

**COUNTERING THE PRODUCTION OF
HEALTH INEQUITIES**

**A Framework of Emerging
Systems to Achieve an
Equitable Culture of Health**

*Extended
Summary:
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Prevention Institute is a nonprofit, national center dedicated to improving community health and wellbeing by building momentum for effective primary prevention. Primary prevention means taking action to build resilience and to prevent problems before they occur. The Institute's work is characterized by a strong commitment to community participation and promotion of equitable health outcomes among all social and economic groups. Since its founding in 1997, the organization has focused on community prevention, injury and violence prevention, health equity, healthy eating and active living, positive youth development, health system transformation and mental health and wellbeing.

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Dedication

This paper is dedicated to the residents of Flint, Michigan and other communities across the U.S. that shoulder a burden of unfairness and diminished opportunities for health as a result of policies, laws, practices, and procedures on the part of government and other institutions. Whether these actions are deliberate and intentional, inadvertent, or neglectful, individually and cumulatively they have contributed to unjust disparities in health and wellbeing.

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Introduction

As the Robert Wood Johnson Foundation (RWJF) developed its bold vision for a Culture of Health – in which every person in the U.S. has the opportunity to achieve health and wellbeing – staff and leadership recognized that, as a nation, we cannot achieve a Culture of Health when there are inequities in health outcomes. This Extended Summary provides a framework for achieving an equitable Culture of Health.

It begins with an analysis of seven *Determinants of Health* that shape health outcomes and health equity. Of significance, it highlights the policies and laws, practices and procedures related to each determinant that have inadvertently or by design contributed to inequities in health outcomes for people of color and people with low incomes. In so doing, it identifies 15 specific sectors that have played roles in producing health inequities. These very same sectors have invaluable roles to play in countering the production of inequities and producing equitable health outcomes. They are the key players in 10 Multi-sector Systems that ‘set the course’ for achieving health equity. Designed to create the opportunity to achieve health and wellbeing in communities – where people live, work, play, and learn – the Multi-sector Systems will be most impactful not only through action at the community level but also through supportive action at local/regional, state, and federal levels, as well as by specific sectors. Finally, to employ rigor to achieving health equity, this Extended Summary describes a System of Health Equity, which among other things creates the mechanism for an intentional feedback loop, critical for effective systems change.¹ Further, the System of Health Equity constitutes a set of system and sector changes that precede population health outcomes. These changes are critical to lasting systems change,² in this case to achieve health equity.

By understanding how historical and current policies, laws, practices, and procedures produce inequities in health outcomes, we can understand concretely how to begin to reverse or ameliorate the inequities, and support communities in transforming to achieve an equitable Culture of Health. Accomplishing this will necessarily require systemic change – a fundamental change in policies, processes, relationships, and power structures as well as deeply held values and norms³ – and this Extended Summary provides a framework for that change.

Purpose and Audience

In recognizing that achieving health equity is integral to achieving a Culture of Health, RWJF launched its Achieving Health Equity (AHE) Team. Subsequently, the AHE Team partnered with Prevention Institute to conduct an analysis of the drivers of inequity with the intention of using this to inform its grant-making goals and strategies. With the understanding that the information gathered has implications for diverse audiences, Prevention Institute has worked to: 1) outline a framework for achieving an equitable “Culture of Health”; 2) provide a comprehensive and thorough discussion of the Determinants of Health and the policies, laws, practices, and procedures related to each that have contributed to ongoing health inequities for people of color and people with low incomes; 3) articulate the connectedness and critical role of 10 Multi-sector Systems in overcoming health inequity; and 4) establish a vision for a System of Health Equity that accelerates progress towards equitable opportunities for health and wellbeing for all.

This detailed analysis has been captured in the form of a full report, “Countering the Production of Health Inequities: An Emerging Systems Framework to Achieve an Equitable Culture of Health”, that provides an in-depth examination of the issues. The full report is also supported by three stand-alone documents that highlight particular aspects of the findings. This Extended Summary scales the full report down to a practical

size without compromising the integrity of the analysis, findings, and recommendations of the full report. A “North Star” document identifies five priorities for the health equity field and highlights where we begin in producing an equitable Culture of Health. An Executive Summary with an overview of the findings, concepts, and framework is also available. The information presented in the various formats is intended to facilitate extensive use and reference by a broad base of readers, including researchers, educators, students, practitioners, and public and private sector users. As a whole, these documents are meant to serve as a “go-to” reference to inform future work to address the systemic changes needed to achieve an equitable Culture of Health.

Methodology and Approach

The AHE team prioritized seven specific Determinants of Health (DOH) – Environment (Sociocultural Environment and Built/Physical Environment), Housing, Public Safety, Education, Employment, Income & Wealth, and Access to Quality Health Systems and Services – with the goal of improving the systems that impact inequities across this broad array of determinants.

In response, Prevention Institute engaged in a multi-pronged effort which included the following activities:ⁱ

- Reviewed relevant documents, reports, and literature
- Conducted interviews
- Engaged in strategy and coordination discussions with AHE team members, as well as the National Collaborative for Health Equity and their national Health Opportunity and Equity measures (HOPE) partners (Texas Health Institute and Virginia Commonwealth University Center on Society and Health)
- Aligned with the Culture of Health Action Framework and RWJF Mission
- Conducted a Collaboration Multiplier Analysisⁱⁱ to 1) identify the roles and contributions of multiple sectors to improve health outcomes and their similarities and differences, and 2) understand how joint efforts across two or more sectors could enhance health outcomes
- Developed definitions for the prioritized determinants and key concepts (see below) and each of the sectors included in the analysisⁱⁱⁱ
- Developed criteria to inform solutions (i.e., Multi-sector Systems and a System of Health Equity)^{iv}
- Engaged in synthesis and analysis throughout the project
- Engaged external reviewers and synthesized feedback

ⁱ For more detail, please see the Full Report.

ⁱⁱ Collaboration Multiplier is a Prevention Institute tool designed to support effective multi-sector collaboration for improved health outcomes.

ⁱⁱⁱ For additional definitions, including for each of the 15 sectors in this Extended Summary, please see the Full Report, Appendix A.

^{iv} For Criteria, please see the Full Report

Definitions and Concepts

This section is intended to provide context for how we are using and defining terms throughout the report and its supporting documents. In some cases, there may appear to be inconsistencies in how terms are being used and/or defined. This is a reflection of an editorial decision to maintain the original use of terms and concepts in cited literature and not alter the terms to reflect our usage. As the field of health equity and literature on the topic evolve, definitions and concepts will continue to be updated.

Health Equity: Health equity means that everyone has a fair and just opportunity to be healthy. This requires removing obstacles to health such as poverty, discrimination and their consequences – including powerlessness and lack of access to good jobs, education, housing, environments, and healthcare⁴. Fairness requires dedicated efforts to remove these obstacles to health.⁵ The concept of health equity focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality—that is, a systematic inequality in health (or in its social determinants) between more and less advantaged social groups, in other words, a health inequality that is unjust or unfair.⁶

Health Inequity: The ‘differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.’ Thus, equity and inequity are based on core values of fairness. The term ‘inequity’ can be used when the referenced differences in health outcomes have been produced by historic and systemic social injustices, or the unintended or indirect consequences of social policies. Health inequity is related both to a legacy of overt discriminatory actions on the part of government and the larger society, as well as to present-day practices and policies of public and private institutions that continue to perpetuate a system of diminished opportunity for certain populations.⁷

Health Disparity: The differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.⁸

Sector: A field, discipline, or area of expertise that is characterized by a combination of related activities and functions that are typically understood as distinct from those of others.

System: A set of interrelated parts that interact and function together to produce a common outcome or product.⁹

System of Health Equity: A way of organizing and structuring relationships, innovation, learning, and advocacy for coherent and interrelated practices – within the foundation, government, private sector, and community – to attain health equity across the population.

Systemic Change: A fundamental change in policies, processes, relationships, and power structures as well as deeply held values and norms.¹⁰

Definitions for the AHE Team's prioritized Determinants of Health (DOH)

1. **Environment**

- **Sociocultural Environment:** This environment, sometimes referred to as social capital, reflects the people within a community, the interactions between them, and norms and culture. It also encompasses social networks and trust, and participation and willingness to act for the common good.
- **Built/Physical Environment:** This environment reflects the place, including the human-made physical components, design, permitted use of space, and the natural environment. It includes, for example, transportation/getting around, what's sold and how it's promoted, parks and open space, look and feel, air/water/soil, and arts and cultural expression.

2. **Housing:** The availability or lack of availability of high-quality, safe, and affordable housing that is accessible for residents with mixed income levels.¹¹ Housing also refers to the density within a housing unit and within a geographic area, as well as the overall level of segregation/diversity in an area based on racial/ethnic and/or socioeconomic status. Housing impacts health because of the physical conditions within homes, the conditions in the neighborhoods surrounding homes, and housing affordability, which affects the overall ability of families to make healthy choices.¹²
3. **Public Safety:** The safety and protection of the general public, characterized by the absence of violence in public settings. Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological or emotional harm, maldevelopment or deprivation,¹³ and trauma from actual and/or threatened, witnessed and/or experienced violence.
4. **Education:** Access or lack of access to high-quality learning opportunities and literacy development for all ages that effectively serves all learners.¹⁴ Education is a process and a product: as a process, education occurs at home, in school, and in the community. As a product, an education is the sum of knowledge, skills, and capacities (i.e., intellectual, socio-emotional, physical, productive, and interactive) acquired through formal and experiential learning. Educational attainment is a dynamic, ever-evolving array of knowledge, skills, and capacities.¹⁵ Education can influence health in many ways. Educational attainment can influence health knowledge and behaviors, employment and income, and social and psychological factors, such as sense of control, social standing, and social networks.¹⁶
5. **Employment:** Level or absence of adequate participation in a job and/or workforce, including occupation, unemployment, and underemployment. Work influences health not only by exposing employees to physical environments, but also by providing a setting where healthy activities and behaviors can be promoted. The features of a worksite, the nature of the work, and how it is organized all can affect workers' mental and physical health. Many Americans obtain health insurance through their employers, another potential impact on health and wellbeing. Health also affects one's ability to maintain stable employment. For most working adults, employment is the main source of income, thus providing access to homes, neighborhoods, or other services that promote health.¹⁷
6. **Income and Wealth:** Income is the amount of money earned in a single year from employment, government assistance, retirement and pension payments, and interest or

dividends from investments or other assets. Income can fluctuate greatly from year to year, depending on life stage and employment status. Wealth, or economic assets accumulated over time, is calculated by subtracting outstanding debts and liabilities from the cash value of currently owned assets—such as houses, land, cars, savings accounts, pension plans, stocks and other financial investments, and businesses.¹⁸ Access to financial resources, be it income or wealth, impacts health by safeguarding individuals against large medical bills while also making available more preventative health measures such as access to healthy neighborhoods, homes, land uses, and parks.¹⁹

7. **Access to Quality Health Systems and Services:** Access to effective, affordable, culturally and linguistically appropriate and respectful preventative care; chronic disease management; emergency services; mental health services; and dental care. This also encompasses the promotion of better social and community services, and community conditions that promote health over the lifespan, including better population health outcomes. It also refers to a paradigm shift that reflects *healthcare* over *sick* care, and promotes prevention.

Beyond Business as Usual: Achieving an Equitable Culture of Health

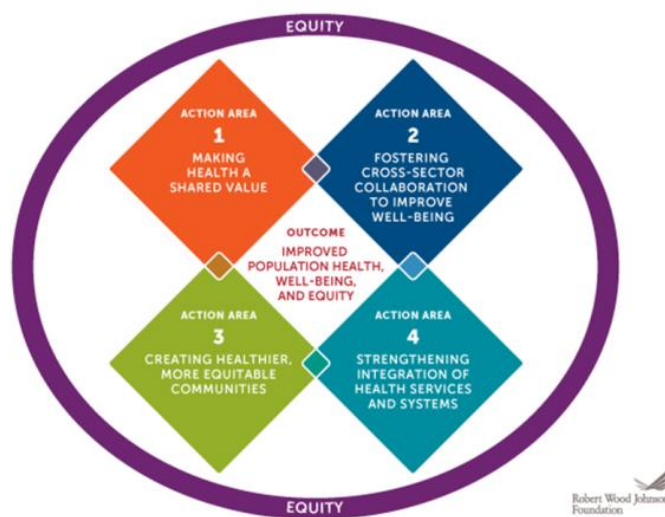
Building a Culture of Health requires action within and across sectors, because progress in one area will advance progress in another. But what areas of action should Americans work toward? How should our actions connect to one another? How can we find starting points that speak to the many different actors within communities?

-From Vision to Action: A Framework and Measures to Mobilize a Culture of Health (p. 14)

RWJF’s Culture of Health Action Framework lays out a bold vision for the U.S. It emphasizes four Action Areas (see Figure 1). These same Action Areas are essential for achieving health equity.

Figure 1: RWJF Culture of Health Action Framework

CULTURE OF HEALTH ACTION FRAMEWORK



As a nation, we cannot achieve a Culture of Health without advancing health equity. With the goal of achieving health equity and an equitable Culture of Health, this analysis yielded the following findings, which are detailed in this Extended Summary.

1. The AHE team’s prioritized Determinants of Health have well-documented connections to health and safety, illness and injury, and inequities in health and wellbeing outcomes.
2. The Determinants of Health are interrelated and interconnected.
3. There is more written about the problem of health inequities than about the solutions for health equity.
4. Health inequities have been produced.
5. Residential segregation is particularly harmful when it creates isolation from opportunity and social mobility.
6. Specific sectors are key actors within the Determinants of Health and, in many cases, across multiple determinants.
7. Bias, discrimination, institutional and structural racism, and classism contribute to and exacerbate inequities in health. They manifest, in part, as norms and shared values within sectors and institutions, fueling the production of health inequities.
8. There is a need for actionable solutions that will produce systemic change.
9. There is a pathway to produce health equity that will require deliberate focus and intentionality on reengineering past and present thinking to develop key components of an integrated “System of Health Equity”.

Findings about the Determinants of Health and Achieving Health Equity

Prevention Institute’s analysis of the AHE team’s prioritized Determinants of Health illuminate a path toward achieving an equitable Culture of Health. The nine findings are described in the following pages.

1. **The AHE team’s prioritized determinants have well-documented connections to health and safety, illness and injury, and inequities in health and wellbeing outcomes.**

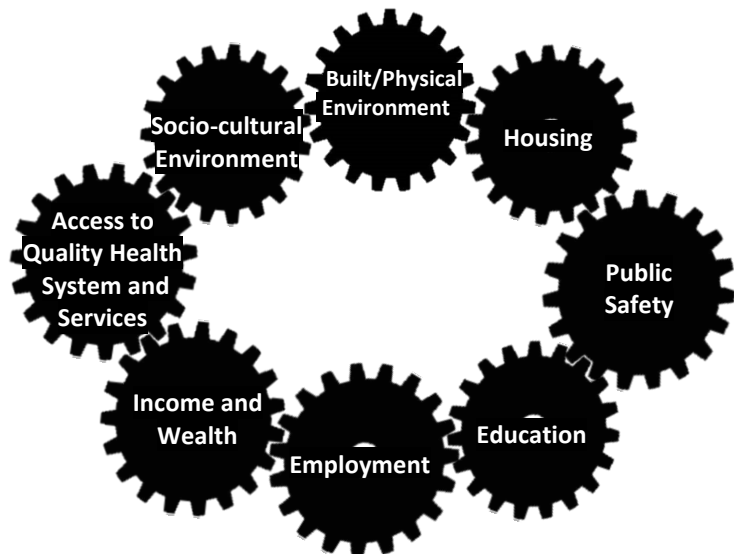
Environment (Sociocultural Environment and Built/Physical Environment), Housing, Public Safety, Education, Employment, Income & Wealth, and Access to Quality Health Systems and Services are all strong Determinants of Health and wellbeing.^y Altering the way they negatively play out in communities is supportive of advancing health equity.

We are at a perilous time in our country – violence, race, mistrust, ignorance, social disconnect provide all the fuel to the fire of health inequity.

– Shavon Arline Bradley

2. **The Determinants of Health are interrelated and interconnected.**

It’s difficult to disentangle one determinant from another when it comes to health equity; they are connected through policies, practices, systems, and sectors, as well as through their impact on communities. For example, a lack of public safety inhibits economic development in communities, which affects employment, income and wealth. Conversely, educational outcomes, income, wealth, and employment are all associated with an increased or decreased risk of violence (public safety), as is the sociocultural and physical/built environment. The graphic of interconnected gears at the right illustrates how determinants influence each other and are influenced by each other. Given the scale and complexity of the problem and the opportunity presented by RWJF’s emphasis on Achieving Health Equity, this analysis recommends going beyond a focus on a specific determinant or strategy within a determinant, and compels audiences to engage in a systems approach to health equity.



^y For detailed information about the relationship between each DOH and 1) health and safety 2) health equity and inequity, please see the Full Report, Appendix B.

In environments where multiple determinants interact to the detriment of health, the production of inequity may be accelerated and compounded across multiple generations. A profound example of this is found in growing levels of poverty in the U.S. Existing anti-poverty efforts are designed for those without serious barriers to employment who can climb back to self-sufficiency within five years or so, but leave out more than 20 million adults and children who live in deep poverty.²⁰ This element of the income and wealth determinant has implications for the other determinants as well.

3. **There is more written about the problem of health inequities than about solutions for health equity.**

The literature is abundant with data that documents inequities in health outcomes. However, there is less written about what to do about it, particularly about the complex interactions between determinants of health, sectors, policies, and systems. An analysis of health equity research has described three generations of research, with the first documenting disparities, the second identifying the underlying causes, and the third – which is emergent – advancing solutions for eliminating health disparities.²¹ A subsequent analysis described a fourth generation of research focused on comprehensive action including evaluation metrics that address race, racism, and structural inequities.²² Currently, the literature tends to emphasize programs, which are easier to evaluate than comprehensive strategies.^{vi}

Overall, because there is more written about the problem than solutions, there is a need to turn to practitioners and communities for direction on solutions. This is consistent with the CDC’s Framework for Evidence which includes best-available research, contextual evidence, and experiential evidence.²³ Consistent with “rules” laid out in Fostering Systems Change (Stanford Social Innovation Review, 2015)²⁴ the Multi-sector Systems laid out in this analysis (see finding 8) “set the direction” for achieving an equitable Culture of Health in the absence of a clear research evidence base about specific solutions. The analysis points to the need for systemic change, which goes far beyond what a specific program could accomplish.

