism has shaped the personal and collective experiences of many in the United States. In so doing, individuals can explore opportunities for healing from racial wounds, while engaging in a broader dialogue that allows the nation to move beyond its racial conflicts. To this end, the foundation and its grantees have sponsored community forums and events on race and racism, have offered trainings on structural racism, and have engaged a variety of news media to advance Americans' understanding of how race continues to shape life experiences in the United States.

Source: W.K. Kellogg Foundation 2012

CHALLENGES AND OPPORTUNITIES FOR ADVANCING HEALTH EQUITY

Health funders working to advance health equity face a number of challenges in 2012. Most significantly, it is likely that the economic downturn of the last four years has made health inequities worse, although these inequities may not be reflected in vital statistics until the coming years (WHO 2009). Record numbers of Americans—disproportionately people of color—have been pushed into poverty or near-poverty as a result of the Great Recession, which has increased their risk for poor health. Growing income and wealth inequality in the United States, which pre-dates the Great Recession but nonetheless contributes to the nation's economic woes, also threatens to exacerbate existing health inequities (Economic Policy Institute 2010). These economic trends, if left unchecked, suggest that the modest narrowing of racial and ethnic health gaps observed over the last five decades may be reversed.

In large part because of the economic downturn, many of the public and private institutions that have played a significant role in creating the safety net (which has provided basic health and economic security for many millions of Americans) have fewer resources with which to address growing needs. Governmental health and social service agencies at federal, state, and local levels have faced significant budget challenges and cuts, and health foundations have similarly faced declining resources. This economic context, according to many of the leaders interviewed for this paper, underscores the need for greater collaboration across public and private sectors, given that no one entity by itself has the resources at the scale needed to effectively address the problem. This point will be revisited in greater detail.

To compound these problems, political gridlock appears to choke policy action at the federal level and in many states and localities. Bipartisan agreement is increasingly difficult to achieve in the current political climate, and most observers expect that bipartisanship will be nearly impossible to achieve in the 2012 election year. Even the narrowest of recent bipartisan “victories”—the Patient Protection and Affordable Care Act (ACA)—faced an uncertain future, given the U.S. Supreme Court's decision regarding the constitutionality of the law. The decision to uphold the majority of the law's provisions validates many new programs and efforts to expand health insurance, improve the quality of health care, and address racial and ethnic health inequities (Andrulis et al. 2010).

Despite these challenges, leaders interviewed for this paper agree that opportunities to advance health equity abound. In April 2011 the federal government released the first national strategy for eliminating health inequities, *National Stakeholder Strategy for Achieving Health Equity*. The national strategy, which was released by the U.S. Department

of Health and Human Services' (HHS) Office of Minority Health, outlines a common set of goals for public and private sector initiatives

Despite challenges...opportunities to advance health equity abound.

to achieve health equity. It is a product of the National Partnership for Action to End Health Disparities and incorporates ideas generated from thousands of individuals and organizations across the country to transform health care and expand health care access; improve the diversity and distribution of the health care workforce; expand the cultural and linguistic competence of health care systems; and improve neighborhood conditions that shape health, among many other objectives (National Partnership for Action to End Health Disparities 2011).

At the same time, HHS released *Action Plan to Reduce Health Disparities*, which coordinates the department's goals and activities and is aligned with the national strategy to expand its impact (HHS 2011b). The HHS action plan outlines strategies and actions to reduce health disparities in five overarching areas, including health care, the health and human services workforce, prevention, scientific knowledge and innovation, and HHS programs. This plan was developed in conjunction with the stakeholder strategy and is intended to amplify its impact.

Both the national strategy and the HHS action plan outline specific examples of ways in which public and private entities can collaborate to promote health equity. Strategies include ways that funders can support partnerships between public and private entities to help make health data more accessible to stakeholders and share evidence-based policies and build community-based leadership, for example.

Finally, it was the sense of many interviewed for this paper that leaders across many sectors, including business, faith, and scholarly communities, are increasingly focusing on the issue of health inequities. Some observed that news media outlets are more frequently reporting on health inequities, which presents opportunities to raise awareness and build political support for action. Elected officials at all levels of government are actively seeking solutions for health inequities, buoyed by the understanding that poor health among some communities ultimately shapes the context for health for all. The increased attention and desire to rectify health inequities present an important opportunity for health funders to advance a bold health equity agenda.

GRANTMAKERS RESPOND TO THE U.S. SUPREME COURT DECISION UPHOLDING THE ACA

Blue Shield of California Foundation: “After months of uncertainty, the decision gives California the green light to make good on the promise of health care reform. It is now up to all of us to take advantage of the greatest opportunity our generation has ever seen to provide all Californians with access to effective, affordable care.”

California HealthCare Foundation: “In the wake of the court's decision, uncertainty remains... The results of the November election could cloud the future of the law if Republicans gain control of the White House and/or Congress... Health care spending continues to rise faster than the rest of the economy, and unless that trend is addressed, any gains in coverage and access under the ACA will be short-lived. We must continue to work on many fronts to help cure our ailing health care system. Coverage is key, but we must also focus on the underlying cost of that care.”

The Commonwealth Fund: “The Supreme Court today ruled that states may expand their Medicaid programs under the conditions of the law and receive federal financing for them. But states that choose not to participate in the expansion may still maintain existing federal Medicaid funding. If all states choose to participate in the expansion, the Congressional Budget Office estimates that 17 million people could gain new coverage under the program by 2020.”

Maine Health Access Foundation: “Important issues remain regarding implementation of the law, and these should be guided by the voices and input of people from all sectors across the state... Maine policy leaders will need to make critical, data-driven decisions about how our state will proceed with either developing a state-based or participating in a federal health insurance exchange.”

The Health Foundation of Greater Cincinnati: “This decision reinforces that everyone needs to understand what benefits they may be eligible for and what changes may occur to their insurance... Sections of the Affordable Care Act have already begun to take effect and several more are scheduled to happen in the very near term. We've worked hard to provide the community with the information they need in an easy to understand format.”

