

PATHWAYS OUT OF POVERTY:

What Can Health Funders Do?

Health funders must work across sectors and disciplines and think clearly, speak loudly, and act boldly on the issue of poverty.

— Ralph Smith

THE CHALLENGE TO HEALTH PHILANTHROPY

At Grantmakers In Health's 2006 Annual Meeting on Health Philanthropy, Paul Farmer and Ralph Smith challenged health philanthropy to confront the root causes of poor health. Describing his work in Haiti, Rwanda, and Boston, Farmer urged health grantmakers to be honest about the social forces and processes that leave many people vulnerable, marginalized, oppressed, and impoverished and to acknowledge that growing social inequity is the basis of many diseases. Calling this inequity structural violence, he asked "Is this the beginning of a conversation or the end of one? Are we going to say...it is really too hard to do this...? Or are we going to say, what do we do next?" (GIH 2006)

Reflecting on grantmakers as change agents, Ralph Smith challenged health funders to offer a rough estimate of the effect of their grantmaking on poverty and argued that funders have "managed to detach our work and our definitions of success from the poverty that is the root cause of the problems we seek to help solve." He recommended that funders work across sectors and disciplines and "think clearly, speak loudly, and act boldly" on the issue of poverty (GIH 2006).

POVERTY AND INEQUALITY IN THE UNITED STATES

Poverty is officially defined in the United States as annual family income that falls below a "poverty threshold" established by the federal government. In 2006 when the poverty threshold was \$20,444 for a family of four, about 36.5 million Americans – 12 percent of the population – lived in poverty. The poverty rate for racial and ethnic minorities, at 21 percent, was more than twice that of non-Hispanic whites (8 percent) (Mather 2007).

Racial and ethnic differences in poverty for children were even more dramatic. In 2006 more than three times as many African-American and American Indian children (35 percent respectively) and more than twice as many Hispanic children (28 percent) lived in poverty than did non-Hispanic white children (11 percent) (The Annie E. Casey Foundation 2007). That year, 12.7 million children in total lived in poverty.

In addition to children living in families defined as poor, another 15.9 million children lived in low-income families in 2006. Based on research that suggests that, on average, families need an income about twice the federal poverty level to meet their most basic needs – and even more than that in some localities – the government defines families whose income is less than twice the poverty level as low-income (Douglas-Hall and Chau 2007). Combining the numbers of poor and low-income children, a total of 28.6 million children, or almost four in 10 (39 percent), lived in families stressed by some level of economic hardship in 2006.

Children living in poverty are six times more likely to have poor health than children living in middle- or high-income households.

In 2000 the proportion of American children living in poor and low-income families began to rise, after declining for a decade (Douglas-Hall and Chau 2007). This increase corresponded with indications that income inequality in the United States had also increased. Data collected by the Congressional Budget Office indicate that the country's economic growth over the past 25 years has largely benefited the very rich, with income gains among high-income households vastly outstripping those among middle- and low-income households (Sherman and Aron-Dine 2007). For example, between 1979 and 2004 the average after-tax income of the top one percent of the population nearly tripled – rising from \$314,000 to nearly \$868,000 (an increase of \$554,000) – while the after-tax income of the middle 20 percent of the population rose from \$39,900 to \$48,400 (less than \$10,000), and the after-tax income of the poorest 20 percent of the population rose a mere \$800 from \$13,900 to \$14,700 (Sherman and Aron-Dine 2007).¹ Inequality has risen more in the United States than in most other advanced industrial countries (e.g., Europe and Canada) and is more extreme than in those countries (Yellen 2006). Rising inequality obviously magnifies the challenges of poverty.

The United States has historically deployed an array of policy tools to combat inequality and diminish economic insecurity. One example is the Earned Income Tax Credit,

¹ Income data are available for the period 1979-2004. These figures were adjusted by the Congressional Budget Office for inflation and are presented in 2004 dollars.

which supplements the earnings of low-income workers. Unemployment and disability insurance cushion family income in the face of job loss and illness, while Social Security shelters many elderly households from poverty. The real question is whether government can and should do more. Compared to Europe, Canada, and other advanced economies, the United States government does the least to target taxes and transfers toward moving families out of poverty (Yellen 2006).

Working both with and without government, there is a vital role for philanthropy to play in developing programs and promoting policies that both directly and indirectly support the goal of alleviating poverty. Foundations can seize this time as an opportunity for experimentation, innovation, and testing of new models – and for putting poverty, racism, and economic segregation back on the nation’s public agenda (Stauber 2005).

Compared to Europe, Canada, and other advanced economies, the United States government does the least to target taxes and transfers toward moving families out of poverty.

POVERTY AND HEALTH

Understanding how health funders can contribute to poverty alleviation begins with understanding the multiple dimensions of poverty that impact health. Guided by this understanding, health interventions can be designed that not only address immediate health problems, but also social, economic, and environmental factors that are contributing to disease. The process can result in individuals and communities acquiring the skills they need to begin moving out of poverty.

The oft-cited World Health Organization (WHO) definition states that health is “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” Although idealistic, this definition captures both the multiple dimensions of health and the fact that disease treatment is just one of several factors that contribute to being healthy (WHO 2007). There is considerable debate among researchers about the relative influence of the factors that lead to health, but it is widely agreed that health care is not the most important one. In fact, one analysis of early death in the United States suggested the following distribution of causes: behavioral patterns, 40 percent; genetic predispositions, 30 percent; social circumstances, 15 percent; shortfalls in medical care, 10 percent; and environmental exposures, 5 percent (McGinnis et al. 2002).

For the poor this means that while health-care related factors such as unequal treatment, language issues, and coverage issues contribute to poor health status, poverty’s primary impact is experienced through the social and physical environment. Health is powerfully influenced by education,

employment, income disparities, poverty, housing, crime, and social cohesion (McGinnis et al. 2002). Thus, when people have limited incomes, live in conditions of personal stress, are exposed to poor quality air and water and other environmental pollutants, and have limited access to healthy food, their health suffers. The evidence of this suffering is their higher rates of sickness and shorter life spans.

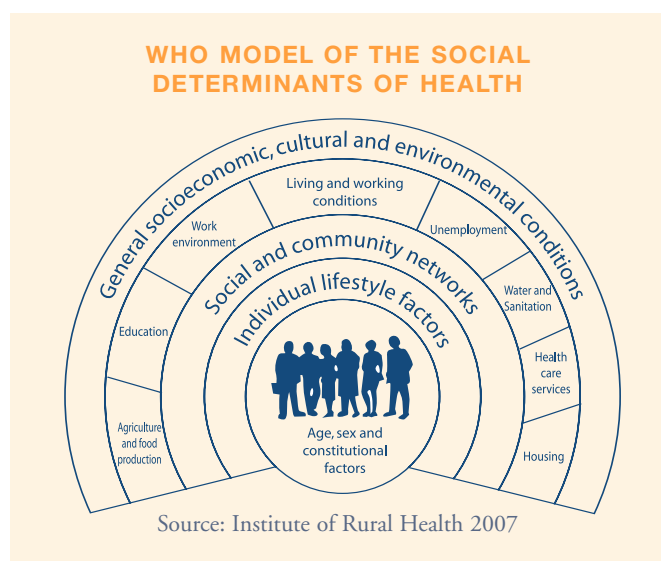
Racial and ethnic minorities and rural populations of all races, who collectively constitute the poorest social groups in the United States, persistently experience worse health and higher mortality than the white mainstream. The differences, generally termed “health disparities,” are seen in areas that include heart disease, cancer, cerebrovascular disease (stroke), chronic respiratory diseases, diabetes, HIV, and homicide. Racial and ethnic groups are not all characterized by the same disparities. For example, African Americans have significantly higher death rates than whites for all the diseases listed above, whereas Hispanics have higher death rates at certain ages for a smaller number of conditions, including cerebrovascular disease, diabetes, HIV, and homicide. For American Indians/Native Alaskans, disparities in cardiovascular disease mortality are a particular problem (IOM 2006).

Within racial and ethnic groups there can also be disparities as a result of income and other socioeconomic factors. Among Hispanics, for example, Puerto-Rican children’s lifetime asthma rates are 2.5 times those of Mexican children. Among Asian Americans, cancer rates differ markedly by nationality, as reflected in a recent California study that found significant between-group differences in cancer incidence and mortality in a sample of Chinese, Filipino, Vietnamese, Korean, and Japanese men and women (McCracken et al. 2007).

One of the most troubling aspects of tackling health disparities is the evidence that even when overall health trends improve, racial and ethnic disparities may persist. Thus, for example, although the overall infant mortality rate in the United States has declined by 10 percent since 1995, the rate for African-American women is still not only the highest in the country, but at 13.6 per 1,000 live births, is twice the rate of non-Hispanic white women (5.66 per 1,000 live births) (National Center for Health Statistics 2007).

The persistence of disparities is one reason for growing attention to the role of social, neighborhood, and environmental factors – the social determinants of health – as both causes of disparities and avenues for addressing them. One way to visualize the role these factors play in relation to individual health is the WHO model, which places biological and genetic factors at the core of health, surrounded by layers of influence that include personal lifestyle, connections to others (social and community networks), and the broader environment of education, employment, environmental quality, housing, and health care (Organisation for Economic Co-Operation and Development 2007).

In the case of the poor, poverty's effects permeate every layer of influence diagrammed in the model below: the level and quality of education that individuals receive, the type and quality of health care that is available, whether or not they are employed and the kinds of jobs they have, the healthiness of their environment, the safety of their communities, their understanding of the health impact of individual lifestyle choices, and so on.



HOW CAN HEALTH FUNDERS BEST CONTRIBUTE TO EFFORTS TO ERADICATE POVERTY?

If health funders want to address poverty and the social and environmental determinants of health through which it operates, there are many things they can do. They can begin by building upon their strengths. They should also be willing to cross borders, both literal and figurative, and build partnerships with those working in other fields.

Recommendations adapted from the international arena provide some guidance (Braveman and Gruskin, 2003).

- Health funders can incorporate the application of equity and human rights perspectives into their grantmaking. These perspectives raise awareness of factors such as discrimination or a lack of health care providers and facilities in poor communities that affect poor people's access to high quality, equitable health care services.
- Health funders can strengthen and extend public health functions – such as environmental standards, access to health-related information, and standards for safe housing and employment – that create the basic conditions needed to achieve health and escape poverty. This is likely to require working collaboratively with other sectors.
- Health funders can support the implementation of equitable health care financing. Equitable financing means that those with the least resources pay the least, not only in absolute

terms but also as a proportion of their resources.

- Health funders can ensure that health care services respond effectively to the major causes of preventable ill-health and associated impoverishment among the poor and disadvantaged.
- Health funders can pay attention to, advocate for, and take action to address the health equity and human rights implications of policies in all areas that affect health. For instance, funders can play a role in making it a standard practice that health implications for different social groups are taken into consideration when public policies are being designed, implemented, and evaluated.

In addition:

- Funders can stimulate, identify, share, and support interventions and strategies that are producing tangible results and identify those that should be dropped (Stauber 2007).
- They can raise awareness of successful experiments taking place in the states and locally.
- Working with communities, they can invest resources to create new knowledge that can be applied to reducing poverty.

Finally:

- Foundations can build public will to demand equity – equality of opportunities – for all. To quote James Joseph, “Philanthropy can help educate the public on the policies and practices needed to make our society work for all of its citizens.” And it can work to “level the playing field for those who pay more to participate in the workforce, provide for their families and build the assets they need to survive” (Joseph 2007).

KEY QUESTIONS

*Is this the beginning of a conversation or the end of one?
Are we going to say...it is really too hard to do this...?
Or are we going to say, what do we do next?*

– Paul Farmer

Using health programs to achieve broad social goals like increasing equity or alleviating poverty is not an easy process. These goals cannot be achieved quickly or cheaply. The effort requires working closely with communities, working across sectors, and investing for the long term. Nonetheless, to achieve lasting solutions to health problems, this approach is essential.