Racial/Ethnic and Socioeconomic Considerations and Implications

In some cases, understanding the nature of the problem and identifying specific solutions is hampered by social constructions around race and limitations of the data. Often in papers and discussions about racial/ethnic and socioeconomic inequities in health outcomes, specific groups are classified and pulled out (e.g. African Americans, American Indians, Latinos, households below the poverty line). Starting in 1997, the Office of Management and Budget (OMB) required federal agencies to use a minimum of five race categories: White; Black or African American; American Indian or Alaska Native; Asian; and Native Hawaiian or Other Pacific Islander. The OMB defines Hispanic or Latino as “a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.” In data collection and presentation, federal agencies are required to use a minimum of two ethnicities: “Hispanic or Latino” and “Not Hispanic or Latino”. Indeed, many of the examples highlighted throughout this paper reference these groups. More frequently, however, this analysis references communities of color and communities with low-average household incomes. It should be noted that not all communities of low-average household incomes are communities of color. However, people of color comprise a

^{vi} For sample programs and policies for each of the Determinants of Health as well as their community-level impacts, please see the Full Report, Appendix C.

disproportionate share of those living in communities with lower average household incomes. These economic impacts are exacerbated by biases related to perceived race/ethnicity.

While having specific categorizations of race/ethnicity has some advantages, notably measurement, this “production” analysis reveals that policies and laws, practices, and procedures do not necessarily impact a specific category. While there are exceptions to this – notably policies concerning tribal communities and, for example, the Chinese Exclusion Act – more broadly policies and laws, practices, and procedures have reinforced a norm and value that all people are not treated equally or given equitable opportunity for good health. More specifically, the application and impact of policies and laws, practices, and procedures has not necessarily stopped at one racial/ethnic category. For example, the practical application of segregation-based policies has been based on perceived race/ethnicity (e.g., physical features such as skin color, eye color, and hair texture), which in itself is a social construction and inconsistent. In her testimony to the Institute of Medicine, Dr. Camara Jones epitomized this construction by sharing that in Washington, D.C., she is perceived to be black; in Brazil, perceived to be white; and in South Africa, perceived to be

Limitations of Race and Ethnicity Data

It is vital to understand historic and current health disparities across racial, ethnic, and socio-cultural groups. But understanding the evolution of socially constructed racial categories for census data and academic research gives context to the analyses and literature on the Determinants of Health. Some identified confounds include:

- 1) **Race and ethnicity is not a fixed measure.** The currently used census (and literature) categories for race and ethnicity in the U.S. have evolved from the late 18th century – based on social norms and the purpose of the data - with significant changes in the 1900’s, the 1930’s and 40’s, the 1960’s and 70’s, and most recently by the OMB standards established in 1997. This has implications for consistency in recording the health of Latino, Caribbean, Asian, and other populations, for example, which have been subject to varying categories and the biases of available categories.
- 2) **Only high index numbers get counted.** Inequities are often framed to show only the most disparate results, sometimes suppressing data that doesn’t represent a significant percentage of the population. This has implications for the underrepresentation of populations in health disparities data and research literature.
- 3) **Segregation-oriented practices affected many populations.** While segregation-oriented literature emphasizes the treatment of blacks, it should be understood that many groups of color have experienced impacts that may not have been quantified through research or published. For example, the racially charged Jim Crow practices are frequently associated with their impacts on African Americans, particularly in the south; these practices, however, affected other ethnic populations based on skin color and other physical features, and extended beyond the geographic south. People with darker skin and non-white features among Latino, Asian, and Middle Eastern Americans were similarly subjected to the norms of a Jim Crow society. The socially constructed categories of race in the context of a historic period, region, and circumstance have implications for the designation of neighborhoods and populations as homogeneous in literature and research.
- 4) **Research bias.** The gap in diversity among academic researchers and the limited use of qualitative data to provide input and analysis within a cultural context has limited the availability of literature on the social determinants of health across populations of color.

colored.²⁵ Another example is that until 1952, the US Supreme Court recognized Asian Indians as “Caucasian,” but it declared that they could not be considered “white” and therefore, were ineligible for citizenship.²⁶ Social constructions of race and ethnicity have helped to reinforce and reproduce white privilege.

Other limitations of the categories and data based on them include: 1) race and ethnicity is not a fixed measure, 2) only high index numbers get counted, 3) segregation-oriented practices have affected many populations, and 4) research bias. This paper’s analysis was confronted with the challenge of breaking down the specific impacts of policies and laws, practices, and procedures on specific racial/ethnic categories. For example, while Jim Crow laws are widely known for their intention and impact on African Americans, the reality is that people perceived to be of color, including, for example, darker-skinned Latino or Asian Americans, were affected by these laws and practices.

Below are examples of how bias in the policies and laws, practices, and procedures highlighted in this Extended Summary have contributed to the production of health inequities, and have affected different groups of people across multiple racial and ethnic lines. Examples of impacts on individuals and communities include:

- **Perceived race/ethnic group based on physical features:** Racial classification in the U.S. has largely been applied using “manifest indicators” such as skin color, eye color, and hair texture. Consequently, the social interpretation of a person’s skin color often dictates whether and to what extent that person will be subject to certain policies and practices. The policies and practices include: redlining; providing access to goods, services, and academic programs; profiling (including stop and frisk) in policing and retail security practices; and providing healthcare treatment (e.g., decision-making in treatments).
- **Immigration status:** Similar to “non-white” U.S. residents, immigrants to the U.S. have been subjected to a wide range of exclusionary policies and practices. For example, the Chinese Exclusion Act of 1882 prevented Chinese workers from immigrating to the U.S., and Chinese Americans were seen as economic competitors and racially inferior— until China became an ally during World War II. These types of policies set the precedent for excluding certain groups based on their country of origin, and helped to shape the classification of different immigrants as “white” and “non-white,” with immigration policies demonstrating preference for people from western European countries. These policies influenced the types of services and supports made available across multiple sectors, including: school enrollment; preventive and routine healthcare; and citizenship and deportation policies and practices.
- **Language preference and fluency:** Due to the growing diversity of the U.S., more than one in five U.S. and foreign-born individuals speak a language other than English at home.^{27, 28} Policies, laws, practices, and procedures that impact health and wellbeing outcomes include: placement in special education; unequal access to legal representation and differential sentencing practices; lower quality healthcare, including as a result of limited English-language capacity; and varying cultural competence within healthcare settings compared to the needs of the population.

- **Neighborhood wealth:** The ability to accumulate wealth is associated, in part, with land and home ownership. A number of historical policies and procedures affect wealth accumulation, including predatory, subprime lending; incentivizing liquor stores and predatory lending outlets; displacement for highways and civic projects; siting of environmental hazards; suburban renewal and urban core disinvestment; civic petitions requiring signature of homeowners despite impacts on rental residents; academic and business loans based on land-based equity; and the Dawes Act, which fragmented American Indian ownership of land.

Health inequity is related to a legacy of overt discriminatory actions on the part of government and the larger society, as well as to present-day practices and policies of public and private institutions that continue to perpetuate a system of diminished opportunity for certain populations. Poverty, racism, and lack of educational and economic opportunities are among the fundamental determinants of poor health, lack of safety, and health inequities, contributing to chronic stress and building upon one another to create a weathering effect, whereby health greatly reflects cumulative experience rather than chronological age.

*-A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety,
Commissioned by the Institute of Medicine’s Roundtable on Health Disparities*

4. **Health inequities have been produced.**

Within each Determinant of Health, there are policies, laws, practices, and procedures – some deliberate, some inadvertent, some historical, some current – that have contributed to health inequities across racial/ethnic and socioeconomic lines. For a historical example: the GI Bill, although it was formally a race-neutral policy – presumably written to honor and offer social advancement to those who served in WWII – contributed to residential segregation, concentrating poverty particularly among African Americans in U.S. cities. For a current example: zero-tolerance policies in schools have played a role in creating a school-to-prison pipeline and racial bias in renting housing units.

The Determinants of Health and the Production of Health Inequities

This section provides an overview of sample policies and laws, practices, and procedures within each Determinant of Health that have contributed to the production of health inequities across racial/ethnic and socioeconomic lines. The analysis emphasizes impacts at the community level, which has implications for solutions that can promote population health.

The challenge with health equity is that there are so many systemic barriers to equality it’s hard to unpack. Health connects to every institution – talk about education, poverty, access to fair housing – how the system was created to keep people divided.

– Shavon Arline Bradley

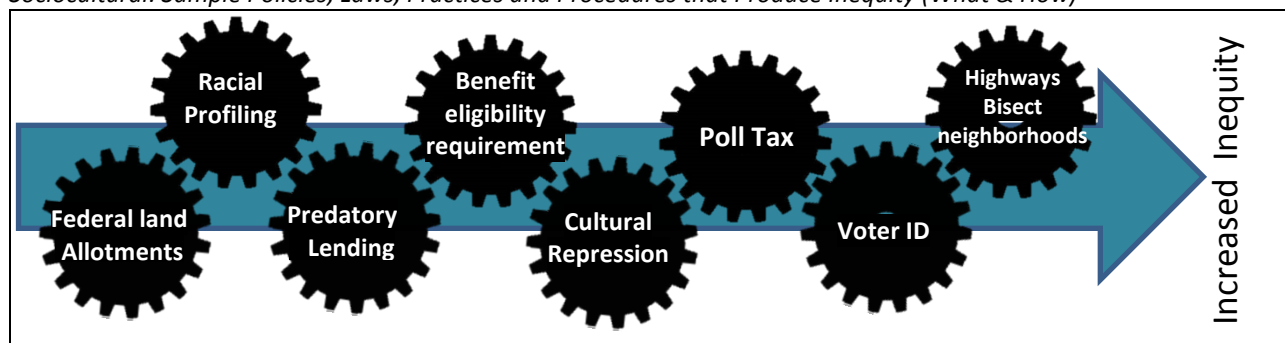
Sociocultural Environment

America gave the world the notion of the melting pot - an alchemical cooking device wherein diverse ethnic and religious groups voluntarily mix together, producing a new, American identity. And while critics may argue that the melting pot is a national myth, it has tenaciously informed America's collective imagination.

- Ivan Krastev

Some public and private policies and laws, practices, and procedures served to undermine the cultural heritage and autonomy of communities of color. The “**doctrine of discovery**” guided European colonization and led to the serial displacement of indigenous people, forcibly removing them from historic homelands and disrupting the sociocultural environment. **Federal “allotment” practices**, or the designation of land to individual American Indians rather than recognition of land collectively owned by tribal government from the late 1800s through the 1930s, not only affected geographic land bases, but disrupted communitarian traditions.²⁹ Government- and church-run boarding schools, in the late nineteenth century, removed American Indian children from their families and forbade them from expressing their cultures or speaking their languages.³⁰ Likewise, the imprisonment of more than 125,000 Japanese Americans (almost two-thirds born in the U.S.) by the U.S. military in **internment** camps during WWII³¹ led to the separation of Japanese families, the reinforcement of negative perceptions of Japanese people and, in some cases, death due to camp conditions.³² Such **cultural repression**, which has also been experienced by immigrant people, undermines and undervalues cultural identity.

Some policies and or practices create barriers to voting and undermine social networks and cohesion. Before the Civil Rights Act of 1964, literacy tests, **Jim Crow laws**, **poll taxes**, and threats of violence were used to prevent people of color from voting in the southern U.S. Current **voter ID laws**, which have been passed in 36 states,³³ affect the ability of Americans to vote, particularly African Americans, students, the elderly, and people with disabilities.³⁴ Drug policy and harsh sentencing laws have contributed to a cycle of mass incarceration, breaking apart families, undermining individual relationships, and destabilizing significant portions of communities. Further, people with felony convictions almost always lose the right to vote. **Racial profiling** is in itself a major source of distrust between residents and authorities and serves to undermine civic trust.³⁵ U.S. Immigration policies that separate family members can decrease trust between residents and authorities.³⁶ This is especially the case when profiling based on race, ethnicity, religion, or dress is concerned.³⁷ **Eligibility requirements** for Aid to Families with Dependent Children (AFDC) separated families, as two-parent households were not eligible prior to 1990 in 22 states.³⁸ The public housing practice of denying Section 8 housing to people with convictions also forced families to choose between being together and receiving benefits for which they were eligible. More recently, predatory lending practices leading up to the Great Recession contributed to a disproportionate foreclosure rate in low-income communities, thereby reducing stability in these neighborhoods, a critical component of social cohesion and collective efficacy.³⁹ *Sample community impacts that contribute to poor health and lack of safety:* weak social networks and collective efficacy; separated families, isolated families; low civic participation and disenfranchised potential voters; reduced trust and confidence in the civic system and government institutions; loss of cultural identity and traditions; and harmful norms.



Key sectors (Who): Banking/Finance, Business/Industry, Education, Housing, Human/Social Services, Justice, Land use & Management, Transportation

Built/Physical Environment

Man did not weave the web of life; he is merely a strand in it. Whatever he does to the web, he does to himself.

--Chief Seattle

As a result of multiple overlapping and interacting policies and practices that govern the built and physical environment, some neighborhoods and communities in the U.S. have physical conditions that promote health while others do not. Many of the circumstances in communities of color today are the result of historical land-use policies and practices that barred people of color from being able to live, work, or spend time in certain neighborhoods.⁴⁰ This practice, also known as segregation, was codified in the 1896 ruling of the Supreme Court *Plessy v. Ferguson*,⁴¹ a case that upheld state laws requiring “**separate but equal**” public facilities that functioned as racially separate spaces. Following *Plessy v. Ferguson*, “**Jim Crow**” laws further advanced the practice of prohibiting African Americans from existing in the same public spaces as whites. For example, in the Jim Crow South, there were segregated park systems with different parks for whites and blacks. Parks designated for people of color were generally smaller, received far less funding, and had fewer facilities.⁴²

More recent policies worked to deteriorate the built environment in these segregated communities of color. **Small Business Administration practices** in the 1980s encouraged liquor store ownership among mostly entrepreneurs of color because minimal capital was required for business startup. This fueled the higher density of alcohol outlets in communities of color and communities with low-average household incomes.⁴³ Similar confluences of government policies and business practices led to the overconcentration of pay-day loan businesses, as well as unhealthy food outlets in communities of color and communities with low-average household incomes.⁴⁴ In the case of food retail, government policies **incentivizing movement away from the urban core** resulted in supermarkets and grocery stores migrating to the suburbs alongside other businesses fleeing central cities, leaving a void for unhealthy food outlets to fill.^{45,46} The cost and availability of land in dense urban areas also contributed to the migration of businesses and loss of jobs and tax revenues,⁴⁷ as well as business decisions about the **siting of grocery stores and supermarkets that are based on community demographics**.⁴⁸ **Limited availability of loans** for local residents to open businesses that sell and promote healthy food options has resulted in limited economic opportunities for residents while also allowing chain restaurants and stores to fill the gap with less healthy or unhealthy products. Commercial marketing and targeted product availability by tobacco, alcohol, fast-food restaurants, and other unhealthy food companies

creates a cultural environment that reinforces alcohol consumption, tobacco use, and unhealthy eating behaviors, which become intergenerational norms.

Land-use practices and **zoning rules** that categorized white neighborhoods as residential while communities of color — mostly African Americans and/or Latinos — were categorized as commercial, industrial, or mixed-use have also contributed to inequities in health.⁴⁹ Decades of land-use decisions and *de facto* segregation, facilitated by a complex system of **weak environmental laws and regulations, poor enforcement, and fragmented authority**, have led to the pervasive overconcentration of environmentally hazardous land uses and exposures in low-income, African American and Latino communities throughout the U.S.^{50,51} **Economic Enterprise Zones** serve to concentrate industry, often with public subsidies, in low-income communities and communities of color.

As racial covenants were overturned in the 1940s and 1950s and white Americans moved to the suburbs, **public and private divestment from the urban core** toward the second half of the 20th century was mirrored by increased investment in and **subsidization of suburban community development**.⁵² Investment in urban parks decreased⁵³ and the highways that were built as part of **urban renewal** to connect suburbanites to city resources cut through many urban parks and neighborhoods,⁵⁴ dividing families and neighborhoods, and undermining locally owned business. These highways fragmented many historic mixed-income, African American and Latino communities, reorganized the urban landscape, diminished affordable housing opportunities, and displaced thousands of residents and businesses.⁵⁵ In response to court-ordered desegregation, many municipalities closed down or privatized public recreation facilities rather than comply. Desegregation in the 1960s coincided with deterioration of recreational facilities, the criminalization of urban open space, and the creation of expensive amusement or theme parks that excluded poor non-whites by virtue of their expense and distance from the urban core.⁵⁶

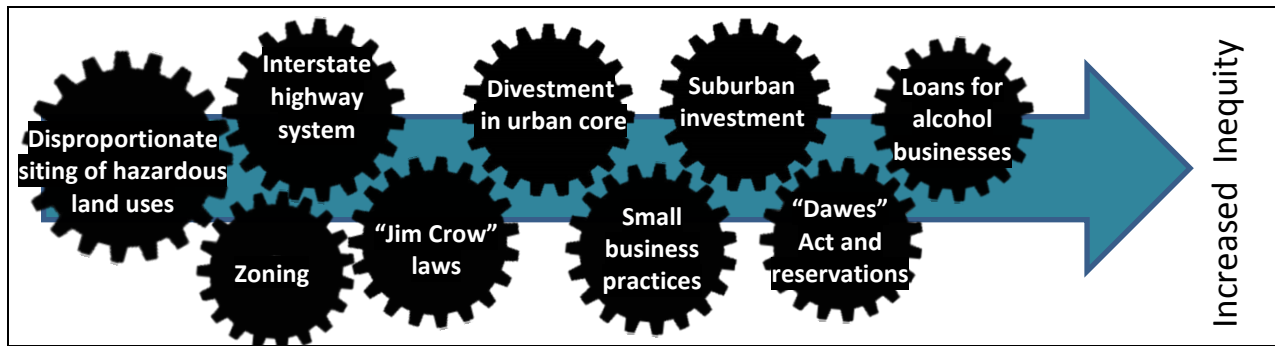
Historically, transportation policies have favored investments in roads and highways over public transportation and pedestrian/bicycle infrastructure. **The Federal-Aid Highway Act (1956)** fueled millions of federal dollars toward developing our current transportation system. While zoning also contributed to American dependence on motor-vehicle travel by creating greater distances between residential, commercial, and industrial uses,⁵⁷ this massive investment in roads and highways cemented the U.S.'s reliance on automotive travel, severed physical connections between neighborhoods — thereby perpetuating residential segregation⁵⁸ — and dramatically undermined walking and biking as a viable means of active transportation in many communities. Local transportation plans and finance measures have also favored roads and highways over multimodal and active transportation. Compounding this, automobile manufacturers purchased rail systems and dismantled them,⁵⁹ contributing to a decreased access to rail travel.