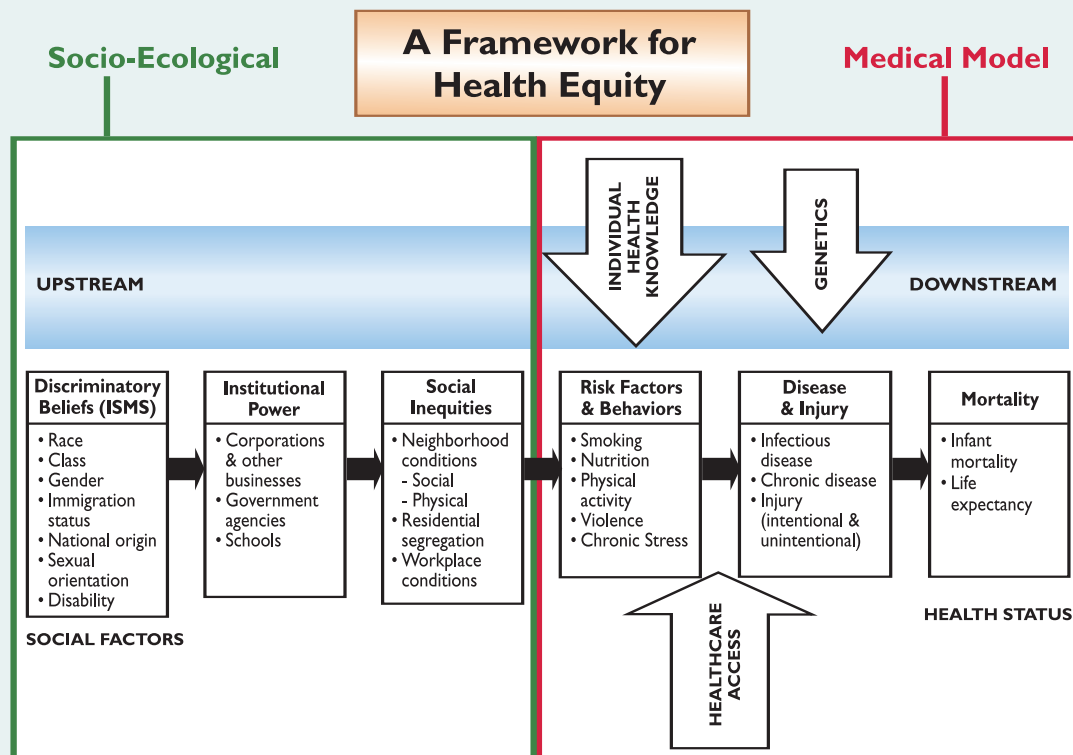
CONCEPTUALIZING INTERVENTION POINTS

Funders work at many different levels to improve conditions for health and eliminate health inequalities based upon their mission, history, constituencies served, and theories of change. The latter, however, has often been constrained because of limited vision, political constraints, and/or an inadequate understanding of the root causes of health inequities.

Anthony Iton of The California Endowment has offered a health equity framework that identifies a range of “upstream” and “downstream” intervention points. The framework is useful for considering key intervention points and how interventions can be developed in concert to build comprehensive, multi-pronged strategies.

In this framework (see Figure 1), health equity practitioners can assess opportunities for intervention and understand the broader context of factors that shape health. The right side of the framework focuses on determinants that are within the realm of individual and family behaviors and medical care. These include risk factors and behaviors such as smoking, nutrition, and physical activity, as well as genetic endowment. Some risk factors and behaviors are modifiable, and historically significant public health and foundation activity has been focused on this area. Many of these factors are powerfully shaped by social and ecological factors on the left side of the framework, which include more upstream inequities in neighborhood conditions (much of which is a consequence of residential segregation), workplace conditions, and the like. These conditions, however, are the result of inequities in political power and institutional arrangements, Iton

FIGURE 1. A FRAMEWORK FOR HEALTH EQUITY



Source: ACPHD 2008

notes, which are themselves the byproduct of and reinforced by broadly held values, ideals, and principles such as individualism, social responsibility, and fairness.

Iton argues that public health practitioners and funders must carefully consider opportunities to intervene at many points along the continuum. Historically, funders have concentrated their work at the right side, according to a medical model, which Iton believes has been necessary but not sufficient. “We need to continue to optimize practice on the right side—but simultaneously, [we must] move to the left side and develop strategies that ultimately reduce the demand on the right side.” But health funders should look at different types of work on the left side, he observed, and particularly at core problems of inequitable political power. “Funders of late have tended to jump to the middle box [institutional policies and practices] by supporting things like health impact assessments. Public health focuses on policy. But these approaches ignore the power dynamic. You can have good policies, but the mal-distribution of power imbalances leads to inequities of [health] outcomes.”

The recommendations that follow fall along various points along the “upstream-downstream” continuum. They include approaches focused “downstream,” on health systems, as well as “mid-stream,” on health behaviors and attitudes. Moving “upstream,” some recommendations are focused on policy and systems change. And one recommendation is focused on the issue noted above—that fundamentally, political engagement and democratic participation in the policy process are necessary to chip away at the inequitable distribution of power that underlies health inequities.

These recommendations are not comprehensive—they reflect the judgment and viewpoints of the individuals interviewed for this study, individuals who are not necessarily a representative sample of leaders working to build health equity. Their observations and recommendations, however, offer thoughtful approaches that may inform a new cadre of health equity initiatives.

SUGGESTIONS FOR METHODS AND STRATEGIES

Several suggestions for methods and strategies—ways of doing the work—emerged from the interviews. They cut across specific policy and program areas and draw upon examples of promising efforts.

FOUNDATION SELF-ASSESSMENT

Several health foundation staff and executives noted that an important—but sometimes neglected—starting point for foundations engaged in or planning to engage in health equity work is to conduct a rigorous equity self-assessment, and to continually monitor the impacts of grantmaking from an equity perspective. Foundations should critically examine their mission statements and assess whether and how equity issues are addressed. In some cases, equity may be an explicit aspect of a foundation’s mission. In other instances, equity may not be directly addressed but is implied in the populations and communities identified as priorities for the foundation. The mission statement can also identify methods and approaches to grantmaking, which can help foundations assess where along the “upstream-downstream” continuum grants and programs should be focused.