Questions to consider as you participate in Fall Forum sessions and as you consider the implications of the discussions for your foundation's work are:

- What are the ongoing antipoverty initiatives of which my

foundation should be aware? Who are the nontraditional partners to whom we can reach out?

- What are the promising solutions and potential opportunities we should know about? What are the big debates and contested issues we should be thinking about?
- What is the spectrum of activities we could support related to poverty and health? Are there entry points we could pursue while remaining faithful to our health mission? Within our realm of local or national funding, what are appropriate strategies?
- How should we talk about these issues with colleagues, grantees, and trustees?
- What are the barriers that prevent us from doing work in this area?

Companion essays in this packet illustrate what is being done in the areas of employment, education, housing, criminal justice, and the environment. Breakouts and presentations at the Fall Forum will provide examples of health-related policy change efforts spearheaded by the income security/antipoverty movement involving frontline health workers, medical debt, paid sick days, early childhood development and education, family leave, prison reentry, and other areas.

By becoming more informed about poverty reduction and learning about initiatives that are already underway, health grantmakers can begin to decide what they are going to do next to address poverty, with an awareness of the vital importance of the leadership they are providing in doing so.

RESOURCES

The Annie E. Casey Foundation, *Kids Count State-Level Data Online, Children in poverty (100%), by Race: Number: 2006* <http://www.kidscount.org/sld/compare_results.jsp?i=191>, accessed September 27, 2007.

Braveman, Paula, and Sofia Gruskin, "Poverty, equity, human rights and health," *Bulletin of the World Health Organization* 81(7):539-545, 2003.

Douglas-Hall, Ayana, and Michelle Chau, "Basic Facts about Low-Income Children Birth to Age 18," <http://www.nccp.org/publications/pub_762.html>, September 2007.

Grantmakers In Health, *From the Ground Up: Improving Community Health, Inspiring Community Action. Keynote Addresses from the Annual Meeting on Health Philanthropy* (Washington, DC: 2006).

Institute of Medicine, *Examining the Health Disparities Research Plan of the NIH, Unfinished Business* (Washington, DC: The National Academies Press, 2006).

Institute of Rural Health, "A Database of Good Practice in Rural Health and Wellbeing," <<http://www.ruralhealthgoodpractice.org.uk/>>, accessed September 27, 2007.

Joseph, James, "Philanthropy and Equity: Challenges and Opportunities for the American South," <<http://www.mdcinc.org/docs/josephspeech.pdf>>, accessed September 27, 2007.

Mather, Mark, "U.S. Racial/Ethnic and Regional Poverty Rates Converge, but Kids Are Still Left Behind," <<http://www.prb.org/Articles/2007/USRacialEthnicAndRegionalPoverty.aspx>>, August 2007.

McCracken, Melissa, Miho Olsen, Moon S. Chen, Jr., et al., "Cancer Incidence, Mortality, and Associated Risk Factors Among Asian Americans of Chinese, Filipino, Vietnamese, Korean, and Japanese Ethnicities," *CA: A Cancer Journal for Clinicians* 57:190-205, 2007.

McGinnis, J. Michael, Pamela Williams-Russo, and James R. Knickman, "The Case for More Active Policy Attention to Health Promotion," *Health Affairs* 21:78-93, March-April, 2002.

National Center for Health Statistics, *Health, United States, 2005 with Chartbook on Trends in the Health of Americans* (Hyattsville, MD: 2005).

National Center for Health Statistics, "Overall Infant Mortality Rate in U.S. Largely Unchanged; Rates Among Black Women More than Twice that of White Women," <<http://www.cdc.gov/NCHS/pressroom/07newsreleases/infantmortality.htm>>, May 2, 2007.

Organization for Economic Co-Operation and Development, World Health Organization, "Poverty and Health (DAC Guidelines and Reference Series)," http://www.oecd.org/document/46/0,2340,en_2649_34621_2505966_1_1_1_1,00.html>, April 28, 2003.

Sherman, Arloc, and Aviva Aron-Dine, "New CBO Data Show Income Inequality Continues To Widen; After-Tax-Income for Top 1 Percent Rose by \$146,000 in 2004," <<http://www.cbpp.org/1-23-07inc.pdf>>, January 23, 2007.

Stauber, Karl, "Money Talks, But What Do We Want It to Say?" <http://dcp.hudson.org/index.cfm?fuseaction=publication_details&id=4492&pubType=DCP_Opeds>, March 17, 2005.

Stauber, Karl, "Poverty and Development in the American South: Can Philanthropy Play a Role?" <<http://www.mdcinc.org/docs/stauber.pdf>>, accessed September 27, 2007.

World Health Organization, "What is the WHO definition of health?" <<http://www.who.int/suggestions/faq/en/>>, accessed September 27, 2007.

Yellen, Janet L., "Economic Inequality in the United States," <<http://www.frbsf.org/news/speeches/2006/1106.html>>, November 6, 2006.

CRIMINAL JUSTICE:

Community Corrections

Nearly 700,000 people in federal and state prisons and more than 7 million people in local jails are released to their communities each year. Most are low-income men of color who are returning to cities and towns with high concentrations of poverty. They reenter their communities with major barriers to success. About half struggle with substance dependence or abuse. More than half experience mental illness. Up to 25 percent have serious health conditions such as AIDS, Hepatitis C, and tuberculosis. They frequently end up without work or in low-wage, sporadic jobs. Two-thirds of released prisoners are arrested again within three years, and about half return to prison (Greenberg et al. 2007). Maintaining the health of prison and jail inmates and helping reintegrate them into their communities can help provide much-needed economic opportunities for ex-offenders, reduce the levels of crime in poor communities, and protect the public's health. Accomplishing this will require major changes in criminal justice policy, however, and will necessitate the involvement of health, mental health, and substance abuse systems. Are there ways for philanthropy to broker relationships between these different sectors and support related policy change efforts?

CORRECTIONAL HEALTH CARE AND PRISONER REENTRY

Jails and prisons are required to provide medical and mental health care for millions of people, most of whom are poor and many of whom enter correctional facilities with serious, unaddressed health needs. Some correctional facilities do a good job of meeting their constitutional obligation to provide health care. Others do not, and there are no federal regulations for the quality of health care provided by jails and prisons. The National Commission on Correctional Health Care sets standards for care, but prisons and jails can choose whether or not to follow these guidelines. The situation is worsened by the fact that correctional health care costs are high (since inmates have higher rates of infectious diseases and mental illness than the general population), and correctional health care is chronically underfunded (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006).

The major barrier to prison and jail inmates receiving health care is lack of access to health insurance coverage. No U.S. correctional facility receives federal Medicaid or Medicare reimbursement for health services, even though most people in prison and jail would meet the programs' eligibility requirements and many were enrolled in the programs before they were incarcerated. States have the option of suspending

JAIL V. PRISON

Jails primarily house people who are not yet convicted of a crime and those with sentences of one year or less. Incarcerations typically average two months and can be as short as 24-48 hours. Once a person is convicted, he or she is sent to a state or federal prison where the median length of incarceration is 2.5 years. The approach to health care changes depending on where within the system an inmate is. The lack of set release dates for those who are jailed makes it much harder to do discharge planning or provide continuity of care. Though jails have more of a community setting, prisons allow for better continuity of care because inmates are there for longer periods and release dates are known, which allows for better prerelease planning.

Supporting jail-focused initiatives may be a more logical place for health funders to intervene, however. Barriers to working within prisons include: geographic challenges, the bureaucratic complexity and politics associated with prison contracts, the difference in health care needs of those in jails (who tend to be younger) and those in prisons (who tend to be older), and issues associated with public perceptions of prisoners as hardened criminals

Source: View Associates 2006

or terminating Medicaid benefits while a person is in prison or jail.

Allowing correctional facilities to receive federal Medicaid and Medicare reimbursements would improve the quality of correctional health care, and convincing states to suspend rather than terminate benefits during incarceration would improve continuity of care since many ex-offenders have no way to pay for their doctor's appointments or medicine until they are reenrolled in Medicaid or Medicare weeks or months after release (Commission on Safety and Abuse in America's Prisons 2006; View Associates 2006).

Another barrier to quality, accessible correctional health care is finding skilled, committed, and compassionate medical and mental health providers. One promising solution is for prisons

Allowing correctional facilities to receive federal Medicaid and Medicare reimbursements would improve the quality of correctional health care.

and jails to partner with public health agencies and community health professionals, which increases the number qualified providers and improves the chances that people will continue to receive disease treatment and preventive care when they return home (Commission on Safety and Abuse in America's Prisons 2006). Counties across the country are beginning to build this link between corrections and communities, developing a new model of correctional health care that includes several key elements:

- recognition of incarcerated and ex-offenders as displaced members of a community,
- strong partnerships among a wide range of stakeholders,
- discharge planning begun well in advance of release and continued planning during the post-release phase,
- personal contact between inmates and community organizations that build rapport before release and have ongoing involvement,
- strong case management and outreach,
- colocation of health practitioners and case managers, and
- operational support for cross-discipline work (View Associates 2006).

This emphasis on discharge planning and ongoing relationships between released inmates and community organizations is an attempt to address the growing concern that people leaving prison find themselves permanently marginalized. The number of people released from prison has increased by 350 percent over the last 20 years. These people are released with limited job prospects, complex health needs, pressing family responsibilities, and little community supervision (View Associates 2006).

Ordinarily, people in need of basic resources, opportunities, and services turn to the public sector for aid. In this case, however, government policies can be more of a hindrance than a help. Public policies restrict ex-offenders' ability to vote, apply for jobs, secure housing, and apply for public assistance. In effect, these policies continue retribution after a person's release from prison or jail and produce a group of people who are forever categorized as ineligible for public support (Moritsugu 2007; Pogorzelski et al. 2005).

So what can help people successfully integrate into the community? Studies have shown that having a job and health insurance after release reduces recidivism, drug use, and crime (Freundenberg et al. 2005). Programs across the country are developing and testing interventions that make coming home

from jail an occurrence that rebuilds rather than disturbs individuals, families, and communities. So far, the characteristics of innovative reentry models seem to be:

- a strong mission to prepare inmates for successful reentry,
- demonstrated leadership by both the correctional and health care agencies of consistent support for reentry preparation programs,
- a holistic perspective to successful reentry,
- a long-term commitment spanning at least five to ten years,
- deep institutional memory among program staff,
- commitment to reentry and transitional health as manifested in program operating budgets,
- intensive reentry planning and focus in the last three to six months before release,
- individual accountability by each inmate for his or her success upon returning home, and
- geographic proximity of facilities to the communities where former inmates will return (View Associates 2006).

At the federal level, the Second Chance Act of 2007 is reentry legislation designed to ensure the safe and successful return of prisoners to the community. The bill has been introduced in both the U.S. House and Senate and has broad bipartisan support, including sponsorship by committee leaders in both

PREDICTORS OF EMPLOYMENT ONE YEAR AFTER RELEASE

Those who have...

- earned their GED while in prison
- very close partner relationships after release
- families that were more helpful than expected
- jobs while in prison
- more time employed since release
- supervision conditions requiring employment

...are more likely to be employed.

Those who have...

- a physical health condition after release
- depression after release

...are less likely to be employed.

Source: Visher 2007

chambers. The Second Chance Act is the first piece of comprehensive legislation designed to reduce recidivism. The bill authorizes up to \$65 million in grants to state and local governments to develop prisoner reentry initiatives and a \$15 million reentry program for community and faith-based organizations to deliver mentoring and transitional services for people returning from prison or jail. On August 2, 2007, members of the Senate Judiciary Committee completed the mark-up of S. 1060, the Second Chance Act of 2007. The bill will now be sent to the Senate floor for consideration (Reentry Policy Council 2007).