American Indians and Alaska Natives (AI/AN) have experienced a unique set of policies and practices. Starting in the 1800s, AI/AN were displaced from their historic and sacred lands, and forced to relocate to government-controlled **reservations**. Additionally, the **General Allotment Act of 1887** (Dawes Act) resulted in fragmented ownership of Indian land. As a result, one piece of land may have hundreds of owners and, consequently, the ability for owners to make use of the land for agriculture or business development is limited.⁶⁰

Sample community impacts that contribute to poor health and lack of safety: Residents in densely populated urban areas are underrepresented in transportation planning because they have the same say as less populated suburban areas. Other impacts of these policies and practices at the community level include:

socially disconnected neighborhoods; disruption of social networks; concentrated pollution and worse air quality; fewer parks and open space; extractive industries (gambling, recycling) sited in communities of color and communities with low-average household incomes; food deserts and food swamps; high alcohol outlet density; disproportionately larger numbers of tobacco outlets, liquor stores, pawn shops, payday lenders and check-cashing establishments; increased alcohol and tobacco sales; concentration of populations with low income and people of color in neighborhoods with poor job opportunities; limited access to jobs that are increasingly located in suburban areas underserved by transit; unequal investment in schools due to school funding based on property tax bases; movement of manufacturing jobs from cities to suburbs; residential segregation; concentrated poverty and disadvantage; displacement.

Built/Physical Environment: Sample Policies, Laws, Practices, and Procedures that Produce Inequity (What & How)



Key sectors (Who): Banking/Finance, Business/Industry, Economic Development, Land Use & Management, Transportation

Housing

The ache for home lives in all of us, the safe place where we can go as we are and not be questioned.
-Maya Angelou

Housing covenants, neighborhood deed restrictions, the GI Bill, redlining maps, exclusionary zoning, and public housing all served to concentrate people with lower incomes in areas with lower quality housing stock. **Housing covenants** and **deed restrictions** were legally binding documents that prohibited the sale of properties in white neighborhoods to people of color, codifying which people could live in which neighborhood by race. In Alameda County, California, for example, housing covenants forbade people of color from living in specific areas of the county, unless they were employed in domestic jobs in white areas and living with those families. Housing covenants and deed restrictions began first as private agreements between neighbors but then became explicit public policy after the U.S. Supreme Court validated their use in 1926.^{61,62 63,64} The Servicemen’s Readjustment Act of 1944, more commonly known as the **GI Bill**, gave white veterans access to credit in high-opportunity neighborhoods that would become the suburbs, while restricting veterans of color to living in the neighborhoods labeled “declining” on Federal Housing Administration (FHA) **redlining maps**.⁶⁵ These maps indicated to lenders the neighborhoods in which to issue mortgages and excluded neighborhoods with substantial numbers of people of color – typically, African Americans and Latinos.⁶⁶ Meanwhile, the Federal Housing Administration (FHA) guaranteed loans to developers of new suburban neighborhoods, as long as they didn’t sell homes in the new subdivisions to African Americans. The FHA even provided model

language for housing covenants for these subsidized suburban developments.⁶⁷ Lastly, **exclusionary zoning** practices that dictated minimum lot sizes and housing types served to bar people of color and people with low-average household incomes from moving to certain neighborhoods while preserving the property values of predominantly wealthy communities.⁶⁸ While the federal government was funding the development of the suburbs, **segregated public housing** was being constructed for mostly African American residents locked out of moving to the suburbs. To this day, public housing units are generally found in areas of disadvantage.⁶⁹ First devised as part of the New Deal in 1937, public housing provided explicitly segregated housing: units could be inhabited only by people of the same race in which the neighborhood was located, ensuring that public housing was built in already segregated communities.⁷⁰ Similar to the impact of 1960s housing projects in inner-city neighborhoods that disrupted social networks, **cluster housing** was introduced on American Indian lands in the 1960s by the U.S. Department of Housing and Urban Development (HUD) as a means to provide “modern housing and utilities” in a cost-effective manner to reservations across the country.⁷¹ This corresponded with a significant increase in drug and crime problems in tribal communities.

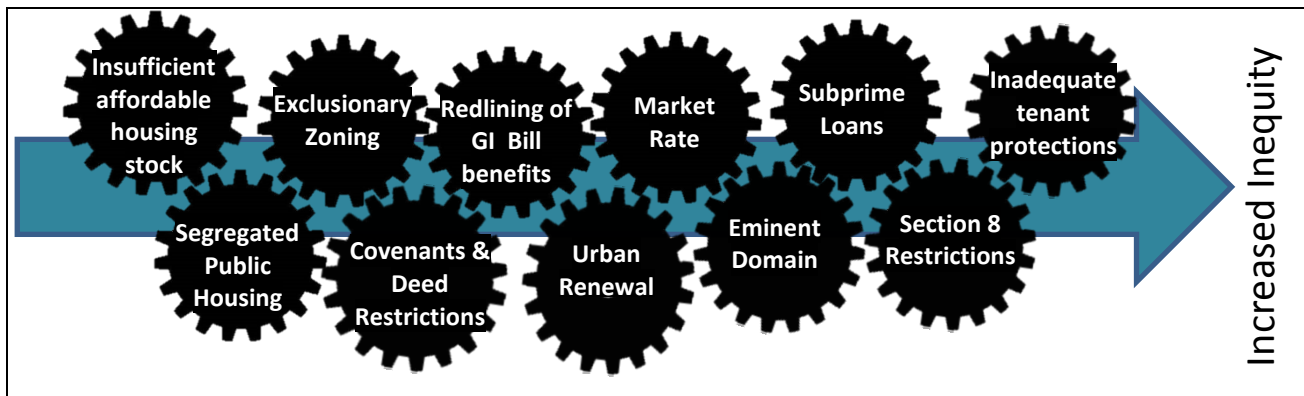
Historically, in response to suburban sprawl and “white flight” during the mid-20th century, municipal governments across the U.S. evoked the **Housing Act of 1949** to set in motion the process of urban renewal. This act sanctioned the taking of land in urban areas deemed “blighted,” under the guise of **eminent domain**.⁷² The land was then cleared and sold at reduced prices to developers for other uses, frequently low-income housing and industrial purposes. It is estimated that of the one million people displaced in 993 American cities, 75% were people of color.⁷³

Market rates threaten housing affordability for many people with lower incomes. Both homeownership and the rental market are affected by housing affordability. During the housing market crash, communities of color – who were disproportionately targeted for and granted subprime loans – lost their homes to foreclosures at twice the rate of whites.⁷⁴ A 2013 report on rental market recovery identified affordability pressures due to increasing demand in the rental market and declining incomes for renters with low-incomes.⁷⁵ Longtime residents can be priced out of their homes and neighborhoods by rising market rates, leading to displacement. Gentrification, a process of increasing wealth, education, and changing demographics in a neighborhood that can be caused by **public or private investment in historically divested communities**,⁷⁶ is a central cause of the increase in housing costs. Such displacement is especially common in the **absence of tenant protections, large and stable subsidized housing stock, strong community organizing, and restrictive zoning**.⁷⁷ Compounding the challenge of affordable housing, more people are renting because wages are stagnant and the housing bubble both added previous owners to the renting pool and tightened mortgage requirements. More people renting means more people with higher incomes are renting and they are living in apartments that lower income people might otherwise claim. New housing stock is rarely affordable to people with lower incomes and low-income housing is vulnerable to demolition.⁷⁸

Families involved with the criminal justice system face additional barriers to residential stability; for individuals with felony convictions or outstanding warrants, securing consistent housing can be challenging. The local practice of applying **Section 8 restrictions** to bar people with felony convictions on their records has shaped family structure and contributed to an increase in single-parent, female-headed households. These restrictions have led many families to fear losing their housing if they welcome loved ones back from prison upon reentry. For people with outstanding warrants, even for overdue fines, staying in one place puts them at risk for arrest and manipulation by those that know their status,⁷⁹ such as predatory landlords who market specifically to individuals who would not qualify for habitable market-rate housing.

Sample community impacts that contribute to poor health and lack of safety: The impact of these policies and practices at the community level has included the creation of racial and economic residential segregation. Economic concentration, or the concentration of poverty, means that there are fewer resources to maintain infrastructure or fund public services, resulting in deteriorating communities, empty or abandoned buildings, and underfunded schools. When displacement occurs, these longtime residents and communities do not reap the benefits of improved community conditions and are subject to housing instability. Gentrification creates areas of concentrated advantage and disadvantage. When people with low credit scores, longer-term residents, or residents without mortgages move out of gentrifying neighborhoods, they are more likely to move to lower-income neighborhoods and neighborhoods with lower quality-of-life indicators, a trend that may be even more pronounced in areas experiencing intense gentrification.⁸⁰ Additional impacts include a lack of affordable, quality housing, instability and displacement, and the breakdown of social networks.

Sample Policies, Laws, Practices, and Procedures that Produce Inequity (What & How)



Key sectors (Who): Banking/Finance, Business/Industry, Economic Development, Housing, Land Use & Management

Public Safety

Where there is darkness, crimes will be committed. The guilty one is not merely he who commits the crime but he who caused the darkness.

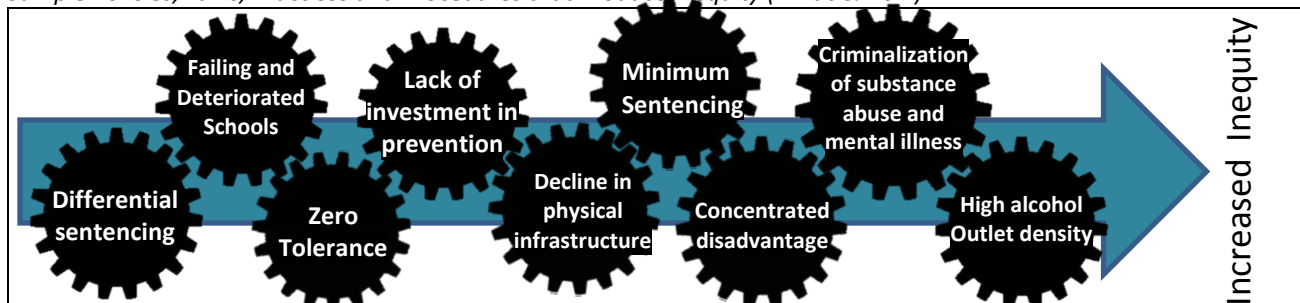
-Victor Hugo

A range of practices and policies have contributed to the reality that some communities are safer than others. Approaches to public safety that have historically been dictated by criminal justice and law enforcement interests have not addressed the underlying conditions that increase the likelihood of violence. For example, **financing and zoning that allows for a high density of alcohol outlets**, proliferation of weapons, concentrated poverty, a lack of investment in some communities including a **disinvestment in physical infrastructure**, and **failing schools** have contributed to conditions that give rise to violence and a lack of public safety. **Zero-tolerance policies** in schools have resulted in differential suspension and expulsion rates for students of color, contributing to a school-to-prison pipeline. A historical reliance on **crime suppression** strategies, coupled with **differential sentencing, minimum sentencing, and criminalization of mental illness and substance abuse** have contributed to a cycle of mass incarceration. Despite the evidence base showing that violence is preventable, the U.S. has invested large amounts of money in building and maintaining prisons, while investing very **little in the prevention of violence** and promotion of safety, including promoting resilience factors which are

protective against violence. Further, whatever the initial reason for detention, prisons can serve as training grounds for violence, and conviction records reduce opportunities— such as for employment— post-release, both of which may contribute to a cycle of violence. Policies that have contributed to **concentrated disadvantage** also influence public safety. People who live in neighborhoods of concentrated disadvantage are more likely to experience violence and to be the victims of violence.⁸¹ Nationally, most or all of the difference in rates of violence between racial and ethnic groups can be accounted for by differences in the neighborhoods in which these groups live.

Sample community impacts that contribute to poor health and lack of safety: The impact of these policies and practices at the community level has been devastating and reinforced a cycle of violence as risk factors for violence have consequentially increased. Social networks and community trust have been broken or interrupted, for example, as a disproportionate number of men of color have been incarcerated. Visible signs of disinvestment in these same communities reinforce a perception of a lack of safety and unattractiveness to potential investors and businesses. In turn, these communities have fewer resources to support quality schools and education, also contributing to a continuing cycle of a lack of safety. The policies and practices have not only contributed to residential segregation but also reinforce it.

Sample Policies, Laws, Practices and Procedures that Produce Inequity (What & How)



Key sectors (Who): Banking/Finance, Business/Industry, Economic Development, Education, Housing, Human/Social Services, Justice, Land Use & Management, Public Health, Workforce Development

Education

You are never strong enough that you don't need help.
-César Chávez

The U.S. **education financing system**, largely funded through local property taxes, results in vast disparities in funding for schools, with broad implications for educational equity. Historical policies that have contributed to residential segregation and concentrated poverty contribute to the underfunding of schools. As compared to students of color, white students attend schools in neighborhoods with greater wealth, have greater funding and increased course offerings, smaller class sizes, better trained and more highly experienced teachers, up-to-date curricula and equipment, and more supportive services, all which lead to better educational outcomes.^{82,83,84} Additionally, many rural school districts are under-resourced in part because of their lower population densities and grant-funding policies and practices that favor large, geographically-compact districts. Rural schools also have unique challenges, including lower salaries for employees and lack of access to professional development opportunities.⁸⁵

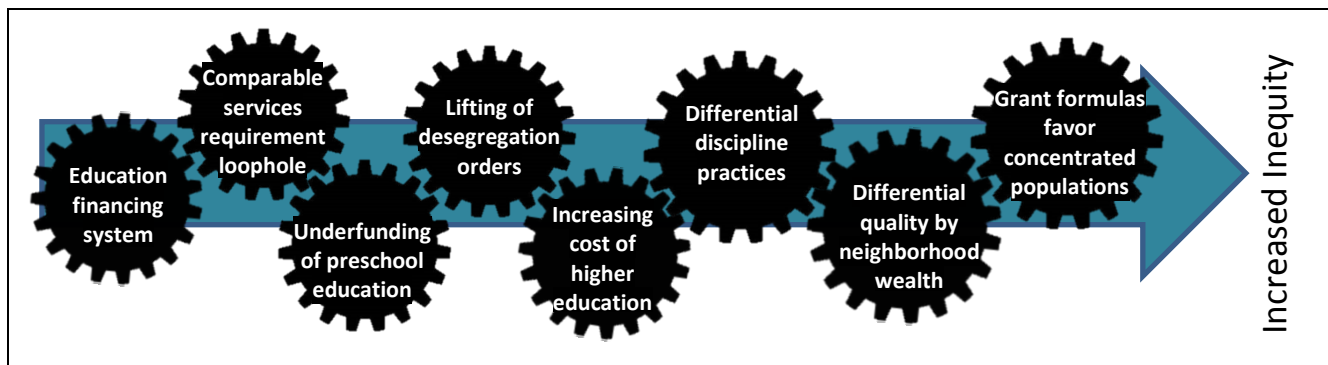
There can also be variations within districts. According to federal law, schools with high numbers of students in poverty that receive Title 1 federal funding are required to provide comparable services to more affluent schools that do not receive Title I funding. However, the **comparable services requirement loophole** undercuts the intention of the law because it allows districts to focus solely on number of services offered, such as number of teachers employed, while ignoring imbalances in expenditure for teachers' salaries and the qualifications of instructional staff.^{86,87} As a result, there is an imbalance in per-pupil expenditures at affluent schools compared to low-income schools, and services may in fact not be comparable in quality.

School segregation by race was legal until the 1954 Supreme Court ruled in *Brown v. the Board of Education* that "separate but equal" facilities were unconstitutional. Since that ruling, however, policies have led to the re-segregation of schools both within and between school districts, such that schools are more segregated now than they were in the late 1960s. For example, the Supreme Court's 1991 decision in *Dowell v. Oklahoma City* empowered districts to **lift desegregation plans** and return to neighborhood schools.⁸⁸ School segregation occurs most commonly by race/ethnicity and by socioeconomic status, with rising segregation by language.⁸⁹

Funding for preschool and higher education also creates barriers to educational attainment in the U.S. **Underfunding of preschool education** at the federal, state, and local levels contributes to lack of high-quality, affordable options. Ten states do not fund preschool at all.⁹⁰ As a result, despite gains in pre-school enrollment overall, only 30% of four-year-olds are enrolled in state-supported preschool education.⁹¹ Meanwhile, at a time when the share of jobs requiring a post-secondary education has doubled, the **increasing cost of higher education** prevents many low-income students and students of color from pursuing a college education.⁹² Largely due to state funding cuts, the cost to attend public universities has risen faster than inflation – quadrupling over the past 35 years.^{93,94} With regard to higher education, black and Latino soldiers returning after World War II as a whole did not receive the same level of educational benefits through the **GI Bill** as their white counterparts. Distribution of GI Bill benefits was controlled at the local level, which resulted in vastly different allocations of benefits across the country.