Once the equity elements of the mission statement are clearly identified, foundations should assess how board members, staff, and community members understand the causes and consequences of health inequities, and the foundation’s approach to tackling them. Particularly when race and racism are addressed, foundations may find that stakeholders have different understandings of how race and racism are relevant to their work and how they operate to structure health. Foundations may also find that board members, staff, and community members are reluctant to discuss these issues for fear of misunderstanding, mistrust, and/or conflict. Some foundation staff expressed support for educational programs or workshops to help these stakeholders come to common understandings of how race is relevant in their work. Particularly useful, they noted, are well-facilitated staff and board conversations and trainings on race and structural racism that offer opportunities for self-reflection and sharing of personal experiences.

Foundation self-assessment should also critically examine board and staff diversity, as well as institutional cultural competence. While not synonymous with cultural competence, board and staff diversity in all its forms (including race, ethnicity, sexual orientation, gender and gender identity, age, ability status, and other dimensions) can help foundations become culturally facile, broker relationships with many key communities, better consider and tackle health equity issues, and reflect the foundation’s broader values and aspirations.

As foundations make grants, it is important that they evaluate both intended and unintended consequences from an equity perspective. For example, foundations might believe that their grants and programs help build the capacity of communities to address health inequities, but they may have the unintended effect of supplanting community leaders and disempowering sources of community resiliency.

The Consumer Health Foundation in Washington, DC, and the Barr Foundation in Boston, Massachusetts, are two foundations that have undergone a rigorous and comprehensive Racial Justice Impact Assessment, which measures how well the foundation advances social justice issues. The assessment was conducted by the Philanthropic Initiative for Racial Equity (PRE) and the Applied Research Center. The report *Catalytic Change: Lessons Learned from the Racial Justice Grantmaking Assessment* emerged from this work, and offers a model of self-assessment across all aspects of foundation programs. PRE also offers a range of tools and educational materials to help foundations consider how to engage in structural and systems change to advance racial justice.

BUILDING UPON SUCCESSES

Several interviewees noted that there appears to be a shift occurring in the field, as funders are increasingly focused on addressing determinants outside of health care. While this might reflect a natural evolution in the field, they noted, there is a need for translation of health care delivery system issues to the work seeking to address broader determinants. There are many lessons learned from areas where the health philanthropic community has made a significant difference in health care settings, these interviewees noted. In the area of cultural competency, for example, health funders have transformed how health care providers and administrators think about cultural and linguistic diversity, and have developed many important and successful programs that have removed barriers to high-quality health care for many underserved populations. Lessons learned from these successful efforts, some interviewees noted, can be applied in the work to address social and economic determinants of health. For example, health care systems are now much more sensitive to the notion that “one size does not fit all” and that different population groups have different needs, values, and expectations regarding care; the same is true for how communities and community leaders respond to efforts to address neighborhood conditions that shape health. Similarly, health care systems have found that lay health navigators, or *promotoras*, can cost-effectively help patients from underserved communities better understand how to access and utilize health care systems. These same lay health navigators can also work at the community level to ensure that community members are better able to interact with public and private entities that shape community conditions for health. Such approaches draw naturally upon the many sources of strength and resiliency in communities, and allow these assets to surface as part of strategies to advance health equity.

LEVERAGING PUBLIC-PRIVATE PARTNERSHIPS

Because resources are scarce and political resistance to new government initiatives is strong, several interviewees recommended that funders look for opportunities to “broker” public-private partnerships that can strengthen investments toward equity. In such arrangements, for example, government and philanthropic organizations can offer incentives to businesses and private investors to increase access to healthy products and services. Several interviewees pointed to the Commonwealth of Pennsylvania’s Fresh Food Financing Initiative as an example of a public-private strategy to entice grocery chains to site new stores in communities that have poor geographic access to healthy foods. Pennsylvania’s initiative, which is supported by The Food Trust of Philadelphia in partnership with The Reinvestment Fund and The Greater Philadelphia Urban Affairs Coalition, seeks to increase access to affordable, quality healthful foods in underserved areas. The program provides loans and grants for the development, expansion, or renovation of fresh food retail establishments such as supermarkets or grocery stores (UNC Center for Health Promotion and Disease Prevention 2011). In the first five years of the program’s inception, over 400,000 residents of “food deserts” had increased access to healthy food, as the fund supported 83 supermarkets and fresh food outlets in underserved rural and urban areas throughout the state. As a result, 5,000 jobs were created or retained. The state’s initial investment in the program was \$30 million, but within the first five years, the fund resulted in projects totaling \$190 million (PolicyLink et al. 2009).

INFLUENCING POLICY

Some interviewees expressed frustration with what they perceived as a “timid” approach among some health funders toward influencing public policy. These leaders expressed the view that addressing structural and systems change requires a robust strategy for educating policymakers and engaging grassroots audiences, and that these efforts are well within the legal limits of lobbying placed on nonprofits. One interviewee noted that his foundation is primarily engaged in building the infrastructure and capacity of other nonprofits in his state to engage elected officials and push for policy change. Such a strategy, he noted, is particularly important when the nonprofit community does not have the resources itself to change the conditions that create health inequities.

REACHING OUTSIDE THE HEALTH SECTOR

Most interviewees expressed a belief that the health equity community—including public health, health funders, community-based organizations, and others—has not done enough to engage and partner with individuals and organizations working to effect change in other sectors such as education, housing, transportation, criminal justice, and the like. They argue that efforts to address the root causes of health inequities must address policies and systems in these sectors and that health and equity considerations must be infused in all policies.