OPPORTUNITIES FOR GRANTMAKERS

A focus on correctional health care and prisoner reentry increases the likelihood of connecting with populations – men, women with a history of sexual and physical abuse, at-risk youth, people of color, low-income people, people struggling with mental illness and substance abuse, and people with high rates of chronic and communicable disease – that are marginalized and hard to pull into traditional health interventions. Grantmakers across the country are supporting innovative programs and policy change efforts that are ripe for adoption by their colleagues.

- **Mental Health Diversion** – There is an urgent need to divert mentally ill people from the criminal justice system to mental health facilities. It has been estimated that there are at least 350,000 mentally ill people in jail and prison each day; in some places, there are more mentally ill people in correctional facilities than in psychiatric hospitals (View Associates 2006; Commission on Safety and Abuse in America's Prisons 2006). The Omaha, Nebraska-based Alegant Health Community Benefit Trust made a recent \$200,000 grant to a pilot program that will divert mentally ill people who are arrested from the traditional criminal justice system into intensive case management services designed to help them establish independent living skills, manage their mental illness, and reduce their contacts with the criminal justice system. The Health Foundation of Greater Cincinnati made a recent \$250,000 grant to implement a police-based crisis intervention team to divert those with severe mental illness from incarceration and into treatment in three local counties, which will enable specially trained police officers to act as primary responders to calls in which mental illness is a factor.
- **Linking Correctional and Community Health** – The Hampden County (Massachusetts) Correctional Center's Public Health Model of Community Corrections has been heralded as one of the most innovative ways to link correctional health care with broader community health objectives. The jail's inmates are assigned to community health centers that correspond with their home zip codes. Health providers practice at the jail and in the health center and attend training sessions with the jail's staff. The health center continues to provide health services to inmates upon their release and partners with other community-based organizations who provide housing and employment services. The Robert Wood Johnson Foundation recently made a \$7 million grant to establish Community-Oriented Correctional Health Services (COCHS), a nonprofit organization that works to adapt and diffuse the Hampden model across the country. COCHS offers technical assistance to help jails develop partnerships with community health centers, builds the capacity of health providers and other community partners, and helps address information technology challenges. Because correctional systems can administer one contract with COCHS instead of several contracts with an array of providers (COCHS manages the subcontracting process), it provides an appealing option (View Associates 2006).
- **Juvenile Justice** – Being in detention, jail, or prison disconnects young people from their communities, damages their family relationships, and makes it enormously challenging for them to go back to school or find a quality job (New York City Commission for Economic Opportunity 2006). The John D. and Catherine T. MacArthur Foundation's \$100 million Models for Change initiative is attempting to create model juvenile justice systems in Illinois, Louisiana, Pennsylvania, and Washington. Each state has a work plan that includes specific steps it will take to bring about reform in physical and mental health. The premise of the foundation's juvenile justice work is that young people need a system that offers redemptive options and supportive services and that such a system will improve youth outcomes, lower crime rates, and be cost effective. The Jacob & Valeria Langeloth Foundation recently made a \$400,000 grant to implement the Massachusetts Health Passport Project, which provides continuous and comprehensive health care access to youth committed to the Massachusetts Department of Youth Services for delinquency or youthful offenses and will develop models that can be used nationally. The foundation has also made a \$200,000 grant to support the National Girls Health Screen Project, which is the first national effort to design, validate, and widely disseminate a gender-specific health screening instrument for use with girls being held in juvenile justice facilities.
- **Prisoner Reentry** – In 2003 the U.S. Department of Labor, U.S. Department of Justice, The Annie E. Casey Foundation, and Ford Foundation jointly funded the Ready4Work program, a three-year national demonstration

Studies have shown that having a job and health insurance after release reduces recidivism, drug use, and crime.

that provided reentry services to almost 5,000 returning prisoners in 17 sites around the country. Early evaluation results suggest that Ready4Work shows promise as a vehicle for helping people returning from prison forge connections in their communities. Sites enrolled ex-prisoners with numerous challenges and a high risk of recidivism and managed to keep participants engaged in the program. A majority of participants found jobs and remained employed for at least three consecutive months. Ready4Work sites provided about half the participants with mentors, and those participants have done particularly well in finding and keeping jobs. The program also appears to play a role in helping participants stay out of prison. Later analyses will examine whether mentoring and employment are indeed linked to enrollees' ability to remain out of prison. If analyses reveal such connections, the initiative could prove to be an important model for states and cities hoping to ease the transition of ex-prisoners back to their communities.

- **Support Services for Families**—The families of people in jail and prison often face complex challenges and are even more at risk once a family member is incarcerated. Assisting these families and including them in the planning for an inmate's return often require the involvement and coordination of a number of community organizations. In 1999 an estimated 1.5 million children had a parent in prison (Moritsugu 2007; View Associates 2006). The Northwest Health Foundation in Portland, Oregon, recently made a \$25,000 grant to develop therapeutic support for children of incarcerated parents and to train professionals to work with them. Alegent Health Community Benefit Trust recently made a \$100,000 grant to support public health nurses in children's shelters where the children's parents are

A focus on correctional health care and prisoner reentry increases the likelihood of connecting with populations that are marginalized and hard to pull into traditional health interventions.

incarcerated or homeless. The Health Foundation of Central Massachusetts has provided a \$35,000 grant to support parenting education to incarcerated and recently released fathers and to support their efforts to establish positive relationships with their children.

- **Research and Evaluation**—Correctional health care as a field recognizes the importance of promoting evidence-based programs and policies, but it suffers from poor data collection systems. Few systems have electronic medical records and reporting methods are frequently inconsistent and incompatible. Increasing support for research and evaluation within the correctional health care field is critical if grantmakers and policymakers hope to measure the impact of new correctional health and prisoner reentry policies and programs (View Associates 2006).
- **Policy Advocacy and System Reform**—Foundations can play a valuable role in supporting advocacy networks to improve Medicaid enrollment and re-enrollment for ex-offenders and in documenting best practice in this area. There is also a role for advocates to ensure that correctional health care is funded at adequate levels.

RESOURCES

Commission on Safety and Abuse in America's Prisons, *Confronting Confinement* (Washington, DC: Vera Institute for Justice, June 2006).

Freudenberg, Nicholas, Jessie Daniels, Martha Crum, et al., "Coming Home from Jail: The Social and Health Consequences of Community Reentry for Women, Male Adolescents and Their Families and Communities," *American Journal of Public Health* 95(10):1725-1736, October 2005.

Greenberg, Mark, Indivar Dutta-Gupta, and Elisa Minoff, *From Poverty to Prosperity: A National Strategy to Cut Poverty in Half* (Washington, DC: Center for American Progress, April 2007).

Moritsugu, Kenneth P., U.S. Department of Health and Human Services, "Improving the Health of Incarcerated Men and Women," remarks at the American Correctional Association 2007 Winter Conference, January 20, 2007.

New York City Commission for Economic Opportunity, *Increasing Opportunity and Reducing Poverty in New York City* (New York: NY, September 2006).

Pogorzelski, Wendy, Nancy Wolff, Ko-Yu Pan, and Cynthia L. Blitz, "Behavioral Health Problems, Ex-Offender Reentry Policies, and the 'Second Chance Act,'" *American Journal of Public Health* 95(10):1718-1724, October 2005.

Reentry Policy Council, "Second Chance Act of 2007," <http://www.reentrypolicy.org/reentry/Second_Chance_Act_of_2005.aspx>, accessed September 21, 2007.

View Associates, *Philanthropic Opportunities in Correctional Health Care* (New York, NY: The Jacob and Valeria Langeloth Foundation, 2006).

Visher, Christy A. and Shannon M.E. Courtney, "One Year Out: Experiences of Prisoners Returning to Cleveland," *Returning Home Policy Brief* (Washington, DC: Urban Institute, April 2007).

EDUCATION:

Curricula for Change

Education is the primary means of social and economic mobility in the United States. We stress the importance of education to young people because it is a key component of the “American Dream,” the most direct route of opportunity available to all of us. Yet, reams of research have made it clear that our nation’s educational system does little to weaken class divisions. Differences between poor and nonpoor children’s development and skills emerge as young as age three. Because school quality is so closely linked to family income, elementary and secondary schooling reinforce these worrisome gaps. College, the key to well-paying jobs, is increasingly out of reach for low-income families.

Are there ways to better organize education in America that would improve its ability to move people out of poverty? Are there natural entry points for health philanthropy – policy debates to which health funders can lend their voice and promising practices – to which they can lend their support?

EARLY EDUCATION

For many, increased public investment in preschool education has emerged as the place to start. There is an intricate collage of public and private programs for three- and four-year-old children, which includes preschool, prekindergarten (pre-K), Head Start, day care, and nursery school. Today, 42 percent of three-year-olds and 65 percent of four-year-olds attend some form of preschool. The best of these programs – those with highly qualified, well-paid teachers; high teacher-to-student ratios; and more hours of education – have been shown to improve performance at grade level, in test scores, in high school graduation rates, in college enrollment, and in adult earnings. Though these results are promising, the field faces some challenges. First, the quality of preschool programs is not uniform. Programs differ in their objectives, financing, rules and regulations, and intensity. It will be a challenge to preserve the success of the best models if policymakers and administrators are under pressure to keep program costs low. Second, there is debate about whether public preschool should be available to all children or should target low-income children. Though the need is great among low-income children and targeted programs would cost less, universal programs are more likely to identify and reach all targeted children and to receive greater public support (Barnett and Belfield 2006; Haskins and Sawhill 2007; Barnett et al. 2004).

Philanthropy has funded much of the research, advocacy, and public education on preschool programs. In 2001 The

KEY STATE POLICIES THAT HELP

Preschool Education

- Access to pre-K for four-year-olds
- Quality pre-K programs
- Access to pre-K for three-year-olds
- Universal access for state funded pre-K

Elementary and Secondary Education

- Rigorous teacher quality standards
- Funding equity among districts
- Funding adequacy
- Funding equity for students in public charter schools

Higher Education

- Lower tuition at four-year colleges
- Increased need-based financial aid
- Lower tuition at two-year colleges

Source: Center for the Study of Social Policy 2006

Pew Charitable Trusts launched the Advancing Quality Pre-K for All national initiative. The foundation’s strategy has been to build the research base on the costs, benefits, and characteristics of high-quality preschool; to identify states that have the opportunity to advance the issue; and to build the networks needed to inform public policy debates in those states and nationally. All told, Pew has invested over \$50 million in more than 20 organizations under the Pre-K initiative. The foundation initially framed the issues of preschool as an integral part of children’s educational experience but has recently begun to frame pre-K as an economic strategy, capable of contributing to the nation’s fiscal health. In 2006 Pew joined a group of funders, business leaders, economists, policy experts, and advocates to create the Partnership for America’s Economic Success. The partnership is in the process of commissioning research on the economic benefits of investments in children, the policy changes needed to fund services at levels appropriate to their economic value, and a communications and coalition-building effort needed to

advance these policies.

In 2003 The David and Lucile Packard Foundation made a long-term commitment to support nonprofit organizations working toward voluntary preschool for every three- and four-year-old in California. Knowing that delivering quality preschool for the one million children of preschool age in California was beyond the budget of the foundation (its entire endowment of nearly \$6 billion could cover only a little more than one year of preschool for every three- and four-year-old child in the state), the foundation's grantmaking has focused on policy change. Its goals are to expand and strengthen statewide advocacy efforts, engage a diverse cross-section of groups in support of preschool, support further research on topics related to ensuring preschool for California's children, and provide ongoing support to local flagship preschool efforts that demonstrate the promise of high-quality preschool when implemented on a large scale. One of these promising programs is Affordable Buildings for Children's Development (ABCD), which seeks to create a system to attract private lending to build and rehabilitate childcare facilities including preschools. The foundation has committed \$3 million in grants and \$14 million in program-related investments to ABCD as a catalyst to investment by other partners.