Lastly, **differential and harsh discipline policies and practices** are disproportionately leveled against students of color and students with disabilities, including disproportionate rates of suspensions and expulsions that contribute to school dropout and other negative outcomes, and increased interactions with the criminal justice system, which fuels the school-to-prison pipeline.

Sample community impacts that contribute to poor health and lack of safety: The impacts of these policies and practices at the community level include: hopelessness; unhealthy norms, such as smoking; decreased civic participation; deteriorated school buildings; reduced graduation, literacy, educational achievement; decreased opportunities for employment and social mobility; and increased residential segregation.



Key sectors (Who): Education, Housing, Justice

Employment

What happens to a dream deferred?

-Langston Hughes

Policies and practices in the U.S. create inequities in health by shaping who has access to employment, as well as the terms and conditions of that employment. A number of past and current policies and practices make American workers vulnerable to poor health outcomes, particularly people of color and workers with low-average household incomes.

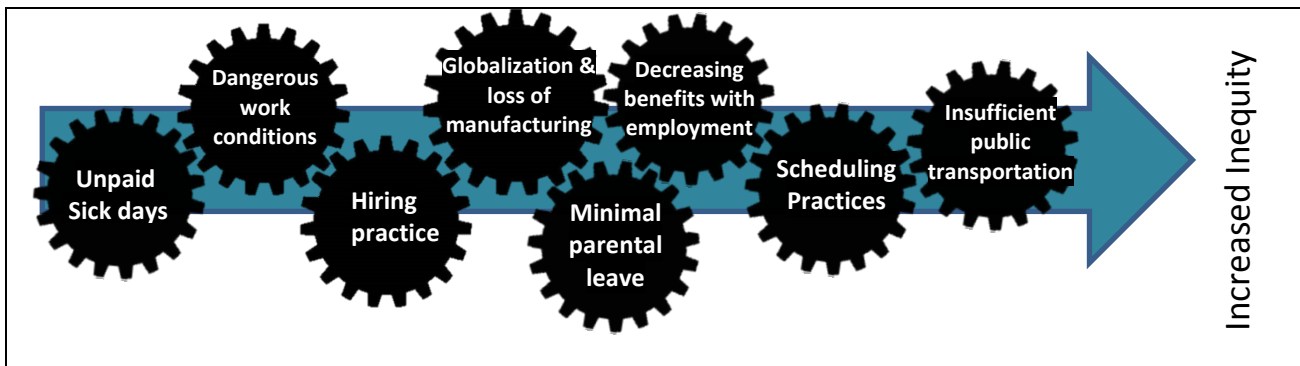
The 1970s represented a decade of dismantling American factories as corporations began to relocate overseas to avoid labor and production regulation and costs.⁹⁵ This part of the **globalization process** led to the loss of thousands of unionized manufacturing jobs and the growth of polarized service positions through the 1980s and 1990s, with high-paid producer services industries (e.g., accounting, finance, law, management, information processing) on one end and low-wage personal services jobs (e.g., hotel and food service) on the other.

Once people are employed, they are subjected to a wide variety of employment environments. Industry practices that put worker health and safety at risk include the **use of dangerous chemicals or pesticides** in manufacturing, production, and agriculture industries. **Scheduling practices**, including short notice, fluctuating hours, lack of schedule control, underemployment (including an inability to qualify for some benefits), and “Clopenings,” (i.e. a practice in retail and service industries where those who have worked the night shift are scheduled to open early the next morning) are legal in the U.S. and have the greatest impact on workers with low-average household incomes. **Right-to-work policies** have weakened unions and employment protections, such as overtime and sick leave rights, and the ability to sue employers for race- and gender-based discrimination.⁹⁶ **Minimal or nonexistent parental leave policies, limited childcare options, lack of family-friendly policies, and lack of guaranteed sick leave** reduce the benefits of employment. For workers at small firms, **small business exemptions** reduce the reach of employment protections that other workers claim. In addition, **industry practices** put worker health at risk, while the **disproportionately low number of small business loans** given to blacks and Latinos makes it more difficult for these groups to start their own businesses.

Post-WWII job placements tracked veterans of color into lower-wage, unskilled jobs with limited options for social mobility, with multi-generational impacts. **Redlining** contributed to residential segregation, which increased the distance between workers of color and jobs, a reality that is exacerbated by **insufficient public transit systems** to connect people with lower incomes to jobs. Modern-day **hiring practices** can also reduce access to employment for people of color and reduce the opportunity for people of color to be employed in high-paying, management positions. For example, a 2008 study – which predates the Great Recession – demonstrated that black men spent considerably more time searching for work, obtained less work experience, and were placed in less stable employment than white males with similar characteristics.⁹⁷ Widely cited in the literature, a 2003 field experiment showed that job applicants with white-sounding names were more than 50% more likely to get called back than applicants with people with black-sounding names despite the same qualifications.⁹⁸ This study also demonstrated that black males without a criminal record were less likely to be called back for an interview than white males with a conviction.⁹⁹ Additionally, some institutions ban or restrict employment for people with convictions, which disproportionately affects men of color.

Sample community impacts that contribute to poor health and lack of safety: The impact of these policies and practices at the community level have been devastating, including barriers to employment, reinforcing a cycle of unemployment, and offering little protection in employment. The impacts reinforce one another: as the unemployment rate grows so do barriers to employment, and the likelihood that a person with a job has few workplace protections.

Sample Policies, Laws, Practices, and Procedures that Produce Inequity (What & How)



Key sectors (Who): Agriculture, Banking/Finance, Business/Industry, Economic Development, Education, Labor, Transportation, Workforce Development

Income and Wealth

The opposite of poverty is not wealth. In too many places, the opposite of poverty is justice.
-Bryan Stevenson

Income is generated primarily through employment, and the policies and practices that create inequities in employment drive income inequities. For those who are employed, wages largely determine income, and myriad policies and practices perpetuate wage and income inequality. For example, since the late 1970s, Americans workers have experienced **wage stagnation**, despite increased productivity, while the earnings of those at the top have tripled.¹⁰⁰ This lopsided growth has increased income inequality.¹⁰¹ Moreover, women

and people of color experience a **wage gap**, earning less than their white male counterparts.¹⁰² For those at the bottom of the earning spectrum, the **federal minimum wage** of \$7.25 per hour is insufficient to lift a single parent working full time at minimum wage out of poverty.¹⁰³ Agricultural workers and domestic workers are particularly vulnerable, as they were not guaranteed a minimum wage through the **Federal Fair Labor Standards Act**.¹⁰⁴

The social safety net is meant to prevent people from falling into material deprivation. While it is successful at preventing poverty for some, gaps in coverage and recent reforms leave certain populations vulnerable. Single-parent families, which are overwhelmingly headed by single mothers, were hit particularly hard by the 1996 welfare reform law. Today, these families receive 35% less in government transfers than they did 30 years ago, while married families receive more than they did 30 years ago and older adults have experienced a 20% increase in funding.¹⁰⁵ In addition, other safety-net policies, such as Supplemental Nutrition Assistance Program (**SNAP**, formerly known as food stamps) and the Special Supplemental Nutrition Program for Women, Infants, and Children (**WIC**) are under threat, experiencing steep **cuts in recent years**. Since 2000, the percentage of families with children living in extreme poverty has risen, even taking into account the role of government support.¹⁰⁶ An important change to government assistance came in 1996 with the passage of the **Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)**, better known as welfare reform. This legislation replaced Aid to Families with Dependent Children (AFDC), a cash assistance program, with Temporary Assistance for Needy Families (TANF), which eliminated the entitlement to cash assistance and instituted work requirements, dramatically changing access to cash for people receiving government subsidies.¹⁰⁷ Along with the **Earned Income Tax Credit (EITC)**, which bolsters the earnings of low-income workers, PRWORA put employment at the heart of government assistance, making those with barriers to employment particularly vulnerable to extreme poverty.^{vii}

We know what the headline is going to be: multi-generational poverty has ended and health outcomes have improved dramatically.

-David Erickson

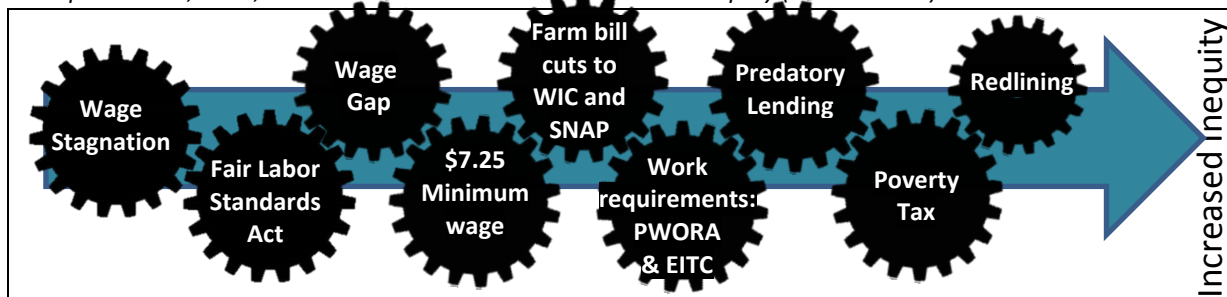
Policies that impact homeownership greatly hinder the ability of communities of color to build wealth. Homeownership is a cornerstone of wealth accrual in the U.S. The **GI Bill**, when implemented along with other practices such as **predatory lending** and **redlining**, has acted as a barrier to homeownership for people of color. Prior to the 1970s, it was nearly impossible for African-American, Latino or Asian-American families to access credit from the commercial banking industry to purchase homes. This led populations of color to rent or to buy homes “on contract”: a **predatory lending** agreement in which the seller held the deed until the home was paid in full, preventing the purchaser from accruing home equity and exposing the purchaser to the increased risk of losing his or her home if the borrower defaults on the loan.¹⁰⁸ Currently, people of color, especially women of color, are more likely to receive **subprime loans** as a result of predatory lending practices by banks, regardless of their income or credit score,¹⁰⁹ to be denied loans, or to lose homes due to foreclosure.¹¹⁰ By impeding homeownership – or homeownership in areas where home values increased significantly in comparison to redlined areas – these policies undermined wealth accumulation for people of color, as homeownership is a central tenet of intergenerational wealth accumulation in the U.S.¹¹¹ Since the economic downturn of the 2000s, poverty has become more concentrated in high-poverty, distressed neighborhoods.¹¹² In addition, people living in areas of concentrated poverty are often subjected to what amounts to a “**poverty tax**,” as goods and services cost more and require more time to procure.

^{vii} Defined as less than \$2 per person per day

In addition, policies affecting homeownership, technological advancements, the economic recession, educational inequities, and tax policies that favor the wealthy, are among the top factors that have hindered the accumulation of wealth for low-to-moderate income households. **Low-skilled jobs have been replaced by machines or outsourced** to other countries, resulting in fewer available jobs and lower wages for less-educated workers, while increasing wages for higher-income earners.¹¹³ Inequitable access to educational opportunities fueled by the rising cost of higher education, along with lower levels of college readiness among those with inadequate K-12 preparation, produce lower rates of educational attainment particularly among children of low-income families, thereby decreasing their job opportunities and earnings. These trends have been exacerbated by the economic downturn during which unemployment among those with the lowest education levels increased more rapidly than for college-educated workers – leading to higher rates and longer periods of disengagement from the workforce. Unlike the wealthiest households, low- and middle-income families rely on wages for their incomes and count homes as their primary assets.¹¹⁴ Consequently, the higher rates of unemployment and the rapid decline of the housing market during the mid-to-late 2000s led to a significant loss of wealth among these families. Conversely, those at the top of the ladder, who earn much of their income through capital investments, recovered their wealth more rapidly since these assets recovered faster than jobs and wages after the recession. Collectively, along with **weakening workers' rights, the exploitation of undocumented workers, a tax system** which protects the wealth of those at the top, along with **very high salary increases** that outpaced productivity among the highest wage earners – the wealth divide has grown substantially between high- and low-to-moderate income families.¹¹⁵

Sample community impacts that contribute to poor health and lack of safety: The consequences of concentrated poverty are many. Residential economic segregation and concentrated poverty – known barriers to economic mobility¹¹⁶ – mean that people with lower incomes not only have a hard time making ends meet at home, but have fewer resources that are easily accessible to them and are surrounded by others who are struggling.¹¹⁷ Concentrated poverty is associated with higher crime rates, lower employment rates, lower educational achievement, and worse health outcomes.¹¹⁸ In areas of concentrated poverty, it is more common to find payday lenders, pawn shops, and corner stores than banks and grocery stores,¹¹⁹ and these alternative financial service providers become relied upon to meet ordinary household expenses.¹²⁰ Predatory lending businesses promote a vicious economic cycle that affects the economic security of people with lower incomes and other vulnerable groups. As concentrated poverty increases, lack of trust, deteriorating housing stock, and perceived lack of safety grow. Other impacts include failing infrastructure, inability to afford adequate housing, increasing concentration of poverty, exploitation of borrowers of color, low-quality schools, limited access to jobs and essential services such as healthy food and public transportation, and an inadequate tax base.

Sample Policies, Laws, Practices and Procedures that Produce Inequity (What & How)



Key sectors (Who): Agriculture, Banking/Finance, Business/Industry, Economic Development, Education Healthcare, Housing, Workforce Development

Access to Quality Health Systems and Services

Of all forms of inequality, injustice in healthcare is the most shocking and inhumane.

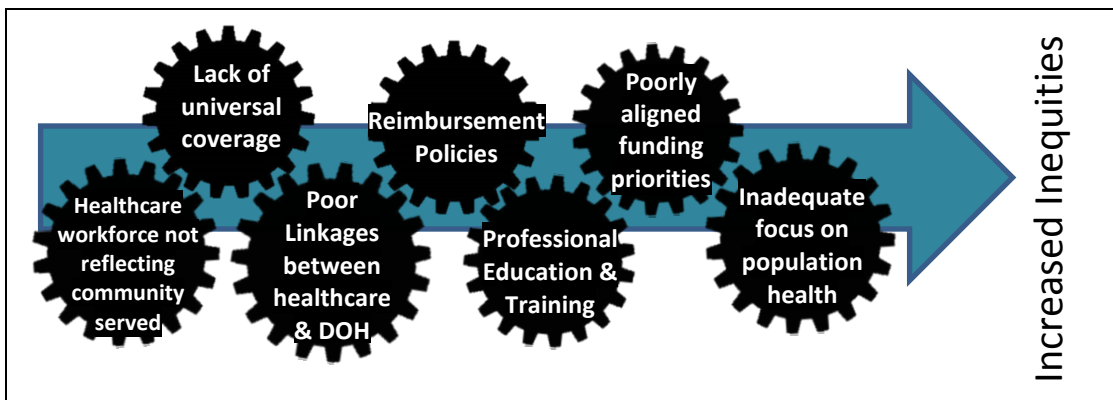
-Dr. Martin Luther King, Jr.

The healthcare system in the U.S. contributes to health inequities in three ways: 1) directing attention to treating illnesses and injury rather than preventing them;^{121 122} 2) dedicating a huge share of public and private resources – such as Medicaid, Medicare, employer-sponsored health insurance, and family out-of-pocket expenditures^{123 124} – to treatment, rather than investing in community conditions to promote health equity in the first place; and 3) producing less-than-optimal health services outcomes for people of color and people with limited economic resources, such that some segments of these populations are unable to access evidence-informed health services.^{125 126} Despite the importance and growing recognition of non-medical and community factors as key Determinants of Health, **public health activities are chronically under-resourced**^{127 128 129} and are not consistently aligned with healthcare to facilitate population health transformation. This transformation must include authentic partnerships with, and resources for, community organizations, residents in communities of color, and residents in communities with limited economic resources. The goal is to assess, prioritize, and implement strategies to promote health equity. Further, **healthcare organizations have an opportunity to play a more critical part in leveraging their roles as anchor institutions.**

After the landmark IOM report¹³⁰ titled “Unequal Treatment,” the U.S. health system has incrementally responded to inequities in access to health systems and services by pushing for increased access to health insurance coverage, improved screening for preventable conditions, implementation of workforce diversity programs, and the encouragement of clinical data integration and analytics. Another important step has been the increased linkage of healthcare services with community-based social services and supports. Yet these efforts have not adequately closed the gap on access to quality health systems and services. Broader attention needs to be given to the entire population in order to address persistent inequities. There remain a remarkable number of **uninsured and underinsured individuals who do not receive timely health screenings for preventable conditions through primary care;**¹³¹ **the healthcare workforce is often not representative of the community it serves;**¹³² and **clinical data is rarely linked to and analyzed alongside data on community Determinants of Health.**¹³³ Despite investment in new reimbursement models, the **funding and financing of the health system still emphasizes volume over value, prevention, and primary care.**¹³⁴

Sample community impacts that contribute to poor health and lack of safety: Inequities in access and system barriers reinforce these policies and practices and result in inequities in premature death and morbidity from preventable chronic diseases, injuries, and disabilities. The health sector continues to under-invest in addressing the Determinants of Health and community factors to promote health equity, such as housing, education, food systems, public transportation, and employment. Other factors include less-than-optimal health services outcomes for people of color and people with limited economic resources, such that some segments of these populations are unable to access evidence-informed health services; historical and current issues of mistrust in healthcare leading to delay of care at later stages of disease; centralization of health systems and services out of reach of communities of need; and disruption of employment and educational opportunities from preventable medical conditions.