Several interviewees offered examples of innovative partnerships that funders could consider as models of engagement. One such example can be found in the community development arena. A recent special issue of *Health Affairs* explores how public health and health care systems can more effectively work with the community development industry—which includes nonprofit service providers, real estate developers, financial institutions, foundations, and government—to improve neighborhood conditions and address upstream causes of poor health. In this issue, Erickson and Andrews (2011) note that despite having similar aims, “the community development industry rarely collaborates with the health sector or even considers health effects in its work.” But many examples of potentially successful opportunities for partnership exist, such as the creation of affordable housing that helps residents maintain healthy and independent lifestyles, construction of high-quality early childhood education centers, and the creation of incentives for grocery chains to establish stores in food deserts and for banks to set up branches in communities that are disproportionately “unbanked.” Erickson and Andrews propose a four-point plan to help ensure that these collaborations achieve positive outcomes and sustainable progress for residents and investors alike. These include harnessing community development work with new funds authorized under the ACA for federally qualified health centers; partnering with health systems to develop community benefit projects that include meaningful community development; incorporating measurement tools used by the health sector to assess the health impacts of community development activities; and creating new business incentives through public and private sector partnerships.

A significant challenge to creating these kinds of partnerships can be found in the field’s heavy use of health policy “jargon” and failure to use broad, inclusive language that allows non-health groups to envision how their work and mission is reflected in health equity work. Terms such as “social determinants of health,” some interviewees noted, are commonly used by health funders and policymakers, but pose barriers to potential non-health partners. These interviewees called for better approaches to communicating with community development groups and other organizations whose work advances health and equity but are not necessarily focused on health. This point will be addressed in greater in the “Communications” section.

COMPREHENSIVE, COORDINATED INTERVENTIONS

Several interviewees stressed the need for multisector, comprehensive, coordinated interventions aimed at key points along the upstream-downstream continuum. Most interviewees commented on the need for funders to support multiple coordinated strategies for equity, rather than narrowly tailored “single-shot” interventions. For example, primary care systems that help address social determinants of health in the communities that they serve may be more effective in narrowing health inequities than primary care services alone. One interviewee offered the work of the Cambridge Health Alliance (CHA) as an example of a comprehensive approach to advance health equity. CHA is an integrated health system that serves Cambridge, Somerville, and Boston’s metro-north communities. Since its founding in 1996, CHA has positioned itself through relationships with various institutions to provide care and promote health in both the clinic and in the community (CHA 2011). The alliance has academic affiliations with nearby institutions, including the Harvard Medical School, Dental School, and School of Public Health, and Tufts University School of Medicine. Through its affiliation with the Institute for Community Health, CHA conducts community-based research, assessment, dissemination, and educational activities. Additionally, its affiliation with the

Cambridge Public Health Department enables the alliance to be continually engaged with public health issues in the community (CHA 2010). CHA's public health efforts include initiatives to improve the overall health of the community and collaborative research projects that tackle critical health issues and influence policy. Specifically, these efforts include programs to address communicable disease prevention and control in local shelters, childcare centers, schools, and businesses; a children's dental program; the Healthy Homes childhood asthma program; Lead-Safe Kids; the Agenda for Children's Literacy Initiative; the Infant-Toddler Home Visiting Program; a school nutrition program; and divisions focused on emergency preparedness, environmental health, and epidemiology/statistics. Two recent campaigns successfully resulted in policies banning trans fats in local restaurants and smoking in workplaces (Cambridge Public Health Department 2012). Funders could help support demonstration and research efforts, such as the CHA model, that explicitly address multiple points along the upstream-downstream continuum.

COMMUNICATIONS

A majority of interviewees expressed frustration with the lack of communications tools and strategies available to scholars, public health practitioners, grassroots organizers, and others working to advance health equity. Many health foundations have worked to address this need by supporting research and disseminating communications information regarding health inequities. The result has been an important array of information that has yet to be synthesized and made broadly available to practitioners, a few interviewees observed. In particular, interviewees noted, communications strategies need to address the challenges of race and racism head

on. Simultaneously, there is a need to disarm messages that exploit racial bias. As one interviewee noted, "Race is complex, and strong emotions are attached to it.

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We need to counteract the 'dog whistle' approach that appeals to ideology, not facts." Interviewees suggested that funders could support more communications training programs to help practitioners communicate about health inequities and build support for strategies for their elimination.

New communications approaches are also needed to help engage with non-health groups that are also working to advance racial equity, as noted above. Several interviewees expressed a need for ways of talking about health equity work that explicitly connect with and open opportunities for dialogue with individuals and organizations working in sectors such as housing, urban planning, criminal justice, transportation, education, and community development. Some interviewees suggested that health funders should explore framing devices, such as statements about how their work builds healthy places and communities, and advances equity and opportunity for all. Others saw opportunities for advocates working in different sectors to come together under a geographic frame, given that many of the places and communities that suffer from health inequities face an assortment of barriers in education, housing, transportation, and related sectors. These strategies de-emphasize health as the key outcome of interest but explicitly focus on equality of opportunity and other "higher-order" goals that organizations working across sectors may share.

DEMOCRATIC PARTICIPATION

Some interviewees noted that many of the core themes above—such as the importance of influencing policy and building multisector alliances—fundamentally depend upon active civic participation. One interviewee observed that "21st century public health practice needs to be muscular, optimizing democratic participation and facilitating the ability of parents to fight for their children." The interviewee noted that, increasingly, equity work depends on building the capacity of communities and community-based organizations to

address challenges to health. Such approaches are being employed by foundations such as The California Endowment whose place-based work, Building Healthy Communities, focuses on organizing communities to encourage grassroots partnerships with public health. The initiative seeks to link policy and systems change with community-level investments in a range of programs targeting the nexus of community, health, and poverty. It does so by engaging public, private, and community leaders to help reduce risk factors, change systems, and policies, and to encourage community members to become more engaged in political processes.

KEY PROGRAM RECOMMENDATIONS

Leaders interviewed for this project saw several opportunities for health funders to advance equity work at many stages along the upstream-downstream continuum. Their suggestions are summarized below, beginning with strategies aimed downstream at health systems and individual behavior change, and progressing upstream to societal and systems changes.