Preschool proponents recommend that programs encompass all aspects of children's development – cognitive, social, emotional, and physical – and that the programs include referrals to health services (Urahn and Watson 2007). This attention to the links between poverty, education, and health is an opportunity for health funders, especially those who have been supporting work related to early childhood development.

ELEMENTARY AND SECONDARY SCHOOLS

The public school system enrolls nearly 50 million students, a third of whom are from low-income families. Because the school a child attends is usually determined by where she lives, school quality varies according to parents' social class, resulting in poorer outcomes for poorer children. The policy change efforts with the most promise are those that try to upgrade the schools low-income children attend. There are competing ideas about how to do this most effectively, however. Some point with hope to efforts to shrink class sizes and improve teacher quality, others back institutional accountability programs like the No Child Left Behind Act of 2001, and still others tout the competitive pressure offered by charter schools and voucher programs. The best research evidence to date lends support to the first and second of these policy strategies as long as care is taken to reduce negative unintended consequences (Grantmakers for Education 2006; Sawhill and McLanahan 2006; Rouse and Barrow 2006).

Since 2000 the Bill & Melinda Gates Foundation has focused on improving high schools in the United States, with the goal of improving graduation and college-readiness rates for low-income students and students of color. Most of the foundation's funding has sponsored new and improved schools, with \$114 million invested in early college high schools where most students will receive high school diplomas and college credit, \$60 million invested in alternative high schools that provide high-quality options for at-risk and out-of-school youth, \$128 million invested in high-performing charter schools, \$448 million invested in urban school districts, \$200 million invested in state networks, and \$85 million invested in state and national advocacy efforts aimed at sustaining and expanding school and district improvement efforts. Over its first seven years of grantmaking, the foundation's education team has found that results take root most quickly in new schools, improvements happen more slowly at existing schools, district-level commitment is critical, efforts must be clear and comprehensive to work, and policy sets the context for school-level change and is a critical path to bringing best practices to scale (Bill & Melinda Gates Foundation 2006).

The fact that many key education decisions are made at the state or local level also provides an area of opportunity for regional, state, and local funders. Education has been a concern of The George Gund Foundation since its inception in 1952. In that time, the foundation has made grants of almost \$27 million to support the Cleveland Municipal School District and its students and has invested more than \$95 million to education overall. The foundation's strategy combines an increasing focus on state policy with involvement in all aspects of Cleveland's public schools. (The foundation was involved in significant efforts on both the state and local levels that led to the takeover of the school system by the mayor, for example.) The foundation's current areas of focus are experimenting with school size and structure, establishing new models for teacher training and retention, and determining how best to meet the nonacademic needs of students, all three of which foundation staff see as essential steps toward closing the achievement gap between privileged and underserved students.

Health funders interested in targeting hard-to-reach, low-income children frequently turn to elementary and secondary schools as the most logical sites to provide health care for young people and to launch child health programs like those that attempt to decrease childhood obesity or increase enrollment in public health insurance programs (Sawhill and McLanahan 2006). The Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, and The Health Foundation of Greater Cincinnati have all made notable investments in school-based health care. There is evidence to suggest that several school-based health interventions have the potential to improve school achievement and reduce school drop out rates (Freudenberg and Ruglis 2007).

HEALTH INTERVENTIONS THAT MAY CONTRIBUTE TO IMPROVED SCHOOL COMPLETION RATES

Type of Intervention	Program Activities	How the Intervention Reduces Dropout Rates
Coordinated school health program	Health education; physical education; health services; nutrition services; counseling, psychological, and social services; healthy school environment; health promotion for the staff, family, and community; partnerships	Teaches decisionmaking skills for better life choices; reduces absenteeism; offers early intervention and referrals for learning, psychological, substance abuse, and mental health problems; makes school more engaging; connects students to caring adults; engages families and communities in lives of young people
School-based health clinic	Primary and preventive health care, referrals, assistance in finding health insurance and health care for family, reproductive health services, mental health counseling	Reduces family health problems, offers early intervention and treatment for psychological and physical health problems that can interrupt schooling, reduces teen pregnancy
Mental health programs	Assessment and early intervention for young people with psychological, learning, or behavioral problems; referrals for children and families; counseling; staff training	Prevents problems that can interfere with school from becoming more serious; connects young people to caring adults, makes school more engaging, provides counseling or referrals for family mental health problems
Substance abuse prevention and treatment programs	Alcohol, tobacco, and drug use prevention education; peer education; early intervention for drug users; support for young people with substance-abusing parents; referrals for drug treatment or counseling	Reduces or delays onset of heavy alcohol or marijuana use, offers young people with a drug-using parent a source of support, makes school more engaging
Sex, HIV infection, and pregnancy prevention programs	Sex education, HIV infection prevention services, referrals for reproductive and sex health services, birth control, peer education, sexually transmitted infection prevention	Reduces or delays teen pregnancy, connects young people to caring adults or peers who encourage healthy behavior

Source: Freudenberg and Ruglis 2007

HIGHER EDUCATION

Research from the U.S. Department of Labor has shown that while the annual income of a 25- to 34-year-old high school dropout is around \$18,000, the annual income for a college graduate is \$36,000. This disparity is compounded as time goes on – the average high school dropout earns \$1 million less over a lifetime than a college graduate does. But students must overcome several hurdles to reap the academic and economic benefits that a college education provides. They need to be academically prepared in elementary and secondary school. They need to know how to select colleges, apply for admission, and gain acceptance. They need to find and secure financial aid. And they need to be psychologically and culturally prepared for college life. Each of these hurdles is more difficult for low-income young people. High schools in poor

neighborhoods are far less likely to offer the rigorous courses, honors course work, or advanced placement classes that college admission offices look for. Low-income families do not always have access to information about how to apply to college or on financial aid. Though financial aid is rising, the share targeted on low-income students has been falling, as needs-based assistance has been increasingly replaced by merit-based aid and has increasingly come in the form of loans, rather than grants. And although 22 percent of youth from the lowest income quartile attend college, only 6 percent graduate. Research suggests that inadequately prepared students are more likely to be from lower-income backgrounds; tend to need remedial classes, extra counseling, and additional services; and are consequently less likely to obtain a degree (Bill & Melinda Gates Foundation 2006, Haveman and Smeeding 2006).

The Indianapolis-based Lumina Foundation for Education has taken these challenges head on. The foundation's mission is to improve college access and success for all students – especially those who face the biggest challenges including low-income students, students of color, first-generation students, and adults in the workforce. The foundation's grantmaking is focused on five barriers to success in higher education: financial barriers, insufficient academic preparation, lack of information about the college application process and financial aid, unfamiliarity with the college going experience, and adverse government policies. In 2006 the foundation launched three major initiatives: the KnowHow2Go campaign, a public awareness and student assistance effort aimed at students in grades 8-10; Achieving a Dream: Community Colleges Count, which works to improve student success at community colleges; and Making Opportunity Available, an effort to make changes in policy and practice that will simultaneously expand college access and success, improve educational quality, and control costs.

Health funders support a wide range of scholarship, pipeline, loan repayment, and retention programs, many of which encourage low-income young people or young people of color to enter the health professions. The California Wellness Foundation has invested over \$15 million in projects related to increasing workforce diversity, for example, including a public education campaign that informs ethnic minority youth about career opportunities that exist in the health profession. If funders can think of ways to link this type of initiative with

initiatives to improve the quality of frontline health worker jobs and initiatives to improve college access and success, the results could be impressive.

CONCLUSION

Even at its best, education is not a panacea. Clearly, change is needed in multiple sectors, including reducing environmental hazards like lead that erode children's learning potential and improving the quality or quantity of jobs so that newly trained workers do not end up all dressed up with nowhere to go (Bernstein 2007). If we are serious about tackling inequity, education is a natural place to start. Health and education are two of the largest line items in most state budgets and, in these trying times, it is important that those with interests in health and education stand together to ensure that funds are not taken from one sector to pay for another and that the efforts of each create enduring pathways out of poverty.

RESOURCES

Barnett, W. Steven, and Clive R. Belfield, "Early Childhood Development and Social Mobility," *The Future of Children* 16(2):73-98, Fall 2006.

Barnett, W. Steven, Kirsty Brown, and Rima Shore, *Preschool Policy Facts The Universal vs. Targeted Debate: Should the United States Have Preschool for All?* (New Brunswick, NJ: National Institute for Early Education Research, April 2004).

Bernstein, Jared, "Is Education the Cure for Poverty?" *The American Prospect* Special Report, *Ending Poverty in America*, May 2007.

Center for the Study of Social Policy, *Policy Matters: Twenty State Policies to Enhance States' Prosperity and Create Bright Futures for America's Children, Families and Communities* (Washington, DC: January 2006).

Freudenberg, Nicholas and Jessica Ruglis, "Reframing School Dropout As A Public Health Issue," *Preventing Chronic Disease* 4(4), October 2007.

Bill & Melinda Gates Foundation, *All Students College-Ready: Findings from the Foundation's Education Work 2000-2006* (Seattle, WA: 2006).

Grantmakers for Education, *A Primer on the U.S. Public Education System: What A Donor Needs to Know About the Biggest Challenges and Biggest Opportunities* (Portland, OR: 2006).

Haskins, Ron, and Isabel V. Sawhill, "Attacking Poverty and Inequality: Reinvigorate the Fight for Greater Opportunity," *Opportunity* 08 (Washington, DC: The Brookings Institution, February 2007).

Haveman, Robert and Timothy Smeeding, "The Role of Higher Education in Social Mobility," *The Future of Children* 16(2):125-150, Fall 2006.

Rouse, Cecilia Elena and Lisa Barrow, "U.S. Elementary and Secondary Schools: Equalizing Opportunity or Replicating the Status Quo?" *The Future of Children* 16(2):93-124, Fall 2006.

Sawhill, Isabel, and Sara McLanahan, "Introducing the Issue," *The Future of Children* 16(2):3-18, Fall 2006.

Urahn, Susan K. and Sara Watson, *The Pew Charitable Trusts Advancing Quality Pre-K for All: Five Years Later* (Washington, DC: Pre-K Now, 2007).

EMPLOYMENT:

Health Works

Employment, poverty, and health interact through a complex, sometimes reinforcing, dynamic. In many respects, the relationships among these conditions seem obvious – underemployment leads to poverty, and poverty, in turn, compromises health status. Yet the causal influences at play are not entirely linear, nor clear cut.

Most Americans earn income by working, with their wages and work hours dictating earned income levels, eligibility for government income assistance, and ultimately poverty status. Over half of all families living in poverty receive some amount of income through employment, while only 21 percent of such families receive means-tested cash assistance (U.S. Census Bureau 2006). While employment does not always ensure sufficient income for basic needs (such as food, housing, child-care, and transportation), employment status has a significant influence on poverty rates. Only 5.8 percent of workers are poor, compared to 21 percent of adults (16 years of age and older) who do not work at all (U.S. Census Bureau 2007).