Sample Policies and Laws, Practices and Procedures that Produce Inequity (What & How)



Key sectors (Who): Healthcare, Human/Social Services, Public Health

5. **Residential segregation is particularly harmful when it creates isolation from opportunity and social mobility.**

Residential segregation is the consequence of policies, laws, practices, and procedures across multiple Determinants of Health, such as redlining by housing lenders, unequal investment in schools and transportation, and judicial rulings supportive of segregation. Economic and racial segregation is one of the most powerful forces shaping health in the U.S. This segregation is not inevitable; it has been established and maintained through government policy and investment, and the practices of institutions and organizations.¹³⁵ Perhaps because there is more data about segregated urban populations, the negative health impact of residential segregation is most commonly associated with African Americans. However, contributing factors and potential impacts are more far-reaching. The health impacts stem from lack of opportunity to health-promoting conditions and exposure to hazardous conditions, and are associated with concentrated disadvantage or economic segregation. Segregated communities are more likely to have limited economic opportunities, a lack of healthy options for food and physical activity, increased presence of environmental hazards, substandard housing, lower performing schools, higher rates of crime and incarceration, and higher costs for common goods and services (the so-called

Communities that experience disparities experience multiple disparities.

—Kathy Ko Chin

“poverty tax”).¹³⁶ While residential segregation has declined overall since 1960, people of color are increasingly likely, relative to whites, to live in high-poverty communities.¹³⁷ This does not negate the positive and protective aspects of people living together in cohesive communities, including, for example, communities comprising immigrants of similar background. However, when any group of people is living in conditions without opportunities for good health, such as highly concentrated, deep, multi-generational poverty, segregation is not conducive to health, especially over time. Addressing residential segregation – focused on segregation from opportunity, income, and power to have and make optimal choices – are key to producing health equity.

6. **Specific sectors are key actors within the Determinants of Health and in many cases, across multiple determinants.**

A sector is a specific field, discipline, or area of expertise that is characterized by a combination of related activities and functions that are typically understood as distinct from those of others. In this analysis, 15 specific sectors emerged as key actors within the Determinants of Health. In many cases, sectors have played historical and/or current roles in the production of health inequities. Examples of how these sectors have contributed to the production of health inequities are below. All of the identified sectors have critical roles to play in achieving health equity. Cross-sector engagement and collaboration becomes an engine that generates new ways to catalyze and sustain change. This is well aligned with the Culture of Health framework, which emphasizes multi-sector collaboration to build health partnerships as one Action Area.

The Production of Health Inequities: Examples across Sectors

Fifteen sectors were identified in this analysis as contributing to the production of health inequities through policies and laws, practices, and procedures. While not every action or every individual involved in each sector has been part of the production of health inequities, it is important to understand the various ways in which health inequities have been produced, whether the production was intentional or inadvertent. This understanding helps inform solutions. Examples of how different sectors have contributed to the production of health inequities are included in each previous section about each determinant of health and some examples are also provided below. Significantly, each of these sectors has a critical role to play in producing health equity.

1. **Agriculture:** Agricultural subsidies incentivize the production of food crops that are cheap, high-fat, high-sugar, and processed, making healthy food less affordable for people of low income, communities of color, and rural residents. Government-sponsored food programs funded through the U.S. Department of Agriculture, such as WIC and SNAP, cannot be widely used at farmers’ markets, limiting access to healthy food for recipients. Pesticides and other environmental hazards, lack of labor protections, and immigration status jeopardize the health and safety of many agricultural workers. Some agricultural rights on American Indian lands are now controlled by corporate interests, limiting tribal capacity to grow food and earn income for it.
2. **Banking/Finance:** Predatory lending practices and inequitable financing options, such as subprime loans, disproportionately target women, people of color, and people with low income, limiting their opportunity to own and keep homes, and hindering their ability to accrue equity and wealth. The practice of redlining undermined wealth accumulation for people of color by preventing them from buying homes in neighborhoods where home values would increase. Bank closings in communities of low income have forced residents to rely on alternative, more costly financial services, such as payday lenders that charge high fees to access money. Banks provide limited access to small business loans for women and people of color and, when loans are granted, tend to grant lower loan amounts and charge

- higher interest rates. Small business loan practices incentivized opening liquor stores, as opposed to other types of businesses, in communities of color, resulting in a high density of alcohol outlets in communities of color and communities with average low incomes.
3. **Business/Industry:** Business hiring practices, such as criminal background checks and a lack of family-friendly policies (such as minimal parental leave, limited childcare options, and a lack of guaranteed sick days) are obstacles for low-wage workers and workers of color. Supermarkets have favored locating in white and affluent communities, resulting in communities with lower average income having fewer chain supermarkets than higher income communities. International trade agreements led to the loss of thousands of manufacturing jobs in the US, and spurred the growth of low-wage service industries.
 4. **Community Development:** This sector was expanded under the 1960's' War on Poverty. As such, it was an instrument in designating entire communities as "blighted," allowing for the use of tools such as Eminent Domain, which removed long-time residents and community businesses in the name of urban renewal. Such practices broke up neighborhoods, social cohesion and local economies with a particular impact on urban communities of color and communities of low-average household income.
 5. **Economic Development:** Publicly subsidized economic development programs, such as Enterprise Zones, have contributed to the concentration of industrial uses in communities of color and communities with lower incomes, increasing these communities' exposure to environmental toxins. Economic development has often contributed to the displacement of communities with low-to-moderate average household incomes, especially communities of color, often without input from community organizations and residents.
 6. **Education:** School funding formulas result in vast disparities in spending-per-pupil. Schools are increasingly segregated along racial/ethnic, socioeconomic, and language lines, as many districts lift desegregation plans. Inadequate funding of public preschool education contributes to a lack of high-quality, affordable options. The rising costs of higher education prevent many low-income students from pursuing a college education. Zero-tolerance policies have resulted in unequal suspension and expulsion rates for students with disabilities and students of color.
 7. **Healthcare:** Healthcare directs its attention to treating illnesses and injuries rather than preventing them. Healthcare systems spend a large share of resources on treatment rather than investing in community factors that promote health equity. The healthcare sector often falls when it comes to meeting the linguistic and cultural needs of the communities it serves.
 8. **Housing:** The Federal Housing Administration incentivized racial and economic residential segregation by guaranteeing loans to suburban developers as long as they did not sell homes to people of color. The Housing Act of 1937 contributed to racial segregation by requiring residents of public housing developments to be of the same race as the neighborhoods where these developments are located.
 9. **Human/Social Services:** The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) reduced eligibility, placed strict time limits on assistance, enacted stringent work requirements, limited access to cash and assets, such as vehicle ownership, and has made recipients with barriers to employment more vulnerable to extreme poverty. Safety net policies, such as SNAP and WIC, are under-resourced and consistently under threat of funding cuts, putting families of low-income at-risk of hunger.
 10. **Justice:** Community policing practices such as "stop and frisk" have disproportionately targeted communities of low-income and people of color, resulting in disproportionate contact with the criminal justice system. Differential sentencing laws, such as those for drug possession of cocaine versus crack, fuel longer prison terms for people of color. Racial bias has enabled police violence against men of color, and fostered mistrust and fear of law enforcement in communities of color. Criminalization of substance abuse and mental illness has particularly affected people with low-incomes who may not otherwise be able to pay for legal services or health services.

11. **Labor:** The declining influence of labor unions is associated with a decrease in wages and benefits; wages, for example, are lower in right-to-work states. Some police unions oppose the reform of racial-profiling practices. Teacher unions have focused on the protection of teacher rights even in cases of retention of poor quality teachers.
12. **Land Use and Management:** Zoning decisions facilitated the overconcentration of environmentally hazardous land uses in primarily communities of color and low income. The General Allotment Act of 1887 (Dawes Act) resulted in fragmented ownership of Indian land hindering their ability to use the land for agriculture and business development. Alcohol outlet density is more concentrated in communities with lower average household incomes. There is less investment in maintenance and improvement of parks, trails, and recreational facilities in communities with low-average incomes.
13. **Public Health:** Public health is under-resourced and not consistently able to work with healthcare to improve population health. Fragmentation of research and funding limit the development and implementation of comprehensive approaches that address the multiple Determinants of Health. Some public health programs and departments rely on a narrow evidence base to inform policy and program development, which undermines their credibility to address populations with health disparities and limits broad adoption of public health strategies. Some public health departments do not engage the communities most affected by inequities in health in finding solutions.
14. **Transportation:** The Federal-Aid Highway Act (1956) financed the building of highways that cut through urban neighborhoods and parks, undermined local businesses, and fostered residential segregation. Transportation funding policies have favored investments in roads and highways over public transit and pedestrian/bicycle infrastructure, leading to an overreliance on automotive travel.
15. **Workforce Development:** Workforce development programs, such as apprenticeships, target male-dominated fields, resulting in fewer opportunities for women to strengthen work skills. Employer-sponsored work development programs target training programs toward employees with higher education, widening the skills gap between workers with less education. Governmental funding of workforce development programs for disadvantaged and disconnected youth has decreased over time, limiting opportunities to increase earnings.

7. Bias, discrimination, institutional and structural racism, and classism contribute to and exacerbate inequities in health. They manifest, in part, as norms and shared values within sectors and institutions, fueling the production of health inequities.

Bias, discrimination, institutional and structural racism, and classism interplay within systems to create and maintain policies and practices that, intentionally or not, produce inequitable outcomes. Organizational norms construct the lens through which policies become practices. Workforces are trained and informal interpretations become decisions at the point of service. These cultural values also become urban myths that present additional barriers to seeking and receiving assistance. An example of this is the widely held belief that the Department of Housing and Urban Development banned people with felony convictions from living in Section 8 voucher and/or public housing programs. HUD has recently clarified that this was not federal policy, but local public housing authority discretion; this mutable discretion, coupled with community perception of the rules, contributed to the break-up of family units, including displacement of youth offenders. A Shriver Center report, *When Discretion Means Denial*, examines the nuances with which this guideline was applied and its impact on recidivism and homelessness.¹³⁸ The strength of shared values among partnering organizations and sectors can accelerate the production of health inequity or health equity. Similar to the culture of discrimination that accelerated the practice of redlining across many sectors, an equitable Culture of Health can

accelerate community transformation when it is shared across multiple sectors focused on reducing inequities in health and wellbeing outcomes. This analysis, delineating the roles that multiple sectors have played in the production of inequity, asserts that the production of inequities has become embedded within and across many policies and practices to such an extent that it must be deliberately dismantled.

8. **There is a need for actionable solutions that will produce systemic change.**

The impact of inequitable policies and practices is felt – among other places – at the community level, resulting in conditions that are not conducive to health and wellbeing. The community is a place for actionable change. Further, looking at the roles and contributions of multiple sectors, which are already engaged in policies and laws, practices, and procedures every day at multiple levels, is a lever for actionable change. The first step in identifying opportunities for each sector in enacting solutions is to understand key information about each sector, such as mandates, activities, and data collected.^{viii}

Understanding these kinds of elements will also inform the best ways to engage sectors in a multi-sector effort to achieve health equity. An analysis of the production of inequities, the potential roles and contributions of 15 sectors, and the need for actionable solutions, informed the development of 10 priority Multi-sector Systems^{ix} that can produce health equity at the community level. While the impact will be felt and experienced at the community level, it will necessarily take actions beyond the community level, including at local/regional, state, and federal levels, as well as among key sectors.

We cannot focus on transportation or housing, but need to look at the relationship between transportation, housing, jobs, and schools. We have to be very deliberate about making sure that these systems actually benefit marginalized communities. To do that, you have to make sure that marginalized communities have a voice and an input.

– John A Powell

Overview of 10 Multi-sector Systems:

- 1) Community-Driven Solutions for Health Equity in Thriving Communities
- 2) Health Equity by Design: Healthy Land Use and Planning
- 3) Active Transportation for Health and Safety
- 4) Housing Choice to Build Opportunity
- 5) Sustainable Food System
- 6) Safe Communities through Preventing Violence
- 7) Cradle to Community
- 8) Developing a Workforce for the 21st Century
- 9) Creating Economic Engines in Service to Community
- 10) Community-Centered Health System

^{viii} For information on the Mandate, Main Activities and Sample Data Collected for each of the 15 sectors, please see the Full Report, Collaboration Multiplier, Phase I Grid Overview.

^{ix} A system is a set of interrelated parts that interact and function together to produce a common outcome or product

Multi-sector System Characteristics

1) Each addresses multiple determinants of health.

2) Each spans multiple sectors such as education, housing, banking and finance, land use and planning, and transportation.

3) The 10 are interrelated. Each Multi-sector System represents a different avenue and focus for producing the common goal of health equity. Further, many sectors show up in multiple systems and will benefit from collaboration for improved outcomes. Finally, by looking at the interrelationship between Multi-sector Systems, there may be efficiencies and synergies. For example, Healthy, Equitable Land Use is a mechanism to promote Active Transportation and to support Community Safety outcomes. Each multi-sector system will have a greater impact on producing health equity when others are also in action to produce health equity.

4) All are focused on promoting change at the community level, informed by the analysis of how the determinants of health play out at the community level. Action beyond the community level – including the development of policies and laws, practices, and procedures at the local/regional, state, federal, and sectoral levels – support and are needed for community change that advances health equity.

5) All are emerging strategies and elements of them are being implemented in communities and by sectors across the country. The Multi-sector Systems are informed by efforts underway across the country. None of them are a specific, evidence-based program; they are far more comprehensive in order to be able to counter the very production of health inequities. However, there is a growing evidence base behind them informed by an analysis of what's creating inequities in health outcomes and emerging practices and policies at the community, local/regional, state, federal, and sectoral levels. Success is possible; however, the production of health inequities has become so ubiquitous, success will require systemic change.

6) All are designed to achieve health equity. Within the production line to inequity, there are lessons that can inform work moving forward on systems and strategies to produce health equity. These and other lessons inform action to produce health equity by:

- Interrupting or reversing the production of health inequity through policy and practice change;
- Ameliorating the impacts through community-level change, supported by regional, state, federal, and sectoral action.
- Accelerating and sustaining the production of health equity;
- Introducing calibration points so that we measure progress in production of health equity at the local level; and
- Changing norms and values to produce equitable opportunities for health and wellbeing.

Multi-sector System Descriptions and Examples:

1. **Community-Driven Solutions for Health Equity in Thriving Communities:** A system to support community-driven solutions for health equity ensures that community members are engaged in the process of creating healthy communities. It ensures that the interests of community residents are addressed fully and appropriately, and that efforts draw on the strengths of a community and are tailored to the community's values and cultures. This system includes elements like community infrastructure, policies, and practices for inclusive planning, decision making, and multi-sector collaboration; capacity building; and evaluation for impact, sustainability, learning, and innovation. It builds the capacity of community members to be engaged in solutions and creates the mechanisms for ongoing engagement. Tools such as THRIVE (Tool for Health and Resilience in Vulnerable Environments),¹³⁹ developed for the U.S. Office of Minority Health, can support community planning processes to shape how the Determinants of Health impact community health. Models, such as the Place Matters initiative, can provide examples of multi-sector approaches to shift Determinants of Health at a local level. This system supports communities to address the sociocultural environment (e.g., civic engagement, norms and culture, and social networks), the physical/built environment (e.g., what's sold and promoted, parks and open space, and arts and cultural expression) and the economic environment (e.g., living wages and quality schools) at the local level to improve opportunities for health and wellbeing.

When you give communities the resources and power to decide what they want to address, and they organize themselves to figure out how they want to go about it, incredible things can happen.

– Kathy Ko Chin

Example: Youth Work Together to Improve Community Conditions, Planada, California¹⁴⁰

A partnership between the Central California Regional Obesity Prevention Program (CCROPP) and the Student Education Empowerment Development Squad (SEEDS) sparked a youth-led initiative to improve community conditions in Planada, California, a town nine miles east of Merced in the San Joaquin Valley. CCROPP and SEEDS used Prevention Institute's *Tool for Health and Resilience in Vulnerable Environments* (THRIVE) to identify community conditions that were detrimental to health in Planada and develop an action plan to improve those conditions. Youth input and perspectives drove the process of identifying which community conditions were most pressing. County CCROPP Program Manager Claudia Corchado asked the youth to take photos of their neighborhoods to connect the community environment to health behaviors and health outcomes. The resulting photos depicted gang graffiti, store windows covered in bars, and young people walking on busy streets because sidewalks were not present. With the THRIVE tool, these photographs and the conversations that followed helped the youth identify their community's concerns related to poor health outcomes and develop action steps based on priorities. When the students connected limited transportation options in their community to injuries, they decided to focus on pedestrian safety, first by creating Safe Routes to School. SEEDS youth developed policy proposals to increase speeding fines in school zones and use the monies to fund improvements in sidewalk infrastructure. The students wrote opinion pieces in local media, presented to their county board of supervisors, testified before the California Senate Transportation and Housing Committee, and worked on a CalTrans Environmental Justice Transportation Planning Grant. This youth-led process influenced Planada's municipal Pedestrian Planning Improvement Plan and created momentum for a state bill to increase fines

for traffic violations in and around school zones, mirrored after increased fines in construction zones.

Example: Engaging Men and Boys of Color to Improve Mental Wellbeing, Tacoma, Washington¹⁴¹

In 2015, the Tacoma-Pierce County Health Department (TPCHD) in Washington State began partnering with several community organizations with expertise in youth leadership, violence prevention, employment, education, urban agriculture, and equity. Through the Making Connections for Mental Health and Wellbeing initiative, this multi-sector partnership mobilizes boys and men of color to improve mental wellbeing among people in their community. Specifically, the initiative focuses on health equity, Adverse Childhood Experiences (ACEs) and toxic stressors, with a particular focus on improving the community's physical/built environment. TPCHD and partners have begun to recruit men and boys of color leaders to be part of ongoing planning processes. Through one-on-one outreach and small group discussions led by boys and men of color, men and boys themselves are identifying specific strategies that will positively impact their community and bolster mental health outcomes. Upon drafting a plan that is informed by participants' input, the leadership group will conduct community forums to gather feedback and ensure that the selected strategies are reflective of the voices of the boys and men for whom it is designed to impact.