FIGURE 2. A FRAMEWORK FOR HEALTH EQUITY STRATEGY MAP

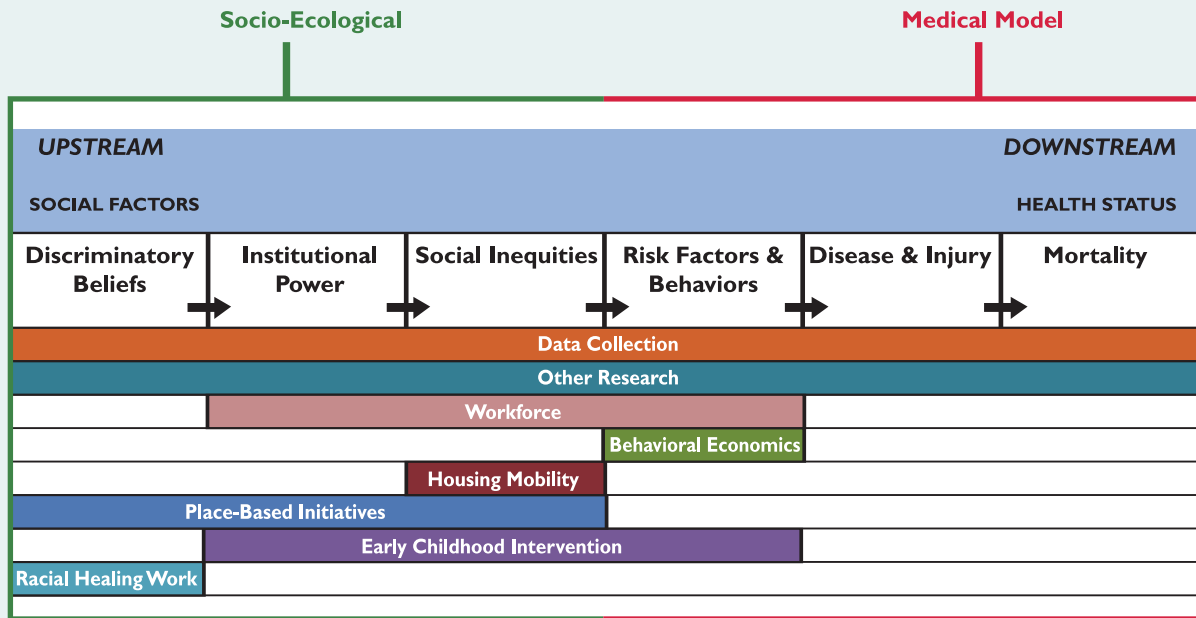


Figure 2 illustrates the cross-cutting nature of the interviewees' program recommendations along the upstream-downstream continuum. Some recommendations span the length of the continuum, while others fall within one particular category. Determining the mapping of strategies relates to the intent of the recommendation—specifically those that seek to address inequities through institutional change fall upstream.

There is a great deal of downstream work that is not depicted in the report's program recommendations. The report and this map capture the applications mentioned by interviewees, which focused heavily on upstream strategies.

- Strategies that address **discriminatory beliefs** seek to change the narrative of the impact of discrimination and exclusion on health.
- Strategies that address **institutional power** focus on targeting policies and practices.
- Strategies that address **social inequalities** aim to build community capacity to participate in decision-making.
- Strategies that address **risk factors and behaviors** seek to change individual behavior.
- Strategies that address **disease and injury** focus on repairing harm.
- Strategies that address **mortality** aim to prevent illness and death through life-saving efforts.

DATA COLLECTION

A majority of the leaders interviewed for this paper noted that more consistent and robust data collection—in health care settings and communities—provides a key opportunity to advance health equity policies, programs, and strategies. Provisions of the ACA require all federal grantees to collect consistent data on race, ethnicity, and primary language, presenting an important opportunity to advance knowledge in the field. Several interviewees argued that health funders can help hospitals and health systems a) train staff at the frontlines of data collection; b) educate patients to help them understand how data are used; and c) support research projects that help understand how, when, and under what circumstances health and health care disparities exist, and, conversely, where they are not found.

An important but often overlooked concern is the need to help scholars, policymakers, health care providers, and consumers understand why the collection of race, ethnicity, language preference, and other social and demographic data is important. Given that health care disparities often occur along the “fault lines” of race, ethnicity, nativity, and other social categories, the ability to disaggregate health care access and quality data along these dimensions allows researchers, health systems administrators, and clinicians to understand when, where, and under what circumstances health care disparities may persist. This information can also point to and help inform the evaluation of intervention strategies. Importantly, all stakeholders involved in data collection efforts must understand how to avoid abuse or misuses of data. For example, in scientific research the terms “race” and “ethnicity” are sometimes used as variables without guiding assumptions regarding why and how they shape health. Absent such information, scholars sometimes implicitly suggest that genetic or biologic differences undergird these categories. The scientific consensus among geneticists and anthropologists, however, is that race and ethnicity are social categories that are not biological in origin, but in effect. Health foundations could help educate target audiences about the meaning of race and ethnicity in health research.

Another interviewee noted that the ACA data collection provisions will result in an “explosion” of data, which needs to be studied to ensure that government programs benefit all populations and lead to reductions in health inequities. Insurance coverage expansions authorized by the ACA, for example, should equitably benefit all communities, but should be particularly beneficial to communities with low rates of insurance coverage. This interviewee recommended that funders support research and evaluation efforts to understand how different communities benefit from insurance expansions (such as assessing “take-up” rates) and whether these expansions lead to improvements in access to high-quality health care.

Yet another interviewee noted that funders can also help government and other stakeholders develop metrics to assess progress toward health equity. For funders, she noted, health equity is the assurance of conditions that promote optimal health for all. Health funders can work with policymakers and other stakeholders on a standard set of metrics to understand what “assurance” would look like. Given the broad array of social and economic inequities that shapes health, there is a need for a set of metrics that provides a comprehensive and theory-driven approach.

RESEARCH OPPORTUNITIES

Several interviewees see important new research opportunities emerging and urge funders to support research that can expand the evidence base for action. While the ACA authorized the elevation of the former National Center on Minority Health and Health Disparities at the National Institutes of Health (NIH) to an institute (now the National Institute on Minority Health and Health Disparities or NIMHD), it is unclear whether the new institute will have the resources necessary to significantly expand its portfolio of research. In addition, despite the efforts of NIMHD to support innovative community-based research on social, economic, and environmental factors that contribute to health inequities, NIH as a whole remains heavily oriented toward the bench and biomedical sciences, according to many of the leaders interviewed for this project. As a result, there is a significant need for health funders to support new, cutting-edge research that is unlikely to be supported by NIH. This research should be focused on understanding the mechanisms

and structures that perpetuate inequities, and the conditions necessary to ameliorate or eliminate them. As one scholar suggested, “So much remains to be learned. We’ve not correctly diagnosed the problem, so many of our interventions are aimed at superficial artifacts of racial inequality, such as health behaviors and health literacy.”