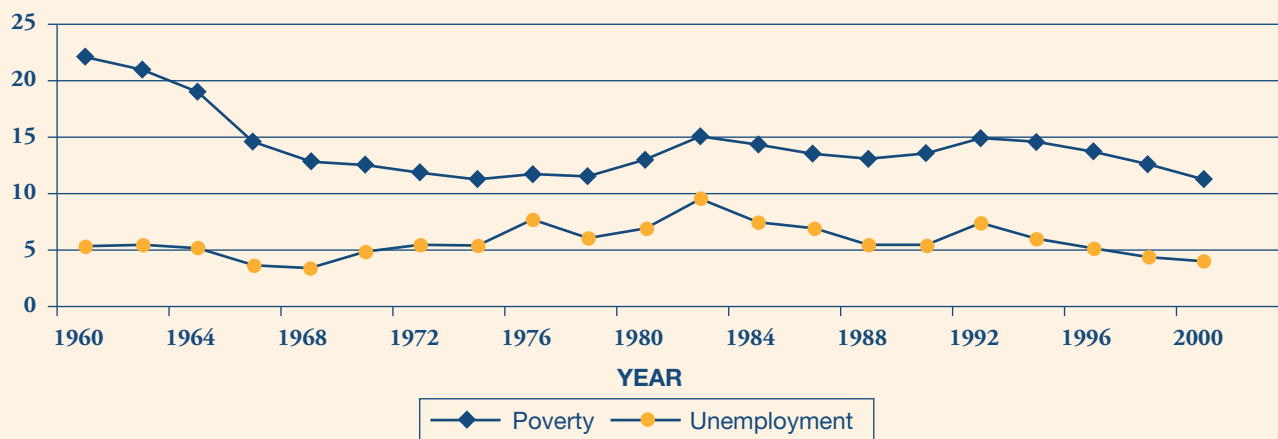
Unemployment and poverty rates have generally fluctuated in tandem over the last four decades (Figure 1). Low rates of unemployment are associated with reductions in poverty both because more people are earning income and also because tight labor markets lead to higher wages. Despite vibrant economic growth, unemployment rates in recent years have not reached the lows achieved in the late 1960s and early 1970s. As a result, wages have been largely stagnant for low-income workers since 1979, and the poverty rate has stubbornly refused to

Unemployment, sporadic employment, or low-wage employment can lead to poverty and all the health risks that life in poverty confers. Alternatively, poor health status can restrict employment opportunities, thereby limiting income and increasing the likelihood of poverty.

decline (Haskins and Sawhill 2007).

Economic trends play a major role in determining employment and poverty rates, but government policies are also critical. Welfare reforms in the mid-1990s created strong incentives for work. These reforms, combined with economic growth and childcare subsidies, led to declines in unemployment and increased income levels for poor, single mothers, along with decreased poverty rates for children living in female-headed households (Haskins and Sawhill 2007). The Earned Income Tax Credit reinforced these trends by offsetting payroll taxes paid by the poor through a refundable credit that varies by income level and family structure. While these trends are promising, concerns have been raised that the time limits imposed under the Temporary Assistance for Needy Families (TANF) program will result in hardship for poor families if unemployment levels increase significantly. Low-wage workers' fragile attachment to employment may result in families cycling in and out of poverty – as well as on and off the welfare rolls – during periods of economic decline. Following the recession of 2001, approximately

Figure 1: **RATES OF POVERTY AND UNEMPLOYMENT, 1960 - 2000**



Source: U.S. Census Bureau 2006 and U.S. Department of Labor 2006

Low-wage jobs often fail to provide compensation levels that support life's necessities and typically lack benefits, such as health insurance coverage and paid sick leave, that can protect families from the financial consequences of illness and injury.

one-quarter of the people who left the welfare rolls between 2000 and 2002 had returned to cash assistance by the end of the two-year period (National Governors Association 2007).

Long before TANF reform highlighted the importance of work, employment was viewed as the key to ending poverty and its negative health effects. However, employment can play a variety of roles in mediating the complex relationship between poverty and health. Unemployment, sporadic employment, or low-wage employment can lead to poverty and all the health risks that life in poverty confers. Alternatively, poor health status can restrict employment opportunities, thereby limiting income and increasing the likelihood of poverty. Working conditions can also directly impose risks that jeopardize health, and low-income workers are particularly likely to hold such high-risk jobs. These occupational health risks can be obvious (such as the high levels of toxic pesticides to which farmworkers are exposed) or they can be more subtle (such as the chronic stress experienced by low-wage workers with limited control over their work demands and responsibilities).

Although occupational health risks are a concern, employment also has the potential to improve health. Increased income, even for those who remain poor, typically leads to tangible improvements in health status and well-being. Some studies show that engaging in productive work can improve self-esteem and reduce depression. Survey research focused on diverse populations, however, suggests that members of minority groups may not fully reap the health benefits linked to increasing occupational status. The reported experience of work-place discrimination compromised health outcomes and increased the prevalence of depression among Asian-American respondents at all earning levels (The California Wellness Foundation 1999). Taken together, the evidence base indicates that the nature of a given job, as well as the standard of living supported by earnings from that job, determine the extent to which employment is likely to produce better health outcomes.

EFFORTS BY HEALTH FUNDERS TO IMPROVE HEALTH BY SUPPORTING EMPLOYMENT

The California Wellness Foundation observes that “the cross-disciplinary aspect of work and health poses particular challenges” (1999). Investments to support employment are not likely to yield measurable health-related results in the short-term, and innovative interventions may be viewed as untested and risky relative to more traditional health improvement

efforts. Despite these challenges, health funders have pursued a wide variety of employment-based strategies to improve health through poverty reduction. These efforts typically fall into two broad types of interventions: (1) facilitating the creation of safe jobs that provide a living wage and (2) helping people build the skills and capabilities needed to secure such jobs.

BUILD IT...

It is difficult for people living in or near poverty to find good, stable jobs that offer economic security and advancement opportunities. Some philanthropic efforts have focused broadly on building economic opportunity in low-income communities. Nurturing Neighborhoods/Building Community, an initiative of the California Community Foundation, has helped low-income individuals improve their lives through jobs, education, better health, and enhanced civic leadership. One facet of the initiative seeks to strengthen and expand economic opportunities by placing adults in jobs that provide livable wages and potential for career growth. Recognizing that job accessibility and success is often limited by practical barriers, such as childcare, transportation, language skills, and personal barriers, such as mental and physical impairments, grants were also provided for wrap-around services that assist individuals to stay in their jobs.

Some job creation efforts have focused specifically on leveraging workforce needs within the health care field. With support from Jane's Trust, The Jacob and Valeria Langeloth Foundation, The Atlantic Philanthropies, and the Charles Stewart Mott Foundation, the Leadership, Education, and Advocacy for Direct Care Support (LEADS) Institute is strengthening the ability of residential and in-home care providers in Maine, New Hampshire, and Vermont to attract and retain frontline caregivers. Developing a pipeline of workers, as well as career ladders for professional growth and development, accomplishes two goals: it builds a strong cadre of direct-care workers providing quality care to long-term care patients, and it creates employers that keep and reward good workers.

Other philanthropic efforts seek to enhance the wages and benefits of existing employment opportunities. The jobs available to unskilled workers are largely concentrated in the service and sales industries such as clerical support, retail sales, and direct-care workers in the health care field. Low-wage jobs often fail to provide compensation levels that support life's necessities and typically lack benefits, such as health insurance coverage and paid sick leave, that can protect families from the financial consequences of illness and injury.

Many health funders have played important roles in expanding health insurance coverage among vulnerable populations, and access to employment-sponsored insurance has been an important component of these efforts. Some health funders have focused specifically on improving the employment bene-

fits for health care workers. For example, the Paraprofessional Healthcare Institute developed the national Health Care for Health Care Workers (HCHCW) campaign. Supported by several foundations, including The Atlantic Philanthropies, The Nathan Cummings Foundation, the Charles Stewart Mott Foundation, Public Welfare Foundation, and The Retirement Research Foundation, the campaign seeks to inform policy-makers and employers about the benefits of health care coverage for direct-care workers. It also supports state advocacy efforts. In Maine, for example, HCHCW advocated for the expansion of affordable healthcare coverage for direct-care workers by broadening eligibility for DirigoChoice, the state's health care program. HCHCW is also reaching out to uninsured and underinsured direct-care workers in Maine and connecting them with resources to find needed health care.

High rates of uninsurance among low-wage workers are well established, but the need for improved leave benefits is less widely acknowledged. In fact, three in four low-wage workers and five in six part-time workers have no paid sick leave (National Association of Working Women 2007). Such benefits appear somewhat more generous within the health care industry, but still more than 2 in 5 direct care workers, such as home health aids and nursing assistants, do not have health insurance (Paraprofessional Healthcare Institute 2007). Workers without health care coverage are substantially less likely to seek preventive health care services for themselves or family members. They are also more likely to put off getting care until an illness or chronic condition worsens. Lack of sick leave can result in people not coming to work – and not getting paid – because they need to care for a sick family member.

The Public Welfare Foundation funded a two-year, \$1 million sick leave initiative to leverage support from a variety of groups, raise awareness of the issue, and identify policy solutions. The foundation awarded its first grant under the initiative to the National Partnership for Women and Families to support the first National Paid Sick Days Summit, held in July 2007. At the summit, participants focused on broadening support for the issue by framing it in the larger contexts of economic justice, support for families, and public health. Participants also examined how local coalitions working on the issue could expand their reach through collaboration with health reform advocates, labor organizations, and others. Additional grants under this initiative will support activities to organize stakeholders at the local, state, and national levels for paid sick leave policies; assess existing sick leave measures and develop new policy proposals; engage the business community by demonstrating the benefits of paid sick leave; and coordinate efforts among groups engaged in the issues to share strategies.

Limited leave benefits coupled with increasing insurance deductibles and co-payments for those with coverage can place low-income individuals and families at risk for unaffordable medical bills and medical debt. Between 25 and 40 percent of

Workers without health care coverage are substantially less likely to seek preventive health care services for themselves or family members.

Americans face problems paying high medical bills, with low-income and chronically ill people most at risk (Pryor 2006). The consequences of medical debt include reduced access to health care, as well as additional financial pressures that can undermine the economic security of individuals and families and exacerbate pre-existing health problems. The Quantum Foundation is raising public awareness about medical debt. It supports community-based groups, such as the Consumer Credit Counseling Service of Palm Beach County, which assist clients in resolving medical debt problems. The foundation also supports research on medical debt. A grant to The Access Project supported an assessment of medical debt in Palm Beach and the development of partnerships with local hospitals and community-based organizations to help ameliorate the burden.

A few health funders have pursued broader advocacy activities to support workers' rights including policy activities related to minimum wage standards, income tax policy, and occupational health hazards. Through its Bridging the Economic Divide (BED) initiative, Tides Foundation has built support for better wages. By partnering with a variety of stakeholders, grantees have successfully advocated for policy change at the state and local levels. The Santa Fe Living Wage Network, for example, achieved a private-sector voluntary living wage ordinance in the city of Santa Fe, New Mexico. BED also provides support to national organizations providing information and technical assistance to local coalitions. ACORN's Living Wage Resource Center received a grant to disseminate information on the living wage movement, as well as to develop a Web site with tools and materials such as living wage ordinance summaries and comparisons from across the country, drafting tips, research summaries, and Web links to other living wage-related sites.

...AND THEY WILL COME

Many factors make it challenging for the poor to secure and retain work even when good jobs are available. Common barriers to employment include low education levels, limited work experience, lack of childcare and transportation, and poor physical health. A recent study of welfare recipients in six states and the District of Columbia found that about 40 percent of recipients had not completed high school or a GED program, and about 20 percent reported physical health problems (Zedlewski et al. 2007).

Low-wage workers often lack opportunities to advance in their careers or develop the skills necessary to obtain well-

paying jobs. Access to job counseling, vocational training, and educational opportunities are often lacking in poor communities. To help low-skill adults prepare for and succeed in the work place, the Charles Stewart Mott Foundation and North Carolina GlaxoSmithKline Foundation support Jobs for the Future (JFF), a nonprofit research and advocacy organization that works to strengthen families and communities through educational and economic opportunity. JFF's Breaking Through initiative assists community colleges throughout the country to build and strengthen occupational and technical degree programs that help individuals gain the skills and credentials needed to obtain family-supporting careers. The program also helps create pathways for low-skill individuals to access educational opportunities.

To address the needs of low-income women with children, The Assisi Foundation of Memphis, Inc. provided support for the DeNeuville Learning Center's Step Forward program. The center helps low-income women with limited resources gain the skills needed to make positive choices for themselves and their families. It offers a variety of classes such as computer hardware and software, GED, English as a Second Language, business and job readiness skills, financial literacy, citizenship test preparation classes, and parenting. It also provides counseling services and assists women with childcare and emergency needs.