- 2. *Health Equity By Design: Healthy, Equitable Land Use and Planning:*** Healthy Equitable Land Use and Planning is a system whereby the decisions, policies, and practices of government, the private sector, and community stakeholders ensure healthy, safe, and resilient built environments. The built environment refers to design, conditions, and infrastructure. The system ensures that both the tools of the planning field and the process through which planning occurs increase community access to health-promoting resources—such as jobs, transit, housing, healthy food retail, and safe places to play—while protecting people from hazardous and unsafe land uses. It also ensures that general plans and other traditional planning tools clearly articulate health equity objectives and that those objectives are translated into innovative projects; improved decision making by and accountability of planning and land-use entities; and enhanced health and safety outcomes through prioritized implementation, interdepartmental and cross-sector partnerships with private enterprise, and robust civic engagement to meaningfully involve residents. In this system, high-quality health- and safety-promoting projects in divested urban communities benefit from streamlined review and permitting, and project-based incentives to reward good investments in community health. This system also facilitates healthy, equitable project design and implementation, as well as policy development through high-level planning and land-use capacity building among community-based organizations and residents, coupled with robust community engagement activities by government agencies and non-profits. The system uses economic incentives as well as political and social support for healthy, equitable investments by public and private agencies, resulting in innovative developments and projects that create value, social capital, and economic growth in underserved neighborhoods.

Example: Healthy Parks and the Interface between State and Local Policy Change, California¹⁴²

In 2006, California voters enacted a bond measure allocating \$400 million to improve access to parks and recreational facilities in California’s urban areas. Two years later, then-Assembly Member Kevin De Leon worked with local advocates in Los Angeles to author AB 31, the Statewide Park Development and Community Revitalization Act of 2008. This act steered the funds that had been allocated in 2006 towards communities with the greatest need for increased access to green space. AB 31 specified funding preference for new parks in communities that were identified as “critically underserved” and had no parks in their neighborhoods, and where applicants had actively involved community-based groups in planning projects. Language was also included that referenced the health and social benefits of parks and the fact that many underserved neighborhoods also experience poor access to parks. In addition, AB 31 included a provision requiring the grant program to offer technical assistance to all potential applicants. This provision addressed key barriers that would have otherwise discouraged applications from cities with smaller populations and a lower average income from applying, since limited budgets, fewer staff, and competing priorities often present obstacles to taking on new and innovative projects. Grant-specific technical assistance helped build capacity, which allowed these entities to compete with jurisdictions that have historically had access to more resources and park development expertise due to their larger population size and affluence. As a result of the equity-focused provisions guiding the AB 31 grant program, \$400 million was invested in 127 new parks in neighborhoods that previously had insufficient or no park land.

3. **Active Transportation for Health and Safety:** An active transportation system enables people of all ages and ability levels to move safely and comfortably around their community without relying on vehicles, and to access essential places and resources, such as schools, workplaces, healthy food markets, and parks. Active transportation includes modes of human-powered transportation like walking, bicycling, and using a wheelchair.¹⁴³ The system ensures that streets, sidewalks, and bike lanes are safe and inviting, and that useful, desirable destinations are located nearby, which increases the likelihood that people will use physically active modes of transportation.¹⁴⁴ An emphasis on active transportation is important for health equity because low-income neighborhoods and communities of color are more likely to face unsafe road and sidewalk conditions,¹⁴⁵ perceived or real threats of violence,¹⁴⁶ and exposure to environmental pollutants,¹⁴⁷ all of which increase the risks of preventable injuries and chronic diseases.¹⁴⁸ When people don't feel safe or comfortable in their communities, they are less likely to walk, bike, and access public transportation.¹⁴⁹ A robust transportation system is one that provides safe mobility and access to resources for all users, particularly those most likely to rely on active and public transportation, such as low-income households, children, older adults, and people with disabilities.¹⁵⁰

Example: Complete Streets, Columbus, Ohio¹⁵¹

Gay Street in downtown Columbus became the first Complete Street in the state of Ohio. Efforts to transform Gay Street were designed to institute policies and practices promoting physical activity by focusing on the built environment and working with residents, policy-makers, and the development community. The program worked closely with rezoning, community design review, transportation, and other key city departments. As a result, Gay Street was transformed into a two-way street with trees in the median, safer bike and pedestrian areas, and a mix of retail and housing on either side. The initiative also helped make Columbus the first city in Ohio to use a Health Impact Assessment to evaluate the health impacts of land use decisions. Columbus’ Complete Streets Policy mandates that all street construction, reconstruction, and repair projects

accommodate all users of the road including pedestrians, bicyclists, motorized vehicles, transit vehicles and users, and motorists of all ages and abilities.

Example: Safe Sidewalks and Safe Routes to School Holladay City, Utah¹⁵²

Holladay City, a small city near Salt Lake City, incorporated the Safe Sidewalks program into its city plan in 2003. The program funded the construction of sidewalks in high-pedestrian traffic areas, focusing on high-priority zones like neighborhood schools. Cottonwood Elementary was one of the local elementary schools involved in the Safe Sidewalks initiative that also incorporated the Safe Routes to School (SRTS) program. With Safe Sidewalks, parents and school staff identified and mapped the walking routes they deemed less safe and worked with engineers employed by the initiative to improve them. Students participated in SRTS activities including annual Walk to School Days, bicycle safety rodeos, and an ongoing safety patrol through which sixth graders help direct traffic around the school during pick-up and drop-off times.

4. ***Housing Choice to Build Opportunity:*** A safe and affordable housing system for inclusive communities ensures that the conditions within and surrounding houses are healthy, and that housing is accessible to people from diverse backgrounds and circumstances. Such a system is created through the engagement of multiple sectors implementing a range of community-informed strategies. In the U.S. market economy, this system advances policies and practices that safeguard affordability, stability, and inclusion, and ensures that renters, homeowners, and businesses are not discriminated against, displaced, and/or segregated by bias and market-driven housing activities. This includes, for example, ensuring adherence to fair lending practices in housing and protections from discrimination,¹⁵³ preventing predatory lending, and reducing mortgage default risk. This system maximizes the existence of the Affirmatively Furthering Fair Housing ruling to improve immediate conditions in low-opportunity neighborhoods so that residents can remain in their neighborhoods and experience improvements in housing or move into long-standing segregated neighborhoods.¹⁵⁴¹⁵⁵ ¹⁵⁶ This system works toward decreasing residential segregation through preserving and expanding mixed-income, mixed-use, inclusively owned, and rental housing connected to schools, public transit, job and retail centers, parks and open space, and other amenities,¹⁵⁷ ¹⁵⁸ by providing debt and equity capital to housing and community development organizations and public-private-nonprofit partnerships.¹⁵⁹ It also ensures “development without displacement” by controlling rental market inflation, incentivizing development of affordable housing, increasing housing density,¹⁶⁰ and increasing community ownership of land,¹⁶¹ and investing in neighborhoods cohesively to protect existing social networks, neighborhood identities, and cultural amenities.

Example: Green and Healthy Homes through People United for Sustainable Housing, Buffalo, New York¹⁶²

People United for Sustainable Housing (PUSH) Buffalo is a local membership-based community organization working to make affordable housing available on the West Side of Buffalo. Many of the residents that PUSH Buffalo works with are immigrants and individuals with low household incomes living in a cold northern climate. PUSH Buffalo’s work brings together residents and a variety of organizations focused on clean energy economies, economic and racial justice, and arts and culture to take direct action to bring resources into Buffalo’s growing community. This work has resulted in the organization’s successful establishment of its first rental property created to provide affordable housing and local jobs. Within their affordable housing work, PUSH seeks

funding to develop properties within the Green Development Zone, a 25-square-block area on Buffalo's west side where PUSH Buffalo focuses their efforts to grow a new community economy. Homes and apartments built within the Green Development Zone are high quality, permanently affordable, and offer environmentally sustainable shelter. The idea is that affordability and sustainability are essential to one another in a climate where heating bills consume a significant portion of the residents' housing costs. In 2011, PUSH transformed a house into the Niagara region's first NetZero Energy house, where the home produces all of the energy that it consumes. It generates hot water and electricity from solar panels, and heat from a geothermal system installed in the vacant lot next door.

Example: Safe and Sustainable Housing for American Indians, Arizona and Montana¹⁶³

After learning about the death of American Indian elders due to inadequate shelter and freezing temperatures, Robert Young created the Red Feather Development Group (RFDG) to bring sustainable and affordable housing to Tribal Lands. RFDG concurrently leads two separate initiatives, one focused on bringing solar energy to tribal lands and the other focused on building sustainable housing. Both of these initiatives seek to identify solutions that are environmentally, culturally, and economically sustainable. They work in collaboration with the communities they serve, fostering mutual learning and cooperation. Through their sustainable housing initiative, RFDG has worked with community members to build their own sustainable homes out of recycled materials in a way that reduces energy consumption and returns the savings to the tribal economic base. Their solar energy work with the Hopi and Navajo Nations helps to reduce coal mining on Tribal Lands and to increase the understanding and use of solar and renewable energy as part of healthier housing. At the foundation of RFDG's community development work is an approach that brings together the tribal community, non-indigenous volunteers, and community-based organizations to bridge the gap between historically divided interests.

5. ***Sustainable Food System:*** A food system influences the accessibility and affordability of healthy food in communities and the sustainability of the natural environment. Elements of a healthy and equitable food system include access to healthy food in retail settings and institutions; infrastructure and programs that foster local, sustainable food production; safe and fair working environments for food system workers; and limits to the marketing of energy-dense, nutrient-poor foods. A sustainable food system not only increases access to healthy foods and fosters better eating habits but also strengthens the economy and social fabric of neighborhoods. For decades, many low-income urban and rural households, particularly low-income communities of color, have had challenges purchasing healthy food where they live. This dearth of healthy food retail options in combination with limited household purchasing power means many low-income families struggle to put sufficient healthy food on the table. The U.S. food system is a large sector in the economy, employing millions in positions ranging from agricultural production and processing to distribution and retail. Many of these workers are in low-wage jobs and many face significant occupational hazards.¹⁶⁴ These multiple impacts make the food system an area ripe for improvement. A sustainable food system advances the triple bottom line of economic development, environmental sustainability, and improved health. It also involves community partners in assessment, strategy prioritization, and planning to ensure that improvements to community food systems meet the needs of community residents and build demand for healthier food.

Example: Bridging Rural Farm Policy with Urban Food Access, Louisville, Kentucky^{165,166}

For Community Farm Alliance (CFA), the health and prosperity of Kentucky’s urban residents is inextricably linked to a thriving rural economy. Using a blend of economic development, youth development, and community development principals, CFA promotes the sale and consumption of food grown by rural family farmers. The group aims to increase access to healthy, affordable food throughout Kentucky, including in urban, African-American communities. The organization’s state-level policy advocacy targets institutional and financial levers to create a more favorable market for rural farmers. For instance, CFA is working to create incentives for neighborhood corner stores to carry Kentucky-grown produce and has helped launched a number of programs and local farmers’ markets to improve urban food availability. Two CFA farmers markets located in Louisville communities that have a low-average household income serve about 8,000 people annually. These strategies have enabled CFA members to help enact two dozen pieces of legislation in support of Kentucky’s farmers and the rural and urban communities that depend on them. Through this mission, CFA was successful in shepherding “preferential purchasing” legislation which mandates that all state government institutions purchase from local growers whenever possible.

Example: Farmworkers’ Union improves Healthy Food Access and Physical Activity Opportunities, Woodburn, Oregon¹⁶⁷

With over 5,300 members, more than 95% of whom are Mexican and Central American, *Pineros Y Campesinos Unidos Del Noroeste* (PCUN) has empowered farmworkers in Oregon to influence the way food is grown and distributed, and improve the safety of working and housing conditions. Many of PCUN’s policy successes have simultaneously addressed farmworker health and food access. PCUN worked intensively to curb pesticide spraying, developed policies to ensure that workers know what chemicals they are using, and convinced growers to utilize organic farming when feasible. Through relationships with local churches, markets, and Willamette University, farmers have helped distribute and market union-label produce grown under humane working conditions. This has increased local access to fresh fruits and vegetables: PCUN has sold six tons of organic produce grown by small farmers to “mom and pop” shops in Latino communities, while promoting workers’ rights through the union-certification labels. PCUN has built a labor-community partnership which has extended beyond the immigrant workforce into the lives of families through its support of youth organizing for better educational opportunities, women working toward economic development, and improved housing conditions for immigrants. Monthly meetings offer a forum to discuss joint concerns, including health issues like diabetes. PCUN has grown into a vibrant and vocal vehicle for Latino farmworkers to speak up about basic issues like access to fresh water and restrooms in the field, and to continue to put issues of how food is grown, where it comes from, and who has access to it on the public agenda.

6. ***Safe Communities through Preventing Violence:*** Safe Communities is a system in which government leadership, community members, public sectors, and other stakeholders come together to improve community safety through planning, implementation, coordination, and measurement and evaluation of multi-sector efforts that span a continuum of prevention, intervention, enforcement, and reentry efforts. Significantly, strategies recognize and address the underlying contributors to violence, known as risk and resilience factors, including those at the community and societal level. Strategies include reducing community deterioration, addressing concentrated disadvantage, limiting access to weapons, increasing social connections, reinforcing norms that support alternatives to violence, and promoting cultural and

artistic opportunities. The selected processes, governance, and priorities must reflect and be inclusive of people and communities most affected by violence. It's also critical that law enforcement agencies embrace procedural justice and 21st Century Policing strategies, and establish trust with the communities they serve.

Example: Blueprint for Action Minneapolis, Minnesota ^{168,169,170}

In 2005, the city of Minneapolis adopted a new approach to addressing violence against youth as a public health issue and created a multi-faceted, long-term solution to address this problem. The effort was in response to the tragic increase in the number of homicides from 2003 to 2006, during which 80 young people between the ages of 15 and 24 lost their lives. Through the Blueprint for Action, the city developed various strategies from mentoring to employment, mapping out plans for the multiple resources in Minneapolis and organizing them into a coordinated framework. Resources included Youth are Here Buses, a transportation service for youth to avoid gang territory and travel safely from community-based organizations to parks and libraries; Step Up, a city-operated employment program where youth ages 14-18 were placed in non-profit organizations; and rites-of-passage programs for American Indian boys, drawing on restorative justice principles and using drum circles to align the program with their traditions and culture. Within two years, focus neighborhoods saw a 40% decrease in juvenile crime rates while arrest rates decreased. The city then expanded their Blueprint to Action framework from five to 22 neighborhoods, resulting in a 60% reduction in juvenile homicides and 46% of Step Up participants obtaining year-round employment. The Minneapolis Blueprint for Action embodied a values change within the community, where their strategies are a mix of evidence-based practices and suggestions from residents, allowing the city to be responsive to the needs of their communities.

A strong link to how well the community is doing is how well the young people are doing.

-Kisha Bird

- 7. Cradle to Community:** This comprehensive system fosters positive early childhood and youth development, invigorates lifelong learning, dismantles the cradle-to-prison pipeline, establishes restorative and inspiring school practices, and strengthens continuity between learning and employment. Early in the “pipeline,” the system ensures universal access to quality early childhood education, which confers lifelong benefits beyond youth. Throughout, it looks to address the underlying reasons for inequities in academic outcomes, including, for example, school funding formulas. It also focuses on keeping young people in school, for example, by establishing equity-oriented school cultures with restorative justice practices for closing achievement gaps and managing school discipline (e.g., attract and retain high-quality teachers, create cultures of engaged parents, ensure buildings are inspiring spaces). Other strategies include establishing linked learning practices that align school course work with existing and emerging careers and/or offer school credit for related entry-level on-the-job training ; improving college and career readiness by ensuring that advanced placement courses are offered at low-income schools; creating comprehensive dropout prevention and recovery systems; and reforming school discipline policies (e.g., eliminating out-of-school suspension for pre-K-3rd grade, creating a public reporting system for discipline data, mandating anti-racism training) and sentencing practices through specialized dockets for mental health and drug offenses. Ultimately, this system supports healthy early childhood, youth development, and learning so that all young people have the opportunity to become engaged and contributing members of society.

Example: Success Courts, Kansas City, Kansas ^{171,172}

The principal of Arrowhead Middle School in Kansas City heard parental concerns about the number of suspensions being handed out at schools within the district. In one year alone, her school had 4,000 in- and out-of-school suspensions. Staff and parents knew that every suspension brings students closer to dropping out and feared the high rate of suspensions would increase the likelihood of students ending up in the criminal justice system. Arrowhead Middle School decided to take a new approach, focusing on the student rather than the infraction itself to curb suspensions. Staff received training on how to deal with the trauma, hunger, and homelessness many of the students were facing outside of school. Students facing such challenges outside of school were sent to a designated class where they received support and extra attention. Meanwhile, the school district hired a specialist in education, gangs, and behavior to improve its student conduct programs and reduce suspensions. In 2012, Kansas City School District developed Success Courts, where every Wednesday, 15-20 students gather in a mock court session to discuss challenges related to growing up in the urban core. The Success Courts are run by Jackson County Circuit Court Judge Kenneth Garrett, who grew up and went to school in Kansas City. Since the implementation of Success Courts, the school district has seen a 13.5% increase in attendance and an increase in students receiving passing grades. These efforts place kids at the center and focus on changing the school culture to be supportive of student success.

Example: Purpose Built Communities, Atlanta, Georgia ¹⁷³

In 2009, Purpose Built Communities (PBC) began their work in the East Lake Area near Atlanta, Georgia, where neighborhoods were experiencing substandard schools, some of the worst crime rates in the country, widespread drug use, and extreme poverty. In response, PBC developed a holistic approach to revitalize the East Lake Area that included opening a charter school with rigorous academics, new mixed-income housing, building a YMCA, and bringing in a variety of resources for the community's youth. These resources included before- and after-school programs centered around intellectual, physical, social, and emotional growth; Creating Responsible Education and Working (CREW) teen programs that help teenagers complete high school and plan for higher education and careers; The Resident and Community Support Program (RCSP), focused on building a sense of community, creating economic stability, career development, financial literacy, and community partnerships; and The First Tee of East Lake, a golf and life skills program. Since the implementation of Purpose Built Communities, Charles R. Drew Charter School has seen an improvement in school performance. Prior to 2009, only 5% of fifth graders in the neighborhood met state math standards. Since PBC's implementation, students at Drew are excelling, with 98% of the students in grades 3-8 meeting or surpassing state standards. With the great success of Purpose Built Communities in Atlanta, additional cities are adopting the model to address intergenerational poverty and bring equitable opportunities to communities.

