# 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).

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## 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).

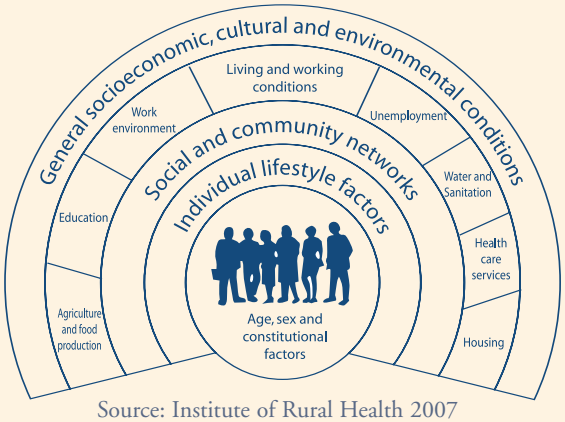
Within racial and ethnic groups there can also be disparities as a result of income and other socioeconomic factors. Among Hispanics, for example, Puerto-Rican children's lifetime asthma rates are 2.5 times those of Mexican children. Among Asian Americans, cancer rates differ markedly by nationality, 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.

### WHO MODEL OF THE SOCIAL DETERMINANTS OF HEALTH




Source: Institute of Rural Health 2007

## 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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