Health foundations can, for example, support research designed to increase understanding of the circumstances and conditions in which health care inequities are less likely to be found, such as the U.S. military and Veterans’ Administration

So much remains to be learned . . . we’ve not correctly diagnosed the problem, so many of our interventions are aimed at superficial artifacts of racial inequality, such as health behaviors and health literacy.

health care systems. The interviewee also suggested that more research is needed to assess health disparities among whites and people of color who face similar geographic or socioeconomic circumstances. Yet another leader interviewed suggested that more research is needed to understand the specific mechanisms through which evidence-based interventions work. For example, as will be discussed later, a large body of research supports the effectiveness of enriched early childhood educational programs even years later among the adults who received the intervention. More research is needed to understand how and why these programs had such long-lasting effects. Some evidence suggests that early enrichment programs have enduring effects on self-regulation and other executive functions, in which case their effects might be replicated and/or expanded by identifying the specific mechanisms that produce protective effects.

HEALTH CARE AND PUBLIC HEALTH WORKFORCE

Some interviewees noted that despite the coverage expansions and health care workforce programs authorized under the ACA, many communities will likely continue to face severe shortages of health care and public health professionals, problems exacerbated by cuts in state and local health programs. There is a significant need to understand how a variety of other health workers can fill these gaps, such as nurses operating in primary care settings, dental assistants addressing oral health needs in underserved communities, and community health workers promoting prevention. Funders could help assess how these health workers are meeting community needs and can fund demonstration or seed projects to fill gaps. The W.K. Kellogg Foundation, for example, has supported research to understand how midlevel dental therapists can provide oral health care in underserved communities that have high oral health care needs. In addition, the foundation has supported projects that bring mobile dental vans to rural communities, improve public health dental education, increase the diversity and distribution of the health workforce, and explore community-generated models of workforce development (W.K. Kellogg Foundation 2011).

BEHAVIORAL ECONOMICS

Some interviewees commented on the range of demonstration projects, both domestically and internationally, seeking to provide economic incentives to individuals to help them adopt positive health behaviors. For example, in high-risk school settings, some programs have offered financial incentives for students who have positive school attendance records and attain high grades; others provide cash rewards for parents who attend parent-teacher association meetings. (Presumably, such educational interventions have health consequences because of the strong relationship between educational attainment and health status.) In the health sector, insurers are experimenting with premium discounts for individuals who comply with recommended screenings and maintain positive health behaviors—a form of “pay for performance” for patients.

Educational incentives are drawing attention as a strategy, but most of these programs are in their infancy.

Among the most promising is the Opportunity NYC conditional cash transfer program, launched in 2007, which sought to “break the cycle of poverty” through providing cash rewards to low-income families who fulfilled specific criteria. It was based on the well-studied and lauded social programs in Mexico—*Oportunidades* and *Progresá* (The World Bank 2009). Opportunity NYC, however, was different from its foreign predecessors in that it was not tied to any form of social welfare and provided rewards for both education achievement and parental work training (Blackburn-Dwyer 2012). Funded by various private partners, including Bloomberg Philanthropies, The Rockefeller Foundation, The Starr Foundation, Open Society Institute, Robin Hood Foundation, Tiger Foundation, The Annie E. Casey Foundation, American International Group, The John D. and Catherine T. MacArthur Foundation, and The New York Community Trust, Opportunity NYC’s randomized control trial involved over 4,800 families and 11,000 children from six communities in New York City with high poverty rates. This cohort was drawn from an application pool and randomly assigned to either a program group or control group (Riccio et al. 2010).

The structure of Opportunity NYC Family Rewards focused on three condition areas: education, health, and workforce. Education outcomes included child attendance in school, standardized tests achievement, school progress markers, and parents’ engagement in a child’s education. Health outcomes included maintaining health insurance for the entire family and obtaining age-appropriate medical and dental preventive visits. Lastly, workforce outcomes, which were specifically aimed at parents, included full-time work and participation in approved education or job training activities. Cash rewards were available to individuals in the experimental group and ranged from \$20 to \$600 for each of the approximately 22 incentives during the first two years of the project. Ninety-five percent of families earned some reward during the demonstration, and over the first two years the average amount earned per family in the program group was \$6,000 (Riccio et al. 2010). Opportunity NYC officially ended in August 2010.

Preliminary evaluation data suggest that for families in the experimental group there was less poverty and hardship from hunger, inadequate housing, or health care; an increase in savings and bank accounts; increased child school attendance, course credits attained, and grade advancement; modest impact on continuous use of health insurance coverage; reduced reliance on hospital emergency rooms for routine care; increased family receipt of preventive dental care; and increased employment. Evaluation of Opportunity NYC is ongoing and expected to be concluded and released in 2012 (Opportunity NYC 2010).

Funders could help support and evaluate such programs, and, where successful, encourage efforts to bring them to scale. While promising, these strategies have also raised concerns about the impact of short-term economic incentives on long-term behavioral change, as well as whether or not there is sufficient cost efficacy and return on investment.