Example: Children's Services Council, Palm Beach County, Florida

The Children's Services Council (CSC) of Palm Beach County, funded through a countywide property tax, focuses on building a comprehensive prevention and early-intervention system that keeps young children healthy, safe, and strong. CSC's work includes a universal screening process for all births in Palm Beach County to identify children and families who need additional

services and supports. Its work also includes place-based initiatives, like BRIDGES – a family and community engagement initiative with 10 locations in neighborhoods with low-average household incomes. Compared to statewide averages, Palm Beach County has fewer low birthweight and preterm babies and lower rates of verified reports of abuse and neglect. Additionally, children receiving services funded by CSC are more likely to be ready for school. Furthermore, recognizing the relationship between early childhood and community outcomes, CSC is a leader in the county’s Birth to 22: United for Brighter Futures initiative, which developed a “staircase model” with the understanding that building strong foundations in early childhood is a crucial part of building safe and strong communities.

8. ***Developing a Workforce for the 21st Century:*** Through the interplay of advocacy, training, and education, and social and economic supports, this system ensures that people are prepared for and connected to quality employment that enables working individuals and families to achieve financial stability. This system endeavors to include all workers - including women, people of color, those returning from incarceration, and young people. The system is forward looking, identifying living-wage employment tracks and opportunities of the future, and prioritizing the needs of communities most affected by the production of inequities. It then proactively readies those community members who have been affected by inequities for successful employment in emerging employment opportunities. This includes, for example, implementing regional, industry-focused approaches that link workforce and economic development in low-income communities and communities of color to create a pipeline between job training and placement, strengthen an industry’s workforce, improve quality of jobs, and increase regional economic vitality.¹⁷⁴ Linked with Cradle to Community, this system includes attention to developing a workforce that is more inclusive and has more diverse leadership in public policy, healthcare, public health, education, and STEM fields.¹⁷⁵ It strengthens the role of community colleges as bridges to quality careers through relevant training, completion of degrees, credentialing opportunities, and linkages to employment, with comprehensive support for students’ economic and social needs. It also strengthens workforce development efforts in Tribal Nations, through streamlining property acquisition and leasing of Indian lands, business and procurement technical assistance, planning and feasibility study funding, financing (e.g., loans, loan guarantees, equity investments, surety bonding, bond financing), and export assistance.

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Example: Green Jobs Central Oklahoma, Oklahoma City, Oklahoma¹⁷⁷

Green Jobs Central Oklahoma (GJCO) recognized that individuals living below or near the poverty level were having a difficult time finding sustainable, full-time employment since the economic downturn of the 2000s. Through a partnership with various community organizations, GJCO aims to create pathways out of poverty for individuals who are unemployed or underemployed, or have a low household income. Their population of focus includes veterans, individuals with criminal backgrounds, and others with barriers to sustained employment. Funded by the U.S. Department of Labor, GJCO offers a variety of free services from career-readiness activities and skills training to strong relationships with employer partners to ensure job access. Once participants complete the Training Opportunity Preparation Services (TOPS), participants choose to train in one of three areas: recycling, wind energy, or green transportation. The project specifically targets the economically depressed community of northeast Oklahoma City, offering green employment opportunities to people with barriers to employment with the goal of increasing individual earnings as well as the overall per capita income in the community.

Example: Veterans Sustainable Agricultural Training, Escondido, California¹⁷⁸

Iraq combat veteran Sargent Colin Archipely and his wife, Karen Archipely, founded Archi's Acres in 2006 to provide business ownership opportunities for veterans while creating a viable, sustainable, and organic produce farming business. Veterans Sustainable Agriculture Training (VSAT) provides agricultural training to veterans to support their agricultural enterprises and provide healing through farming. Through VSAT, veterans learn about Archipely's highly efficient methods that maximize available natural resources and capitalize on local sales distribution channels. The idea behind the training program is to help comrades in the military move into civilian careers in agriculture and business ownership. Archi's Acres has trained more than 300 people since 2009. Graduates have gone on to be farm owners and workers, soil-testing pioneers, and restaurant and food company owners. In 2014, the Archipelys were recognized by the "Champions of Change: Veteran Entrepreneurs" program in Washington, D.C., for their empowering and inspiring work.

You can't talk about housing affordability just on supply side. You have to increase income-generating capability in neighborhood.

-Jeff Taebel

9. **Economic Engines in Service of Communities:** This system drives economic and job growth in areas that fuel the economy for people and communities that have been left out of economic opportunities and investments. It is fundamentally about creating economic opportunity for the people and communities who need it most while also protecting people and the planet, and improving other Determinants of Health. One aspect of this is a focus on the *local*: as *local* procurement, to ensure that *local* businesses – especially those that are owned by people of color and women – are prioritized to fill *local* needs;¹⁷⁹ hiring *local* people for local jobs in the government, anchor institutions, and initiatives to improve community infrastructure; enhancing *local* people's – especially people of color and women – interest in entrepreneurship and capacity to start businesses; expanding access to funding and financial capacity of small and *local* businesses, especially those that are owned by people of color and women; equipping communities to identify *local* assets and opportunities for economic growth, so they may plan for and drive *local* economic growth based on community assets;¹⁸⁰ and growing commercial corridors in neighborhoods to support *local* business, meet the needs of *local* residents, ensure resources remain in communities, and drive *local* growth.¹⁸¹ The system will also need to support local success with broader strategies including instituting financial incentives for investment, including capital investment, in sectors and projects that fuel the economy while improving the Determinants of Health, such as green energy, affordable housing, healthy food, or sustainable development; protecting against unfair and discriminatory banking and finance practices;¹⁸² and instating complete tribal control over tribal lands (i.e., unlocking) to allow for economic development.¹⁸³

We think that health equity is a manifestation of economic equity.

– Cecilia Estolano and employees

Example: Safe and Sound, Hillsborough County, Florida^{184,185}

The Hillsborough County Community Violence Prevention Collaborative (VPC or Collaborative) was created in the summer of 2013 to shift safety policy from a public safety to a public health model and align community and professional stakeholders to develop a

comprehensive prevention plan. The Collaborative features a Leadership Council of local elected policymakers and diverse community stakeholder subcommittees that focus on healthcare, education, community-based organizations, faith groups, and public safety/judiciary. While working towards their goal of improving conditions in neighborhoods most affected by violence, they formed a partnership with the Corporation to Develop Communities of Tampa to alleviate poverty and physical deterioration. They created a business plan to fuel economic development based on drivers that include competitive sites and redevelopment, technology and innovation, competitive positioning, entrepreneurial and small business ecosystems, and more. They are expanding their partnerships and message to involve the business sector in their violence prevention work by demonstrating how preventing violence is also good for business.

Example: Economic Opportunity Strategy, New Orleans, Louisiana¹⁸⁶

Under the Mayor's leadership, the Economic Opportunity Strategy was launched in 2014 to implement a comprehensive strategy to create new business and job opportunities in New Orleans. In a city where 52% of working-age, African-American men are unemployed, the strategy prioritized "equity as a growth strategy." The strategy connects local training providers, social service agencies, and community advocacy organizations to increase New Orleans's economic resilience. More specifically, the strategy includes collaborating with local anchor institutions to expand opportunities to job seekers and businesses; providing case management, foundational skills training and supportive services; connecting businesses to contracting opportunities; creating a worker-owned cooperative for those seeking employment; and providing customized job training to prepare job seekers. Recently, the New Orleans City Council passed a "Hire NOLA" ordinance requiring companies working under city contracts of more than \$150,000 to hire skilled residents of New Orleans. The equity component in particular will expand the employee base for those looking to relocate or build their businesses in New Orleans and support the emergence of small businesses owned and employed by people of color.

- 10. Community-Centered Health System:** A Community-Centered Health System marshals the resources and influence of healthcare delivery organizations and healthcare payers to work with governmental public health and community partners to prevent illness and injury by focusing on the community factors that shape health outcomes. In a Community-Centered Health System, healthcare organizations and health insurers acknowledge that factors outside the healthcare system significantly affect patient health outcomes and actively participate in improving community conditions to support health. This system operates from a shared understanding that quality physical and mental health treatment are vital to improving health outcomes, but they do not impact health outcomes as much as the social, physical, and economic environments in communities – sparking the need for community-wide strategies. In addition to providing timely, high-quality care rooted in the understanding of each patient's personal and community context, a Community-Centered Health System connects people to non-medical supports and services necessary to support health, and most importantly, catalyzes community-wide solutions to address the community factors that shape health outcomes. This is particularly important for vulnerable and disenfranchised populations who are at greater risk for poor health outcomes driven by these community factors. By strengthening community resilience factors, a Community-Centered Health System both improves recovery/disease management for those who are sick or injured and prevents illness and injury. A Community-Centered Health System expands from a primary focus on sick care to include prevention,

and from a focus only on individual patients to a focus on community conditions driving inequitable patterns of illness and injury. The goal is to truly transform *population* health to achieve health equity.

Example: Cincinnati Children's Hospital, Cincinnati, Ohio¹⁸⁷

Cincinnati Children's Hospital launched the Community Health Initiative (CHI) in 2011 to improve the health of all of the county's children and provide treatment to those who are sick. In one effort, the CHI staff mapped the neighborhoods of children admitted to the hospital for asthma and found huge variations in admission rates across the county. There were about seven neighborhoods with very high hospital admission rates for asthma, compared to a dozen neighborhoods that did not have any admissions. The average incomes in the high-admission neighborhoods were closer to poverty than those in the low-admission neighborhoods. CHI sought to understand the environmental differences between these neighborhoods, given that much of the risk for asthma is environmentally determined. A home visit to a particular child who had been admitted to the hospital four times over the span of five months revealed many asthma triggers in the home due to poor housing quality. In response, Cincinnati Children's Hospital established a relationship with Legal Aid and the Cincinnati Health Department. The Health Department conducts home inspections and provides landlords with information about needed repairs for families with children suffering from asthma. Legal Aid is brought in when landlords don't comply with needed repairs. An average of 700 cases per year is referred to legal aid. The actions have led to specific building improvements, and in one case buildings were acquired by a non-profit housing developer, which was able to leverage a \$29 million grant from HUD to bring the buildings to code. Cincinnati Children's Hospital is applying similar approaches to preventing injuries among children identified through analysis of patient data.

Example: Lei Hi ʻpuʻu o Kalihi Valley, Honolulu, Hawaii¹⁸⁸

Kalihi Valley is a densely populated, low-income community in Honolulu, Hawaii. The valley lacks sufficient sidewalks, bike lanes, and public green space to support regular physical activity for its residents. Kokua Kalihi Valley Comprehensive Family Services (KKV), a community health center, obtained a 20-year lease on a 100-acre parcel in Kalihi Valley. In partnership with local organizations and agencies including the City of Honolulu, a local bike shop, leaders from a public housing development, and other community-based organizations, KKV has transformed the parcel of land into a nature park with hiking trails, walking and biking paths, community food production, and a cultural learning center. The park has 10 acres of community gardens, which provide space for people to be physically active and grow healthy foods, as well as gather to build community and social supports. The opportunities for safe physical activity and healthy food access that the park provides will support the health of those living in the KKV community.

9. *There is a pathway to produce health equity that will require deliberate focus and intentionality on reengineering past and present thinking to develop key components of an integrated “System of Health Equity”.*

Across the 10 Multi-sector Systems, the need for an integrated approach emerged: the need for a system to drive health equity. A System of Health Equity is a way of organizing and structuring relationships, innovation, learning, and advocacy for coherent and interrelated practices – within the foundation, government, private sector, and community – to attain health equity across the population. This system can track and account for the overarching findings that emerged and will help ensure all efforts, including those to build and strengthen the Multi-sector Systems, will advance health equity. This system provides a mechanism to employ rigor through intentional feedback loops and being intentional about measuring change, which promote systems change.¹⁸⁹

Essential Elements for a System of Health Equity:

<p>1. Purpose: Intentionality for Health Equity</p> <ul style="list-style-type: none"> a) Applies a health equity lens b) Intentionally addresses bias, discrimination, institutional and structural racism, and classism c) Acknowledges the systematic production of inequities by accounting for community trauma d) Fosters connections 	<p>3. Practice: Methodology and Capacity</p> <ul style="list-style-type: none"> a) Tools, approaches, and methodologies b) Training and capacity building
<p>2. People: Leadership and Engagement</p> <ul style="list-style-type: none"> a) Shared vision and leadership b) Community voice, participation, and leadership c) Multi-sector engagement 	<p>4. Platform: Infrastructure to Support Success</p> <ul style="list-style-type: none"> a) Communications/Make the Case b) Financing and funding equity c) Metrics and measurement

1. Purpose: Intentionality for Health Equity

a) Apply a health equity lens: Without explicit attention to improving health outcomes for communities with low-average household incomes and communities of color, the outcomes cannot be maximized. According to the CDC, “[*Policy improvements, systems improvements, and environmental improvements*] have great potential to prevent and reduce health inequities, affect a large portion of the population, and can be leveraged to address root causes, ensuring the greatest possible health impact is achieved over time. However, without careful design and implementation such interventions may inadvertently widen health inequities.”¹⁹⁰ This means that for each action – policy and law, practice, procedure – these questions must be asked: Is this producing health equity? How will this achieve health equity? How is this appropriately accounting for culture, gender, power, and other important considerations? Will this counter the production of health inequities? Within Multi-sector Systems and across sectors, these questions can be asked. It’s also critical that each sector look at its own historical role in

Strong programs need to be embedded in a strong system.

-Kisha Bird

producing inequities, and how it can play a role in producing more equitable outcomes moving forward. A System of Health Equity can provide tools, checklists, or discussion guides to prompt and support exploration of these questions.

A health equity lens builds on a Health in All Policies⁺⁺⁺ approach, making explicit the notion of *health equity in all policies and laws, practices, procedures, systems, and sectors*. As Multi-sector Systems are developed (e.g., Cradle to Community), it is critical that a health equity lens be applied to ensure that these systems benefit those who most need it, and weigh opportunities to maximize outcomes. For example, as the Multi-sector Systems are implemented, it is critical that this is done in a way that is responsive to community voice, reflective of community culture, and accounts for the risk of residential displacement. As another example, as active transportation strategies are developed and implemented, exploration about intersections with community safety and affordable housing can begin to unearth strategies that build new multi-sector opportunities to foster equitable health outcomes—not just one issue at a time but for the population or community as a whole.

It's a difficult issue, but there is a benefit to looking at health disparities with a racial lens.

-Laura Choi

b) Addresses bias, discrimination, institutional and structural racism, and classism. To reverse the production of inequities, it is critical to examine how bias, discrimination, institutional and structural racism, and classism explicitly play out in policies and practices, and within sectors and systems. Whether it is implicit (unconscious) or explicit (with awareness), bias enables discrimination. Though bias acts at the individual level, it has greater mutability through approaches that interrupt and inform norms at the organizational or community level.¹⁹¹ Discrimination is a practice based on values and norms that reinforces the benefits of privilege. Structural racism and/or structural discrimination are similarly defined as the macro-level systems, social forces, ideologies, and processes that interact and reinforce inequities involving race/ethnicity, immigrant or socioeconomic status, gender, disability, or age – through which *health* inequities manifest.^{192,193} Structural classism is also perpetuated and exists through systems, policies, and practices that devalue people based on them having little wealth or education, or low social status. Equally as harmful as structural racism, structural classism reinforces inequities in status, income, and power. It is these structural values and practices that persist across multiple generations through a diverse set of actors – including governmental and non-governmental entities, cultural groups, and individuals – maintaining the norms and conditions that accelerate the production of health inequities.^{194,195} In order to change macro-level structures, intentionally focusing on practices of bias across multiple sectors can create momentum of awareness and explicit equity-oriented decision-making. For example, organizations and sectors can advance health equity by performing internal reviews of their policies and practices to identify “blind spots” that may be perpetuating differences in the treatment and

⁺⁺⁺ The term Health in All Policies (HiAP) was first used in Europe during the Finnish Presidency of the European Union (EU), in 2006, with the aim of collaborating across sectors to achieve common goals. HiAP is a strategy which aims to include health considerations in policy making across different sectors that influence health, such as transportation, agriculture, land use, housing, public safety, and education. HiAP re-affirms public health’s essential role in addressing policy and structural factors affecting health and has been promoted as an opportunity for the public health sector to engage a broader array of partners. [Source: http://en.wikipedia.org/wiki/Health_in_All_Policies; accessed 2/6/2014].

outcomes of the communities they serve. At its core, this is about changing the culture and norms within sectors and across systems.

c) Acknowledges the systematic production of inequities by accounting for community trauma: A framework for trauma, *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community-Level Trauma*,¹⁹⁶ underscores the need to address community trauma as an integral strategy for achieving health equity. Trauma is pervasive and has a significant impact on human development, health, and wellbeing. Trauma-informed care is becoming a standard of care in a growing number of places. Thus far, the predominant approach to dealing with trauma has been screening and treatment for individuals. However, there is emerging evidence that trauma manifests at the community level; in high-violence neighborhoods, the belief that whole communities are traumatized is widespread. A community trauma framework postulates that community trauma is produced both from experiencing violence and experiencing structural violence. Structural violence refers to what individuals, families, and communities experience from the economic and social structure, social institutions, and relationships of power, privilege, inequality, and inequity that may harm people and communities by preventing them from meeting their basic needs.¹⁹⁷ This is consistent with what was described earlier in the production of inequities. Despite the understanding of the widespread nature of trauma, the emergence of understanding trauma beyond an individual level, and an epidemic of trauma at the population level, the predominant focus in addressing trauma remains at the individual level. Community trauma is not just the aggregate of individuals in a neighborhood who have experienced trauma. There are manifestations, or symptoms, of community-level trauma. The symptoms are present in the sociocultural environment, the physical/built environment, and the economic environment. Because trauma serves as a barrier to effective solutions to promote health, safety, and wellbeing, it is critical that community trauma is addressed in conjunction with advancing systems.¹⁹⁸ A key premise behind trauma-informed care is the concept of recognizing previous trauma in order to move past it. Addressing community trauma includes acknowledging the legacy and impact of historical and current practices and policies that have produced inequities as a first step toward healing and moving forward with solutions.