Health funders have been instrumental in addressing the health-related barriers that can lead to unemployment or undermine the productivity and earnings of low-wage workers. Health-related employment barriers are not uncommon among

the poor. About 30 percent of welfare recipients report having mental health problems, and almost 33 percent report having a special-needs child (Zedlewski et al. 2007). Recognizing these needs, The New York Community Trust supports NewTel, Inc., a nonprofit program that trains recovering substance abusers for employment in telemarketing. Trainees spend six months learning customer service, reservations, billing, and telephone surveys. They also attend classes in oral communication and telephone etiquette and receive counseling and job placement assistance. The foundation's grant was used to provide continued mental health and addiction counseling services for clients during their first 18 months of employment, covering work-related problems and personal crises, relapse prevention counseling, and referrals to a full range of outpatient activities.

CONCLUSION

The American work ethic is an important part of our cultural norms and expectations. As a society we value work – we believe that able-bodied adults should work and that workers should be fairly compensated for their labor. Expanded employment is likely to be the cornerstone of any successful effort to combat poverty. Increasing workforce participation, however, is unlikely to yield meaningful health benefits for low-income workers and their families unless wage levels and working conditions associated with that employment improve substantially. Health funders have a unique role to play in making employment a true gateway to income security, self-sufficiency, and well-being.

RESOURCES

The California Wellness Foundation, *Preliminary Observations About Grantmaking in Work and Health* (Woodland Hills, CA: 1999).

Haskins, Ron, and Isabel Sawhill, "The Next Generation of Antipoverty Policies," *The Future of Children* 17(2):3-16, Fall 2007.

National Association of Working Women, "10 Things That Could Happen To You If You Didn't Have Paid Sick Days," <<http://www.9to5.org/downloads/booklet.pdf>>, accessed September 26, 2007.

National Governors Association, *Issue Brief: State Strategies for Improving the Employment Outcomes of TANF and Low-Income Families* (Washington, DC: June 13, 2007).

Paraprofessional Healthcare Institute, *The Facts About a Critical Gap in Long-Term Care: Caregivers Without Coverage* (Bronx, NY: 2007).

Pryor, Carol, *Playing By the Rules But Losing: How Medical Debt Threatens Kansans' Healthcare Access and Financial Security* (Boston, MA: The Access Project, January 2006).

U.S. Census Bureau, "Current Population Survey, Annual Social and Economic Supplement, 2006, Table POV27," <http://pubdb3.census.gov/macro/032007/pov/new27_001.htm>, accessed September 26, 2007.

U.S. Census Bureau, "Poverty Status of People by Family Relationship, Race, and Hispanic Origin: 1959 to 2006," *Income, Poverty, and Health Insurance Coverage in the United States* (Suitland, MD: 2006).

U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006* (Suitland, MD: 2007).

U.S. Department of Labor, Bureau of Labor Statistics, "Employment Status of the Civilian Noninstitutional Population, 1940 to Date," *Current Population Survey* (Washington, DC: 2006).

Zedlewski, Shelia, Pamela Holcomb, and Pamela Loprest, *Hard-to-Employ Parents: A Review of Their Characteristics and the Programs Designed to Serve Their Needs* (Washington, DC: The Urban Institute, June 2007).

HOUSING:

Home, Safe Home

Having a safe and healthy home is paramount to prosperity. Yet in light of rising housing costs and declining real wages, it is increasingly difficult for low-income families to secure a suitable place to live. Too often, affordable housing units are located in undesirable locations, marked by pollution, violence, and crime.

Poor housing conditions can significantly affect public health. Childhood lead poisoning, injuries, and respiratory diseases, such as asthma, have been linked to the more than 6 million substandard housing units nationwide. Residents of these units are also at increased risk for electrical injuries; falls; rodent bites; and exposure to pesticides, tobacco smoke, and carbon monoxide. In its Healthy People 2010 goals, the U.S. Department of Health and Human Services calls for a 52 percent reduction in the number of substandard occupied housing units throughout the United States (CDC 2007). In addition to environmental risks, residents in substandard public housing also face increased risk of crime and violence. Gun-related crimes disproportionately affect low- and moderate-income families residing in public housing. These residents are more than twice as likely to suffer from firearm-related crimes than other U.S. residents (U.S. Department of Housing and Urban Development 2000).

While findings are mixed, some studies suggest that residents of public housing have weaker social networks and experience social isolation. In many housing projects, which are typically densely populated, a lack of public spaces may foster distrust and conflict. Public spaces, such as sidewalks, well-maintained parks, and plazas where people can meet informally, help develop social trust and a sense of community. Some studies suggest that predictors of an individual's satisfaction within a community were the number of neighbors he or she could name and the number of years he or she expected to remain in the community (Glynn 1981).

For some, however, finding any home at all is an insurmountable challenge. Most homeless people have incomes below 50 percent of the federal poverty level¹, making it nearly impossible for them to afford rental housing, health care, or other basic human needs. It has been estimated that between 2.5 and 3.5 million people experience homelessness during any

AFFORDABLE HOUSING: A STRATEGY FOR BETTER HEALTH

One study from The Greenlining Institute examines the relationship of poor housing conditions, lack of affordability, and the location of housing to health impacts. In particular, a shortage of affordable units leaves individuals and families fewer dollars for other necessities such as nutritious food and health care coverage. In addition, the concentration of affordable housing in core urban areas or older suburbs has led to segregation of low-income people in these areas who then face a burdensome combination of poor physical conditions, little job growth, and limited economic mobility. Increasing opportunities for home ownership will not only allow low-income people to build their asset base, but will also allow them to exert control over their living conditions.

Source: The Greenlining Institute 2002

given year (U.S. Department of Housing and Urban Development 2007). Nearly 70 percent of the homeless population face serious health problems that increase the risk of becoming homeless and also make it more difficult to overcome homelessness.

Certain groups, such as people with mental illness or substance abuse disorders, returning veterans, and discharged prisoners, are at particularly high risk of becoming homeless. Serious mental illness plagues 20 percent of the chronically homeless (HHS 2003). Over the past several decades, the majority of the care for people with serious mental illness has shifted from state hospitals to the community. While many communities have designed programs to help homeless people with mental illness, the number of people in need far exceeds the capacity of such programs. With no way to track the homeless population, individuals with special needs, such as medication to control their illness, may find themselves in the emergency room or jail. Homeless people with substance abuse problems may wind up spending time in jail or in temporary rehab. While medical treatment is considered standard in most cases, it tends to be expensive and does not always offer adequate discharge planning, often sending individuals right back to the streets.

¹ The 2007 HHS poverty guidelines indicate a threshold of \$10,210 for a single individual. Source: *Federal Register*, 72 (15):3147-3148, January 24, 2007.

Returning veterans are also at increased risk for homelessness. Estimates indicate that nearly one-third of homeless men are former service members. The majority are single men from disadvantaged communities, nearly half of whom suffer from a mental disorder (National Coalition for Homeless Veterans 2007). Veterans face the same personal risk factors for homelessness as other vulnerable populations do – a shortage of affordable housing options, poor access to health care, a lack of social supports – and many live with lingering trauma from war.

To make matters worse, the health care system is simply not set up to effectively serve the homeless. The lack of a physical address makes service coordination difficult, and as a result, many homeless people receive their health care in the emergency room. In most cases, homeless people have a wide range of social service needs, ranging from health care, housing, employment, and access to public benefit programs. The current fragmented system places the burden on the individual to coordinate his or her own care. This evidence of health problems among the homeless exposes the strong connection between housing and health. The devastating combination of poverty and poor health makes finding adequate housing a near impossibility.

A GUIDE TO ENDING COMMUNITY HOMELESSNESS

The National Alliance to End Homelessness has created a ten-step checklist to help communities identify effective permanent solutions to prevent and end homelessness. Each step involves every sector of the community. Based on the alliance's Ten Year Plan to End Homelessness, the plan outlines a blueprint for communities to follow. Strategies include preventing homelessness, collecting data to improve the system's effectiveness, developing housing options that ensure long-term stability, and improving social supports for low-income individuals.

Source: National Alliance to End Homelessness 2007

Ending homelessness requires more than just building structures. Simply putting people in emergency shelters or other housing will not attack the underlying causes of poverty. Homeless or formerly homeless individuals who suffer from mental disorders or substance abuse problems need coordinated assistance to overcome their health problems. In addition, they need support to find employment, if they are able, or to pursue education. Studies suggest that supportive housing for the chronically homeless more than offsets the costs incurred by emergency rooms, prisons, and shelters (HHS 2003). In fact, within 12 months of moving into supportive housing, use of emergency rooms falls by 58 percent and use of hospital

inpatient beds falls by 57 percent, with another 20 percent decline the next year (Proscio 2000).

THE ROLE OF PUBLIC POLICY

Public housing has been supported by a variety of federal policies and programs. The 1978 Housing Choice Voucher Program, more commonly known as Section 8, encourages the private sector to construct affordable homes and subsidizes public housing. Section 8 can also provide tenants with a voucher, accepted by some rental property owners. Only recently was Section 8 expanded to assist first-time homebuyers. In 1993 the Department for Housing and Urban Development (HUD) developed its HOPE VI program to replace severely distressed public housing projects with well-designed mixed-income housing. In addition, the program seeks to address the social and economic needs of residents in public housing. Studies have shown improvements in new housing developments such as lower levels of poverty, lower rates of violent crime and gang activity, and improved overall safety (Popkin and Cove 2007).

Over the past two decades, the homeless service system has grown remarkably, largely because of federal leadership and funding (Burt 2001). The McKinney Homeless Assistance Act of 1987 focused on providing care to homeless individuals with mental health or substance use disorders and resulted in a number of demonstration projects intended to build the evidence base. The Act, later the McKinney-Vento Act, marked the first time that federal resources for transitional and supportive housing were made available to communities. With this funding, HUD established its Continuum of Care program in 1996. HUD provides annual awards for homeless assistance projects that provide a comprehensive array of integrated services in communities.

Putting an end to chronic homelessness is no easy feat. Yet hundreds of cities and states across the nation have launched campaigns with that very goal. In 2001 the federal government adopted the goal of ending chronic homelessness in 10 years, and more than 200 communities, including Denver, New York City, and Nashville, have followed the federal lead to develop 10-year plans to end long-term homelessness. Many of these communities have implemented these plans, mobilizing both homeless-related and mainstream agency resources to address the needs of the chronically homeless population.

Despite concerted efforts to improve public housing and reduce homelessness, daunting policy challenges and choices remain. When local housing agencies create mixed-income developments, the number of units available for the poorest families may shrink. Racial and ethnic discrimination may limit families' options as they search for affordable housing in the private market. States and local communities are under pressure to respond to federal housing mandates, but shrink-

HOUSING TRUST FUNDS

Housing trust funds (HTFs), typically created by legislation or ordinance, are distinct funds established by cities, counties, or states that commit revenue to support affordable housing. An innovative departure from historical efforts to promote affordable housing, HTFs provide a dependable source of funding that does not rely on interest or earnings from a fixed fund or on contributions from private donors. Funds can be used to support the creation and maintenance of affordable housing, subsidize rental housing, improve homeless shelters, or provide start-up funding to housing developers.

Source: PolicyLink 2007

ing federal resources make it harder for local communities to design policies that respond to local circumstances and needs (Urban Institute 2007).