Other cautions and concerns exist from an equity perspective. In health insurance contexts, the adjustment of premiums based on employees’ health-related behaviors or outcomes may undermine the ACA’s attempts at increasing access to coverage for all Americans, and dissuade insurers from only enrolling “lowest cost” or healthy individuals. Systems that link premiums to health outcomes may in turn lead to higher premiums amongst lower-income individuals and families (Volpp et al. 2011). Behavioral economics has a mixed record in health systems. For example, a randomized control trial of financial incentives for smoking cessation showed a statistically significant difference between subjects in a smoking cessation program that included financial incentives versus subjects in smoking cessation programs alone (Volpp et al. 2009). In general, however, the effectiveness of outcome-based wellness incentives remains uncertain and raises concerns about equity, even though incentive programs are gaining momentum because of rising costs in health care and the apparent success of incentives in other environments (Volpp et al. 2009). Starting in 2014, the ACA allows employers to use up to 30 percent of the total amount of employees’ health insurance premiums to provide outcome-based wellness incentives. Additionally, with rising health care costs many policymakers are looking for ways to curb behaviors that exacerbate an already complex situation. Health funders should

consider supporting rigorous evaluation of behavioral economics programs and demonstration projects, both to assess their overall impact on health circumstances and outcomes, as well as to determine if they influence health inequities.

EARLY CHILDHOOD INTERVENTIONS FOR AT-RISK YOUTH

In 2005 Lauren LeRoy and Anne Schwartz observed that “[a] number of health funders are choosing to make a difference in the health of children by using strategies not typically considered as falling within the purview of the health sector.” Since that time, there has been significant growth in the number and scale of privately funded efforts to ameliorate the negative effects of poverty and toxic community conditions on the health and well-being of young children.

Several interviewees pointed to the strong and growing evidence that high-quality early childhood education programs can “inoculate” children living in challenging conditions and help them achieve better educational and vocational outcomes, and in some instances, better health as adults. Significant educational, behavioral, and vocational outcomes have been found as a result of longitudinal research on programs such as Head Start, Early Head Start, Model Early Childhood Programs, and Nurse Home Visiting programs. All of these early childhood education programs have demonstrated positive impacts on children’s cognitive skills and educational outcomes, with the largest effects reported from some prekindergarten programs and the model center-based programs. Most early childhood interventions also have had positive impacts on children’s emotional and behavioral outcomes, including long-term reductions in criminal behavior (Isaacs 2008). High-intensity home visitation programs, for example, that include visitation of parents and children in their homes at least once per week by trained personnel who provide information about child health, development, and care, are associated with improved parenting and children’s socio-emotional and cognitive development, as well as less risky adolescent behaviors among participating children (Bilukha et al. 2005). Meanwhile, evidence is growing that such programs can also improve children’s long-term health. For example, the Carolina Abecedarian Project, a randomized control study that enrolled 111 infants in the 1970s and continued to follow them through age 21, demonstrated that individuals who had received intensive education intervention starting in infancy had significantly better health and health behaviors as young adults (Muennig et al. 2011).

While not explicitly a “health” intervention, health funders can collaborate with other public and private funders and partners to support expansion and enrollment of eligible children in early childhood intervention and enrichment programs, and promote program fidelity so that such programs provide consistently high-quality services.

PLACE-BASED INVESTMENTS

Several interviewees commented on what they saw as a positive trend among funders to adopt a “place-based” frame in their work, which generally seeks to reduce exposure to health risks and increase access to health-enhancing resources at the community level. The recent work of The California Endowment, W.K. Kellogg Foundation, and Robert Wood Johnson Foundation was cited by these interviewees as examples of place-based work, but each also noted that smaller foundations could support similar efforts. Such strategies, they noted, require long-term investments and a commitment to building the capacity of local leaders so that policy and systems changes are sustainable.

The Harlem Children’s Zone (HCZ) was cited as an example of a comprehensive place-based approach designed to meet an array of needs of vulnerable children that likely will have important positive health consequences. HCZ is based on the assumption that effective, achievement-oriented schools and strong social and community services are necessary to support the educational achievement of children in poverty. HCZ’s intensive school curriculum and services are effective in improving the academic achievement of children living in high-poverty communities. But its community and social services appear “neither necessary nor

sufficient” to close education gaps (Dobbie and Fryer 2010). A similar program focused on health, the Joint Center for Political and Economic Studies’ PLACE MATTERS initiative seeks to build the capacity of community leaders to identify and address social, economic, and environmental conditions that shape health. Supported by the W.K. Kellogg Foundation, the initiative has supported efforts to build strong multisector coalitions and educate policymakers about local policy decisions that affect health.

The Convergence Partnership was also cited by leaders interviewed for this project as an important example of a collaborative effort to promote healthy places. Formed in 2006 by The California Endowment, Kaiser Permanente, The Kresge Foundation, Nemours, Robert Wood Johnson Foundation, and W.K. Kellogg Foundation, the partnership receives technical advice from the Centers for Disease Control and Prevention; program direction from PolicyLink; and policy research, analysis, and strategic support from the Prevention Institute. The Convergence Partnership’s goal is to develop and promote policies and environmental changes that will transform communities from places ridden by chronic disease and obesity to those where people have access to and eat healthy foods and enjoy active lifestyles. The partnership’s approach hinges on the engagement of experts from a variety of fields, and the influence of funders, advocates, and practitioners (Prevention Institute 2010). Program strategies include efforts to support policy and systems changes that promote:

- safe neighborhoods, communities, and buildings that support physical activity as part of everyday life;
- access to fresh, local, and healthy food;
- healthy foods and beverages in grocery and other food stores, restaurants, and entertainment venues;
- schools that offer and promote only healthy foods and beverages to students, and promote healthy physical activities and incorporate them throughout the day, including before and after school;
- workplaces and employers that offer and promote access to healthy foods and beverages and encourage opportunities for physical activity;
- government and private sector support for healthy eating and active living environments; and
- childcare organizations, including preschool, afterschool, and early childhood settings, that promote healthy foods and beverages to children and provide sufficient opportunities for physical activity (Prevention Institute 2008).

HOUSING MOBILITY

It is now well-known that neighborhoods with high concentrations of poverty can impair the health and human development of their residents. It follows efforts to de-concentrate poverty, such as assisting people who seek to move out of high-poverty communities, and should be considered a health equity strategy. One interviewer noted that health funders have an important opportunity in the coming years to advance housing mobility as a public health intervention. Housing mobility entails the use of housing assistance to help families in high-risk neighborhoods move to communities with better opportunity structures and, therefore, better conditions for health. Recent findings from the federal Moving to Opportunity program suggest that families who moved out of distressed neighborhoods and into lower-poverty communities experience better mental health, lower rates of risky health behaviors, and modest reductions in obesity and diabetes (see Box 2). While the results of this longitudinal study have not been uniformly positive (adolescent boys did not benefit as much as adolescent girls), the findings nonetheless suggest that housing mobility, when combined with other family support strategies and investments in distressed communities, can reduce the concentration of poverty and associated health risks that are among the root causes of health inequities. Funders, interviewees observed, could help support other smaller or existing housing mobility demonstrations and work to ensure that the public health community is more aware of and works in partnership with housing mobility efforts.