PROMISING PRACTICES

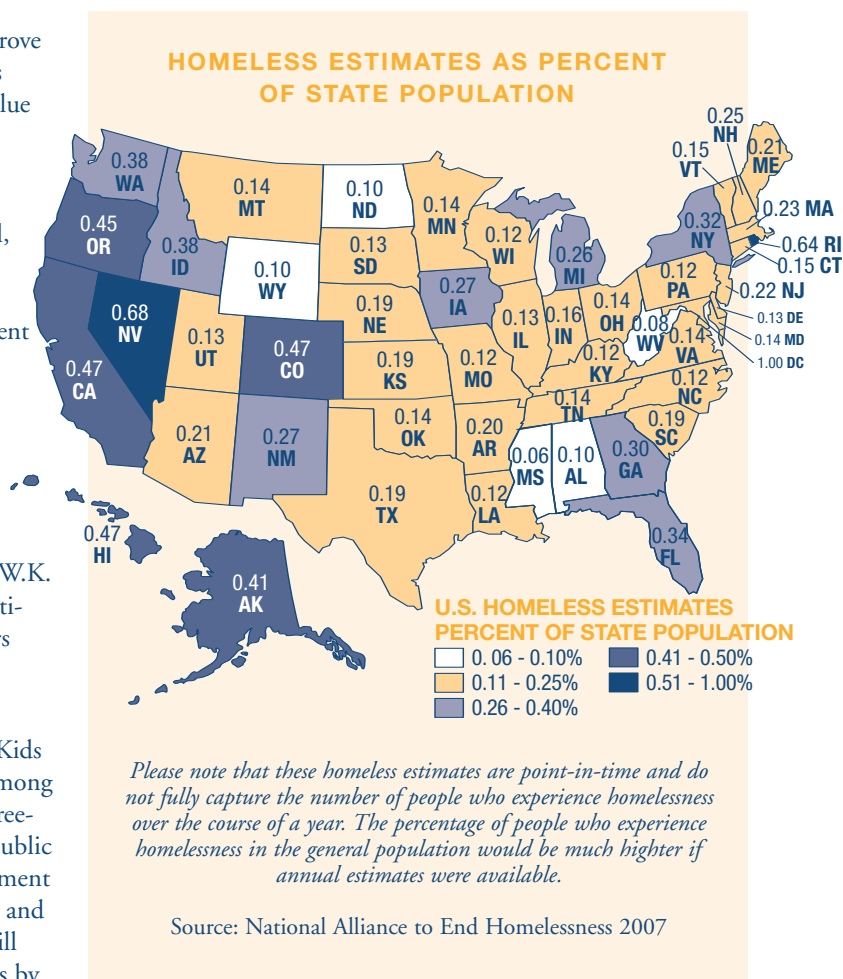
Organizations throughout the country are working to improve inadequate housing that can cause health problems such as asthma and lead poisoning. For example, the Blue Cross Blue Shield of Minnesota Foundation supports the National Center for Healthy Housing and its mission to reduce children's risk of lead poisoning and decrease children's exposure to other hazards in the home including biological, physical, and chemical contaminants. With a three-year, \$150,000 grant, the foundation tasked the center with conducting a health impact study in a low-income apartment complex in Worthington, Minnesota, and examining how housing rehabilitation can improve health status.

The Medical-Legal Partnership for Children addresses residential issues that cause health problems such as mold, pests, and exposure to smoke and other pollutants. Funded by The Atlantic Philanthropies, the Jessie B. Cox Charitable Trust, Robert Wood Johnson Foundation, the W.K. Kellogg Foundation, and others, the partnership uses multi-disciplinary teams of social workers, attorneys, and doctors to leverage community resources and provide integrated, preventive services to children and families.

Saint Luke's Foundation of Cleveland, Ohio's Healthy Kids in Healthy Homes project strives to end lead poisoning among Cleveland children. In 2004 the foundation awarded a three-year planning grant of \$1.3 million to a collaborative of public and private organizations including the Cleveland Department of Public Health, the Cuyahoga County Board of Health, and Lutheran Metropolitan Ministry. This planning project will use advocacy, adoption of lead-safe standards and practices by

property owners, promotion of lead-safe maintenance work, and the testing of 100 percent of the children at risk to identify and eliminate lead poisoning. The end result of the three-year planning process will be the development and implementation of a 10-year strategy to address the issue and completely eliminate its effects.

In 2005 The California Wellness Foundation awarded a \$225,000 grant to Collective SPACE, a community-based organization in Los Angeles that mobilizes residents of substandard housing to change their living conditions. Collective SPACE works primarily in the MacArthur Park/Westlake community, a high-poverty neighborhood that is the largest port of entry for new immigrants. An estimated 70 percent of its residents live in crowded, substandard housing, marked by deteriorating structures, inadequate heating and ventilation, high levels of mold and lead, asbestos, unreliable plumbing, and rodent infestation. A large segment of the community is comprised of undocumented immigrants who may be unaware of their rights as tenants or afraid to voice their concerns. Collective SPACE aims to improve housing conditions by working with residents to address health hazards found in their homes and providing educational workshops.



It also collects data about existing health hazards that help to inform community-driven action plans and policy recommendations to improve living conditions.

Creating supportive housing requires coordination among many fragmented systems including health care, housing, and public financing. In 1991 Robert Wood Johnson Foundation awarded a \$4 million grant to create the Corporation for Supportive Housing (CSH), a national resource center that assists individuals and organizations with developing supportive housing for the chronically homeless. The organization acts as an intermediary organization to share expertise and best practices, develop replicable models, educate public agencies, and draw on federal funding streams. Stemming from earlier work in providing health care to the homeless, CSH has offices in over ten states and works on initiatives in several others and has developed over 15,000 units of supportive housing (Green 2007).

The Brandywine Health Foundation leveraged community resources to develop the Brandywine Housing and Health Center, a nearly 50,000-square foot building that will house a federally qualified health center, a dental center, and behavioral health center as well as 24 units of affordable housing for low-income individuals ages 62 or over. The health services provided will be targeted to the uninsured and underinsured residents of Chester County, Pennsylvania. It is the hope of the

partnership, which includes local banks, the Chester County Department of Community Development, and the U.S. Department of Agriculture, that the center will aid the area's economic development, improve area residents' health, and increase the availability of affordable housing for seniors.

The Colorado Health Foundation, along with The Colorado Trust and other Colorado foundations, supports Denver's Ten-Year Plan to End Homelessness. Based on the Housing First model, the plan aims to end homelessness by providing comprehensive services including housing, mental health and substance abuse treatment, and job training. The foundation will support outreach to the homeless population to access Medicaid, Supplemental Social Security, and other government programs as well as fund primary health, mental health, and substance abuse services. In particular, the foundation will fund mental health and substance abuse treatment services for those who are ineligible for public programs or who are waiting for their applications to be processed. In its first year, the plan accomplished several goals including developing over 200 affordable transitional housing opportunities, adding over 100 temporary emergency shelter beds, providing anti-discrimination training to local agencies, increasing coordination between treatment providers, and increasing the number of outreach workers to assist the homeless.

RESOURCES

Burt, Martha, *What Will it Take to End Homelessness?* (Washington, DC: Urban Institute, September 2001).

Centers for Disease Control and Prevention, "Healthy Homes Initiative," <<http://www.cdc.gov/healthyplaces/healthyhomes.htm>>, accessed September 27, 2007.

Glynn, Thomas J., "Psychological Sense of Community: Measurement and Application" *Human Relations* 34(9): 789-818, 1981.

Green, Lee, "Supportive Housing," in Stephen L. Isaacs and James R. Knickman, eds., *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care: Volume X* (Princeton, NJ: 2007).

The Greenlining Institute, *Housing: The Foundation for Individual and Community Health* (San Francisco, CA: 2002).

National Alliance to End Homelessness, *Homelessness Counts* (Washington, DC: January 2007).

National Alliance to End Homelessness, <<http://www.naeh.org/section/tools/essentials>>, accessed October 15, 2007.

National Coalition for Homeless Veterans, "Background and Statistics," <<http://www.nchv.org/background.cfm>>, accessed August 30, 2007.

PolicyLink, <<http://www.policylink.org/EDTK/HTF>>, accessed August 6, 2007.

Popkin, Susan and Elizabeth Cove, *Safety Is the Most Important Thing: How HOPE VI Helped Families*, Brief No. 2 (Washington, DC: Urban Institute Metropolitan Housing and Communities Center, June 2007).

Proscio, Tony, *Supportive Housing and Its Impact on the Public Health Crisis of Homelessness* (New York, NY: Corporation for Supportive Housing, 2000).

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and/or Co-Occurring Substance Use Disorders* (Rockville, MD: 2003).

U.S. Department of Housing and Urban Development, *The Annual Homelessness Report to Congress*, <<http://www.huduser.org/Publications/pdf/ahar.pdf>>, accessed August 28, 2007.

U.S. Department of Housing and Urban Development, *In the Crossfire: The Impact of Gun Violence on Public Housing Communities* (Washington, DC: March 2000).

Urban Institute, "Housing America's Low-Income Families: A Research Focus of the Urban Institute," <<http://www.urban.org/toolkit/issues/housing.cfm>>, accessed September 17, 2007.

UNEQUAL EXPOSURE:

Addressing Disparate Environmental Health Risks

Environmental justice seeks to remedy the unfair burden of environmental health hazards borne by low-income communities. While all communities face some level of risk, research has documented that environmental hazards are particularly pronounced in poor and minority communities. The Environmental Protection Agency (EPA) has identified at least 80 studies, which consistently find that minority and low-income communities face disproportionate exposure to environmental hazards (U.S. Commission on Civil Rights 2003). The poor tend to live in the least desirable neighborhoods, which are characterized by older housing stock and close proximity to sources of environmental risk such as highways, dumps, and heavy industry. The poor also tend to be employed in jobs with increased risk of occupational exposure to hazardous materials.

The racial composition of an area, independent of income, education, or other indicators of socioeconomic status, is the strongest predictor of where commercial hazardous waste facilities are located.

The aftermath of Hurricane Katrina, the worst environmental disaster in the history of the United States, horrifically exposed how race and income determine environmental risk. When flood waters inundated the low-lying areas of New Orleans that were home to the city's poorest – predominantly African-American – residents, the disparate risk facing minority communities became tragically clear. Across the nation, the poor, particularly communities of color, tend to live in the most environmentally dangerous areas.

A recent report sponsored by the United Church of Christ found that the racial composition of an area, independent of income, education, or other indicators of socioeconomic status, is the strongest predictor of where commercial hazardous waste facilities are located. Of the 9.2 million people who live within three kilometers of the nation's 413 commercial hazardous waste facilities, nearly 56 percent represent people of color. Given the link between race and poverty, host communities' poverty rates are on average 1.5 times greater than in communities that do not host such facilities (United Church of Christ 2007).

INCREASING COMMUNITY PARTICIPATION IN THE POLICY PROCESS

Environmental hazards are often located in or near poor and

minority communities not only because land in these neighborhoods is undesirable and inexpensive, but also because these communities are politically disenfranchised. Lacking political clout, residents face a variety of obstacles in mounting "Not in My Backyard" campaigns to fend off environmental encroachment. These challenges are apparent at the local, state, and national levels.

Local and state authorities are responsible for the majority of decisions related to:

- **Zoning** – regulations that establish the types of land-use permissible in various geographic areas
- **Siting** – decisions that allow a particular facility or roadway to be placed in a particular location
- **Permitting** – rules that govern the environmental restrictions under which a facility must operate

These decisions significantly affect the type and amount of environmental risk to which a community will be exposed. Participating in these decisionmaking processes, as well as challenging decisions once they are made, requires technical knowledge, legal acumen, and political power, which vulnerable communities may be unable to access.

As the presence and activity of environmentally hazardous enterprises increase, property values in these neighborhoods decline and further industrialization and pollution become increasingly likely. Residents themselves are often unable to

EXAMPLES OF ENVIRONMENTAL HAZARDS

Heavy metals	Pesticides
Herbicides	Toxic chemicals
Particulate matter	Radioactive wastes
Microbial contaminants	Noise
Electromagnetic waves	

EXAMPLES OF SOURCES

Agricultural runoff	Incinerators
Industrial facilities	Land fills
Toxic waste sites	Vehicle emissions
Waste treatment facilities	

Environmental hazards are often located in or near poor and minority communities not only because land in these neighborhoods is undesirable and inexpensive, but also because these communities are politically disenfranchised.

take advantage of low real estate prices as mortgage lenders may be unwilling to issue loans in these neighborhoods. Low rates of home ownership and renter transience compound the political disadvantage facing vulnerable communities. This downward spiral culminates in the creation of multiple environmental hazards that both jeopardize health and perpetuate poverty.

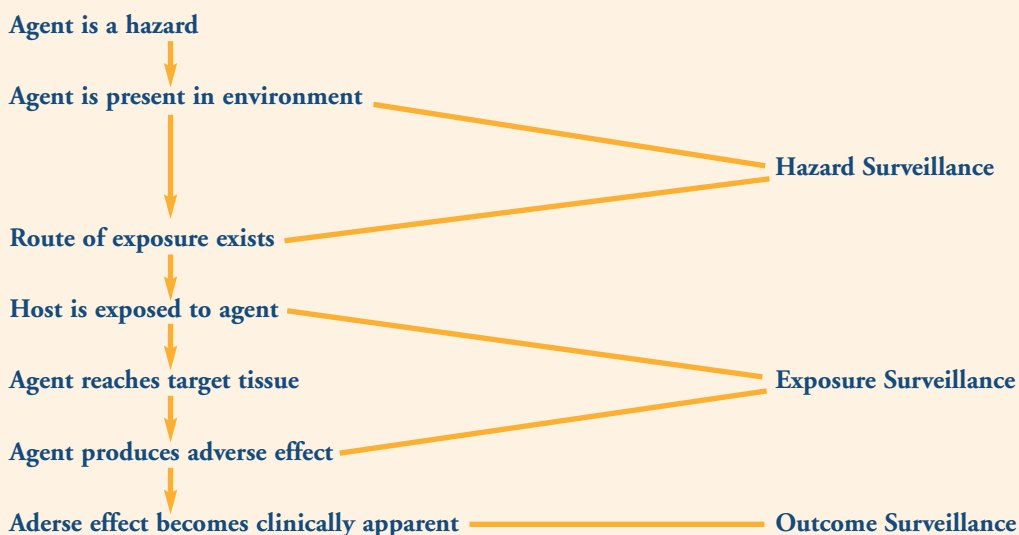
A number of health funders have sought to improve the capacity of low-income and minority communities to participate in policy decisions that influence the nature and extent of environmental hazards within their neighborhoods. For example, The California Wellness Foundation has provided core operating support to a broad range of community-based organizations seeking to educate and engage community residents on environmental justice issues. A \$225,000 grant to the Liberty Hill Foundation helps fund the organization's Environmental Justice Fund, which provides grants to grass-roots organizations in the Los Angeles area and promotes leadership around environmental issues at the community level. The Paso del Norte Health Foundation has provided \$200,000 annually to the Center for Environmental Resource

Management at the University of Texas, El Paso over the last three years. These funds support outreach to community organizations in order to address water supply and wastewater management issues in colonias (unincorporated areas lacking basic infrastructure such as running water).

These efforts often seek to be proactive in improving the economic, as well as environmental, circumstances of communities. The Ford Foundation has provided grants ranging from \$75,000 to \$250,000 to non-profit organizations in Detroit, Harlem, New Orleans, and Camden to engage residents in community organization, education, advocacy, and public policy activities related to sustainable development. These activities seek to minimize the influence of facilities that negatively affect the environment as well as advance economic development in businesses that create employment opportunities while protecting the environment.

Attempts to mobilize community action can often be hampered by the lack of local-level data documenting disparate exposure levels and disease rates. Grantmakers have funded locally relevant data collection and analytic activities to inform the efforts of environmental justice advocates. For example, a study conducted by the Ohio Environmental Council and funded by The George Gund Foundation identified neighborhoods in the Cleveland area which are "hot spots" for diesel exhaust emissions levels that pose significant health risks. Exposure to diesel exhaust has been linked to asthma and childhood cancer (Ohio Environmental Council

OPPORTUNITIES FOR MONITORING ENVIRONMENTAL HAZARDS



Source: McCauley 2007

2007). This type of data can be used to advocate for a variety of policy changes such as rerouting traffic patterns for trucks and other heavy vehicles and influencing roadway improvement planning. In a similar vein, Blue Cross Blue Shield of Minnesota Foundation made a \$20,000 grant award to help fund the retro-fitting of Head Start buses to demonstrate how new technology can minimize diesel emissions from school buses and reduce absenteeism due to asthma and related illnesses.

The nature of specific environmental hazards can vary across communities, but state regulatory actions are influential in establishing the standards and protections that govern local decisions. Recognizing the importance of state policymakers, the Beldon Fund has helped to establish five state-level alliances to improve the environmental protection activities of state regulatory bodies. These collaborative groups inform the public, policymakers, and state officials about chemical release and exposure policies that are more proactive in protecting human health.

While grassroots efforts are critical for ensuring environmental justice, policies at the national level are also important as they shape the direction of state and local decisions. More rigorous enforcement of federal statutes and regulations provides important avenues for challenging zoning, siting, and permitting decisions. The federal government also provides the most substantial sources of funding for environmental clean-up efforts. Major activities include the Brownfield program (which funds the assessment and remediation of abandoned properties that have the potential for redevelopment following decontamination) and the Superfund program (which funds environmental clean up in cases where the party responsible for contaminating the property can not be located). Although both programs have benefited poor and minority communities, critics question the extent to which sites in these communities have been appropriately prioritized and raise concerns that redevelopment efforts have merely introduced new forms of environmental risks.

Several health funders have supported capacity to monitor, publicize, and catalyze action on federal policy issues related to environmental health. For example, the Public Welfare Foundation, the Ford Foundation, and the Charles Stewart Mott Foundation each provide funding to the Environmental Justice Resource Center at Clark Atlanta University to serve as a national clearinghouse on issues related to research, policy, and program. The center also leverages its expertise to reach

out and provide technical assistance to community-based organizations.

Other national efforts have focused more specifically on environmental risks in rural communities. For example, The Pew Charitable Trusts has partnered with the Johns Hopkins School of Public Health to establish the National Commission on Industrial Farm Animal Production to assess the industry's impact on public health, the environment, farm communities, and animal well-being. The commission is preparing to issue a report that will outline the key issues related to the industry and make recommendations for mitigating the negative effects of industrialized livestock production.

BUILDING THE EVIDENCE BASE

Political and financial support for reducing environmental risks are often contingent on the strength of the evidence base establishing a direct impact on human health and documenting inequity in terms of exposure levels and disease burden. This evidence base is still developing, and the contributions of environmental hazards to health disparities have not been clearly established. The strength of the evidence base varies significantly across types of environmental hazards. For some agents, such as lead, these relationships are fairly well established. Because lead is toxic to children even at fairly low levels and exposure levels can be monitored, the impact of lead poisoning on cognitive impairments and developmental delays is well documented, and the disparate risk facing the poor has been clearly demonstrated. The rate of elevated blood lead levels in African-American children is twice that of the rate in white children.

For many other potential environmental hazards, key pieces of information remain missing. More research is needed to establish the biological mechanisms through which potential hazards affect human health, to document differential levels of exposure within human populations, and to monitor disease rates for environmentally sensitive conditions at the community level. The susceptibility of different populations to environmental risks and the interactive, cumulative effects of multiple hazards further complicate efforts to clarify the disease burden caused by specific environmental hazards and to document elevated risks facing poor and minority communities.

Recently health philanthropies have played important roles in sponsoring epidemiological research to explore the relationship between environmental hazards and disease incidence as government support for this type of research has lagged. The New York Community Trust awarded \$110,000 to fund a study to screen chronically ill children for exposure to toxic chemicals, focusing on how polychlorinated biphenyls (PCBs) and pesticides contribute to the statewide distribution of asthma, birth defects, and learning disorders.

The nature of specific environmental hazards can vary across communities, but state regulatory actions are influential in establishing the standards and protections that govern local decisions.

Establishing a clear causal link between a substance and its human health effects often necessitates identifying the biological mechanism through which this damage occurs. A few health funders have supported basic research to elucidate how environmental hazards interfere with metabolic and developmental functions. For example, the Northwest Health Foundation provided \$40,000 in funds for basic research to determine how a specific class of pesticides acts as a developmental toxin using an animal model.

INCREASING AWARENESS TO MITIGATE RISKS

Future research linking environmental exposures to health inequities will bolster policy change efforts, but the existing evidence base can be used now to inform and empower individuals about environmental health risks. The Paso del Norte Health Foundation has supplemented its support of advocacy work related to environmental improvements with short-term interventions to educate at-risk populations about the environmental challenges they face. Funded at \$300,000 over five years, these efforts promote behavioral changes related to personal hygiene, waterless sanitation, and drinking water protection that can reduce exposure to environmental hazards. The Public Welfare Foundation awarded \$90,000 to the Safety and Health Institute for Farmworkers to educate workers about how they can reduce the use of toxic pesticides and protect themselves from the adverse effects of pesticide exposure.

Some educational efforts have focused on health care providers to ensure that early screening and treatment for environmentally sensitive diseases occur. Clinicians may not be aware of the environmental hazards facing vulnerable populations, and this lack of awareness can hinder their ability to recognize or correctly diagnosis environmentally induced diseases. The David and Lucile Packard Foundation funded a \$250,000 initiative to increase lead screening and treatment for children insured by Medicaid. Blue Cross Blue Shield of Minnesota Foundation supported the Institute for Agriculture and Trade Policy with a \$30,000 grant to train providers and early childhood educators about environmental risks and give guidance regarding how these topics could be introduced into patient care and parent education.

Health care professionals have also been mobilized to provide leadership in grassroots efforts to reduce environmental health hazards. The Long Beach Alliance for Children with Asthma, currently funded by The California Endowment, has advanced community activism on air quality issues related to pollution from ships and trucks transporting goods through the port at Long Beach. A strong presence from the Children's Clinic, a community health center, has helped demonstrate how these hazards influence the rates of asthma and other respiratory diseases within the Long Beach community.

Other approaches have targeted the business practices of health care providers to ensure that they are not inadvertently adding to the environmental burden in low-income communities. The Jenifer Altman Foundation's \$50,000 grant spearheaded efforts to launch Health Care Without Harm, a campaign to decrease pollution caused by the health care industry such as dioxin and mercury emissions from medical waste incinerators.

CONCLUSION

Addressing environmental injustice promises not only to improve the health of poor, but also to decrease the prevalence of poverty itself. The environmental health risks facing vulnerable communities are varied, ubiquitous, and, in many ways, still undefined. These environmental hazards undermine the employment potential of individuals by engendering disease and disability. Environmental risks further compromise economic development prospects of low-income communities by creating powerful investment disincentives. Community organizations, advocacy groups, health care providers, and researchers, however, are making great strides to identify and address these environmental hazards. Health philanthropy can continue to play important roles in supporting the environmental justice movement by asking provocative questions, moving the knowledge base forward, and providing key resources to the disenfranchised.

RESOURCES

Institute of Medicine, *Toward Environmental Justice: Research, Education, and Health Policy Needs*, Committee on Environmental Justice (Washington, DC: National Academy Press, 1999).

McCauley, Linda A., "CBPR Research: Results from 10 Years of Studying Pesticide Exposure, Biomarkers, and Potential Health Effects," presented at Northwest Health Foundation's Healthier Communities Through Action and Research meeting, July 20, 2007.

Ohio Environmental Council, *Cleveland Diesel Hot Spots: Dirty, Detrimental, and Deadly* (Cleveland, OH: July 2007).

United Church of Christ, *Toxic Wastes and Race at Twenty, 1987-2007* (Cleveland, OH: March 2007).

U.S. Commission on Civil Rights, *Not in My Backyard: Executive Order 12, 898 and Title VI as Tools for Achieving Environmental Justice* (Washington, DC: October 2003).