BOX 2: HOUSING MOBILITY AS A HEALTH EQUITY STRATEGY

Does place really matter when it comes to specific health outcomes? This topic is probed in a recent special article in *The New England Journal of Medicine*. The study, reported by Ludwig et al., draws on the Moving to Opportunity for Fair Housing (MTO) 10-year research demonstration project conducted by the U.S. Department of Housing and Urban Development. MTO's initial aim was to test and understand if housing counseling and/or assistance through vouchers had a long-term impact on housing, employment, and educational achievement.

MTO has had an open application for families living in public housing in high-poverty census tracts (that is, 40 percent or more of residents with incomes below the federal poverty threshold) in Baltimore, Boston, Chicago, Los Angeles, or New York City. Approximately 4,498 families (consisting of only women and children) were randomized into three groups. The low-poverty voucher group included 1,788 families who were eligible to receive counseling on moving and housing vouchers, redeemable only if they relocated to an area where less than 10 percent of the residents were poor. The traditional voucher group included 1,312 families who were eligible to receive only unrestricted housing vouchers. The control group consisted of 1,398 families who were offered neither housing vouchers nor counseling. There were no statistically significant differences in any of the 57 baseline parameters between the randomized groups.

Beginning in 2008 and lasting until 2010, the groups were surveyed to assess long-term follow-up on health outcomes, including height, weight, and chronic serum glucose levels. This data collection occurred on average 12.6 years following initial randomization. On follow-up, the opportunity to move from a neighborhood with high poverty to one with low poverty was associated with lower prevalence of obesity and diabetes.

CONCLUSION

Interviewees expressed optimism about the potential for health funders to significantly advance the health equity movement over the coming years and decades by utilizing the kinds of strategies noted above. Key themes and opportunities are summarized below. These strategies, however, will require greater collaboration among funders and with public and private entities both within and outside the traditional health sector. These partnerships should ultimately help stakeholders understand how health and health inequities are shaped by policies across a range of issues and sectors, and serve to promote the goal of assuring optimal conditions for health for all people.

SUMMARY OF KEY THEMES AND PROGRAM RECOMMENDATIONS	
KEY THEMES	
Conduct Foundation Self-Assessment	Evaluate the foundation mission for its equity elements; educate foundation board members, staff, and constituents; conduct Racial Impact Assessments of foundation grantmaking and programs.
Build Upon Successes	Draw upon successful practices and approaches in health care settings, such as those focused on building cultural and linguistic competence, and apply them to other determinants of health.
Leverage Public-Private Partnerships	Look for opportunities to “broker” public-private partnerships that can strengthen investments toward equity. For example, government and philanthropic organizations can offer incentives to businesses and private investors to increase access to healthy products and services.
Shape Public Policy	Build the infrastructure and capacity of other nonprofits in states to engage elected officials and push for policy change.
Partner Outside the Health Sector	Engage and partner with individuals and organizations working to effect change in other sectors such as education, housing, transportation, and criminal justice.
Develop Comprehensive, Coordinated Interventions	Support multiple coordinated strategies for equity, rather than narrowly tailored “single-shot” interventions.
Develop and Disseminate Model Communications Strategies	Support communications training programs to help practitioners communicate about health inequities and build support for strategies for their elimination.
	Develop communications strategies that allow health funders to connect with non-health sectors, such as transportation, housing, and education.
Build Democratic Participation	Support efforts that encourage activism and partnerships between grassroots organizations and public health.

Continued on next page.

SUMMARY OF KEY THEMES AND PROGRAM RECOMMENDATIONS *(continued)*

PROGRAM RECOMMENDATIONS

Data Collection	Train staff at the frontlines of data collection; educate patients to help them understand how data are used; and support research projects that help understand how, when, and under what circumstances health and health care disparities exist.
	Support research and evaluation efforts to understand how different communities benefit from ACA insurance expansions.
	Develop metrics to assess progress toward health equity.
Research	Support research to understand the mechanisms and structures that perpetuate inequities, and the conditions necessary to ameliorate or eliminate them.
Health Care and Public Health Workforce	Assess how a range of health workers (including paraprofessionals) meets community needs, and fund demonstration or seed projects to fill gaps.
Behavioral Economics	Support and evaluate demonstration programs, and, where successful, encourage efforts to bring them to scale.
	Evaluate and monitor behavioral economics initiatives to determine their impact on health equity.
Early Childhood Educational Intervention/Enrichment	Collaborate with other public and private funders and partners to support expansion and enrollment of eligible children in early childhood intervention and enrichment programs, and promote program fidelity so that such programs provide consistently high-quality services.
Place-Based Investments	Support initiatives that reduce exposure to health risks and increase access to health-enhancing resources at the community level.
Housing Mobility	Support housing mobility demonstrations, and work to ensure that the public health community is more aware of and in partnership with housing mobility efforts.

APPENDIX

LIST OF INTERVIEWEES:

Dolores Acevedo-Garcia, Northeastern University

Karen Anderson, Institute of Medicine

Paula Braveman, University of California, San Francisco

Anthony Iton, The California Endowment

Cara James, The Henry J. Kaiser Family Foundation

Camara Jones, Centers for Disease Control and Prevention

Ichiro Kawachi, Harvard School of Public Health

James Kimmey, formerly with Missouri Foundation for Health

Thomas LaVeist, Johns Hopkins School of Public Health

Marsha Lillie-Blanton, Centers for Medicare and Medicaid Services

Gary Nelson, Healthcare Georgia Foundation

Mildred Thompson, PolicyLink

David Williams, Harvard School of Public Health

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