Hope in health – health as a sector is the one that intersects everything, more than any other.
-Shavon Arline-Bradley

d) Fosters connections between people, systems, issues, and opportunities: The System of Health Equity encourages mastery at fostering connections between people, systems, issues, and opportunities. To maximize health equity outcomes, new connections become vital conduits for information, ideas, and emergent solutions. These connections can be very tangible, such as linking two program areas or grantees together, or conceptual as in exploring the connections between issues that haven't typically been linked in order to explore root problems and shared solutions. Paying attention to connections and interdependence is a critical component of systems change.¹⁹⁹

2. People: Leadership and Engagement

a) Shared vision and leadership: A System of Health Equity – and, indeed, health equity itself – will not happen by accident. A shared vision can be an overarching frame for multiple partners to rally around and can galvanize the imagination of a nation. Strong leadership can bring key partners and diverse elements

of a growing movement together to advance a shared vision and promulgate the tools and standards needed to hold others accountable. For a System of Health Equity, it is worth looking at the needed leadership to advance a national movement as well as what’s needed within the health sector and at state, regional and local levels to advance a coherent system in support of health equity. For a system of Health Equity, it is important to look at the specific leadership needs and roles of the health sector – healthcare and public health.

If leaders and actors in diverse parts of the system embrace the vision and principles of health equity⁺⁺⁺, the system is more likely to be effective in sparking innovation. A shared vision creates the context for decision-making and provides a shared “operating system” for people within the System of Health Equity. For those uncomfortable with health equity, leadership within the System of Health Equity will play an instrumental role in understanding barriers, determining opportunities for building bridges and reaching new audiences, and assessing where collaborations may or may not yield benefits.

b) Community voice, participation, and leadership: A System of Health Equity moves from community as recipient to community at “the center of efforts” and it recognizes that health equity outcomes are not produced by formal institutions alone. Community engagement, participation, and leadership represent key elements in a health equity system as voices of those traditionally under-represented in leadership and decision-making, including youth, become elevated as stewards of the system. The System of Health Equity makes training, capacity building, and frameworks available to support engagement, participation, and leadership by community members. A useful function of the health equity system is to blend community wisdom with technical expertise and use community experience to interpret metrics.

c) Multi-sector engagement: The System of Health Equity fundamentally acknowledges the importance of multi-sector engagement and collaboration—a very specific form of fostering connections. It further considers what skills are needed to engage different sectors and systems in the work of accelerating health equity and stopping the production of inequities. The System of Health Equity will encourage and catalyze these multi-sector engagements through a variety of tools including reframing of issues, convening, and exploring win-wins. While there are many, one particular opportunity for the System of Health Equity is to identify and elevate multi-sector practices leading to health equity that could be fostered elsewhere. Identifying models that are scalable and replicable, then promoting those models and providing supports for further cross-system integration, will help the System of Health Equity build bridges between sectors. While multi-sector engagement is increasingly common, this doesn’t mean the skill and know-how to build and sustain multi-sector participation is prevalent. Tools, frameworks (see below), and facilitation can increase the likelihood of success for multi-sector participation. The System of Health Equity can serve as a hub for some of this.

3. Practice: Methodology and Capacity

a) Tools, approaches, and methodologies: Federal agencies and foundations have supported groups—including Prevention Institute, the National Collaborative for Health Equity, PolicyLink and others – to develop tools/frameworks, approaches, and methodologies for making health equity work practical and actionable. To support effective efforts, the System of Health Equity can get these tools and frameworks

⁺⁺⁺ Health Equity Principles are included at the end of this section.

out to people, make them available, and inform the field of new developments that further advance the practice of health equity. These tools, approaches, and methodologies can become the basis for funding proposals, training, technical assistance, and capacity building, and the subject for communication and making the case. Fostering development of new tools and promulgating effective methods will help the System of Health Equity remain vibrant while supporting practitioners.

b) Training and capacity building: The CDC’s *A Practitioner’s Guide for Achieving Health Equity* notes the importance of building organizational capacity to advance health equity, including articulating an institutional commitment; aligning funding decisions with a commitment to health equity; being deliberate in recruiting and building staff skills; tracking and capturing health equity efforts in training and performance plans; integrating health equity into services and resources; and establishing multi-sector collaborations and relationships with diverse communities.²⁰⁰ These are critical capacities that a System of Health Equity can support at the local level. More broadly, there is a need for training and capacity building across systems and sectors to foster collaboration with each other, advance comprehensive approaches, actively engage in Multi-sector Systems to produce health equity, and apply a health equity lens. This is not only about building skills, but about shifting cultures and norms within and across sectors and systems. A System of Health Equity will advance multiple levels of training and capacity building for “early adopters,” leaders, and managers within the system, and for people who serve as liaisons across systems, for both programmatic and administrative staff. A key aim of the training and capacity building from the standpoint of a System of Health Equity is to help define it for stakeholders, help people to understand their role and contribution to the system, and aid them in seeing how this system helps them better achieve their purpose. One important area for training and capacity building will involve issues such as work force development, and the pipeline for generating new leadership and energy within the System of Health Equity.

We’ve got to figure out a way to convey a message that has meaning across sectors.

-Ashby Johnson and Kelly Porter

4. Platform: Infrastructure to Support Success

a) Communications/Make the case: It is critical to make the case for an emphasis on health equity, for systems that work together, and for community approaches. Effective communication can help build and sustain health equity efforts. Informed by effective framing, successful communication via channels such as the media, social media, public officials, and others in the public sphere can convey positive messages about achieving health equity and foster buy-in into prevention strategies and priorities. Related to training and capacity building above, “making the case” requires building the skills of participants within the health equity system to feel comfortable talking about health equity in relationship to other key values and developing the language to integrate health equity aims within diverse sectors, particularly those who do not yet embrace their role in fostering health equity. An overall communications strategy takes into account multiple audiences and channels and diversifies accordingly, accounting for the need for published literature and a media strategy, for example. A communications strategy advances all of the other elements of a System of Health Equity and supports an equitable Culture of Health.

b) Financing and funding equity: Financing must be a key component of the system that will interrupt and reduce the ongoing production of inequity, ameliorate the impacts, and accelerate and sustain the

production of health equity. This means “thinking and operating at the edge of the box,” building in renewed and bold commitment to innovation and outcomes to meet the need and demand, fund population health and health equity, and fulfill the nation’s potential. One premise of a System of Health Equity is that issues and sectors are interconnected. Yet, funding for health—particularly from the public sector—is often isolated. There is a need to diversify resource and financial investments and incentives across multiple sectors, removing funding silos and building partnerships for long-term investments in community change. The financing of Multi-sector Systems requires greater integration of funding across sectors to create a larger pool of funding sources that can be flexibly and efficiently woven together through, for example, alignment of regulations and timelines. Additional financing tools are also needed, including: incentives and rewards for cross-sector collaboration; new sources of capital, such as tax credits and socially motivated investments by foundations and investors; and tools to finance the operations and innovation of organizations and partnerships, rather than projects and programs alone. Financing tools could also have a greater focus on innovation and learning (with flexibility for creative risk-taking), and “closing the loop” to pool and manage prevention funding, invest in an evidence-informed core set of prevention strategies, and capture and reinvest savings.²⁰¹ The financing system must also address the specific regulatory and governance complexities between the federal government and tribal nations to unlock capital and other resources for Native communities. Where complete blending of funding sources or unrestricted pots of money is not possible, or doesn’t make sense, assessing opportunities to braid together funding streams (i.e., maintain the separate funding streams and track those resources, while building greater alignment and a sense of shared purpose across funding streams) will represent an important way to advance efforts within a System of Health Equity.

c) Metrics and measurement: Metrics are important both as a tool for measuring health inequity at all levels and for fostering understanding of solutions. Establishing metrics that measure and track our progress on the Determinants of Health can help set priorities and inform necessary actions that can and will make a difference in the health and wellbeing of the populations in the U.S. who are most at risk for poor health and safety outcomes. Metrics also can help to demonstrate social, economic, and environmental impacts to build support for increased investment. Within the domain of metrics are at least two important subsets of data and information that may be particularly relevant to a System of Health Equity: performance metrics and real-time system-improvement analysis. Developing performance metrics within a health equity system will require defining the kinds of behaviors that people and players within the system should be doing to help meet the aims of the system. Behaviors that reinforce the vision and move toward improved health equity can be acknowledged and rewarded. Real-time system-improvement analysis involves examining where elements of the system appear to be working well and revisiting areas where the system is not performing as intended or not producing the expected outcomes. This is a way to embed the practices that are necessary for systems to monitor progress toward health equity.

In 2014, Prevention Institute, working with the RWJF Achieving Health Equity Team, developed a priority set of recommended health equity metrics. These metrics are intended to be used to measure progress toward achieving health equity related to the Determinants of Health, structural drivers, community determinants, and healthcare. For the full Health Equity Metrics table and more detailed discussion of health equity metrics and measuring progress on achieving health equity, please refer to *Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health*.²⁰²

Health Equity Principles^{§§§}

Working in Multi-sector Systems and building the infrastructure for a “System of Health Equity” requires a foundational set of principles that can be used to review, consider, and prioritize health and equity in new policies, laws, practices, and procedures. To prioritize health and equity, our work must:

- Understand and account for the *historical forces* that have left a legacy of racism and segregation, as well as structural and institutional factors. This is key to enacting positive structural changes.
- Acknowledge the *cumulative impact of stressful experiences and environments*. For some families, poverty lasts a lifetime and even crosses generations, leaving family members with few opportunities to make healthful decisions. Continued exposure to racism and discrimination may in and of itself exert a great toll on both physical and mental health.
- Recognize the *role of privilege* in contributing to disparities in health outcomes and acknowledge that policies have afforded privilege to some groups at the expense of others.
- *Encourage meaningful public participation* with attention to outreach, follow-through, language, inclusion, and cultural understanding. Government and private funding agencies should actively support efforts to build resident capacity to engage, and to foster ongoing civic engagement.
- Adopt an overall approach that recognizes the cumulative impact of multiple stressors and focuses on *changing community conditions*, not blaming individuals or groups for their disadvantaged status.
- Strengthen the *social fabric of neighborhoods*. Residents need to be connected and supported and feel empowered to improve the safety and wellbeing of their families. All residents need a sense of belonging, dignity, and hope.
- Promote equity solutions that address urgent survival issues for people with lower incomes and people of color, while simultaneously responding to *national and international concerns*, such as the global economy, climate change, U.S. foreign policy, and immigration reform.
- Address the developmental needs and transitions of *all age groups*. While infants, children, youth, adults, and the elderly require age-appropriate strategies, the largest investments should be in early childhood, which establishes the foundation for lifelong health.
- *Work across multiple sectors* of government and society in order to make the necessary structural changes. Such work should be in partnership with community advocacy groups that continue to pursue a more equitable society.
- *Measure and monitor the impact of social policy* on health and safety to ensure equity goals are being accomplished. Institute systems to track governmental spending by neighborhood. Monitor changes in health equity over time and place to help identify the impact of adverse policies and practices.
- *Enable groups heavily affected by inequities to have a voice* in identifying helpful policies and in holding government accountable for implementing them.
- Recognize that eliminating inequities provides a huge *opportunity to invest in community*. Inequity is not acceptable, and everyone stands to gain by eliminating inequity.
- Efforts should build on the *strengths and assets* of communities, recognizing that communities are resilient and have a strong history of making change.

^{§§§} Adapted from *Life and Death From Unnatural Causes: Health & Social Inequity in Alameda County*. Alameda County Public Health Department September 2008 and featured in Prevention Institute. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Commissioned by the Institute of Medicine’s Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

Conclusion: The Imperative for Action to Achieve Health Equity

Health inequities have been produced in this country, and isolation from opportunity is the consequence of policies and laws, practices, and procedures across multiple Determinants of Health. These include redlining by housing lenders, unequal investment in schools and transportation, and judicial rulings supportive of segregation. We know, based on progress made, that comprehensive solutions are necessary to address the complexity of the challenge; there is a clear path forward. Specific sectors have played roles in creating the current conditions, and have invaluable roles to play in solutions. Further, making change at the community level – through local, regional, state, national, and sectoral actions – can and will make a difference for communities that carry a disproportionate burden of illness and injury without equitable restoration and access to social mobility.

Multi-sector Systems can interrupt or reverse the production of health inequity through policy and practice change; ameliorate the impacts through community-level change, supported by regional, state, federal and sectoral action; accelerate and sustain the production of health equity; introduce calibration points so that we measure progress in production of health equity at the local level; and change norms and values to produce equitable opportunities for health and wellbeing. All of this will be supported through a System of Health Equity and its components.

Social justice and health equity work is not neutral – it is a values proposition that at times goes against the status quo and business-as-usual for fundamental change. There is a growing appreciation of the importance of a health equity approach, but too often determinants are thought of on a broad national scale without adequate translation to being actionable—that is, aimed at specific systems and local action, while still supporting national, state, and sectoral action. Further, changes need to be accelerated – evolution is too slow; transformation is needed. There are actionable solutions to reversing inequities and disparities, and there is a clear pathway for creating health equity. There is a role for every institution, sector, and system working together to achieve an equitable Culture of Health across the United States. It is our social imperative.

References

- ¹ Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ² Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ³ Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ⁴ Braveman, MD, MPH, Paula. *What is health equity? And why does it matter how we define it?*
- ⁵ Paula Braveman, draft definition presented for discussion at RWJF, May 2016
- ⁶ Braveman, PA. Monitoring equity in health and healthcare: A conceptual framework. *Journal of Health Population and Nutrition*. 2003;21(3):181–192.
- ⁷ Prevention Institute. *A Time of Opportunity: Local Solutions to Reduce Inequities in Health and Safety*. Oakland, Ca: Prevention Institute; 2009.
- ⁸ Prevention Institute. *THRIVE Clusters and Factors*. Oakland, Ca: Prevention Institute; 2013.
- ⁹ Prevention Institute System of Prevention Team. *Toward a System of Prevention (draft)*. Oakland, CA: Prevention Institute; 2016.
- ¹⁰ Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ¹¹ Prevention Institute. *THRIVE Clusters and Factors*. Oakland, Ca: Prevention Institute; 2013.
- ¹² George Galster, “The Mechanism(s) of Neighbourhood Effects: Theory, Evidence, and Policy Implications.” Pp. 23-56 in *Neighbourhood Effects Research: New Perspectives*, edited by M. van Ham, D. Manley, N. Bailey, L. Simpson, and D. Maclennan (Dordrecht, Netherlands: Springer, 2012).
- ¹³ World Health Organization. *World Report on Violence and Health*. Geneva, SUI; World Health Organization; 2002.
- ¹⁴ Prevention Institute. *THRIVE Clusters and Factors*. Oakland, Ca: Prevention Institute; 2013.
- ¹⁵ Hahn R, Truman B. Education improves public health and promotes health equity. *International Journal of Health Services*. 2015; 45(4): 657-678. doi: 10.1177/0020731415585986.
- ¹⁶ Zimmerman EB, Woolf SH, Haley A. Understanding the Relationship Between Education and Health: A Review of the Evidence and an Examination of Community Perspectives. Rockville, MD: Agency for Healthcare Research and Quality, 2015.
- ¹⁷ Sources of Personal Income, 2013 Update. Tax Foundation Fiscal Fact No. 492 (2015). http://taxfoundation.org/sites/taxfoundation.org/files/docs/TF_FF492_Sources_of_Income_2013_Update.pdf
- ¹⁸ Estimating the absolute wealth of households. Daniel J Hruschka, Drew Gerkey & Craig Hadley. *Bulletin of the World Health Organization* 2015;93:483-490. doi: <http://dx.doi.org/10.2471/BLT.14.147082>.
- ¹⁹ Robert Wood Johnson Foundation. *Exploring the Social Determinants of Health*. 2011. Princeton, NJ: Robert Wood Johnson Foundation; 2011. Issue Brief #4, Income, Wealth and Health.
- ²⁰ Aron LY, Jacobsen W, Turner M. *Addressing Deep and Persistent Poverty: A Framework for Philanthropic Planning and Investment*. Washington, DC: Urban Institute; 2013.
- ²¹ The State of Health Equity Research: Closing Knowledge Gaps to Address Inequities. Association of American Medical Colleges: Health Equity Research and Policy. Available at:

<https://members.aamc.org/eweb/upload/The%20State%20of%20Health%20Equity%20Research%20-%20Closing%20Knowledge%20Gaps%20to%20Address%20Inequities.pdf>. Accessed August 3, 2016.

²² Thomas, S. B., Quinn, S. C., Butler, J., Fryer, C. S., & Garza, M. A. (2011). Toward a fourth generation of disparities research to achieve health equity. *Annual review of public health, 32*, 399.

²³ Puddy RW, Wilkins N. *Understanding Evidence Part 1: Best Available Research Evidence. A Guide to the Continuum of Evidence of Effectiveness*. Atlanta, Ga: Centers for Disease Control and Prevention; 2011.

²⁴ Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.

²⁵ Presentation to the Institute of Medicine Committee on Community-Based Solutions to Promote Health Equity in the United States. January 6, 2016

²⁶ Spring, Joel. Deculturalization and the Struggle for Equality: A brief history of the education of dominated cultures in the United States, 7th Edition (Chapter 4).

²⁷ Frequently requested statistics on immigrants and immigration in the United States (2015).

<http://www.migrationpolicy.org/article/frequently-requested-statistics-immigrants-and-immigration-united-states>

²⁸ Overcoming the challenges of providing care to LEP patients.

http://www.jointcommission.org/assets/1/23/Quick_Safety_Issue_13_May_2015_EMBARGOED_5_27_15.pdf

²⁹ Coates J. *Trail of Tears*. Santa Barbara, CA: Greenwood; 2014.

³⁰ National Museum of the American Indian. Native Words, Native Warriors - Boarding Schools: Struggling with Cultural Repression. Available at: <http://americanindian.si.edu/education/codetalkers/html/chapter3.html>

³¹ Ayers E, Gould L, Oshinsky D, Soderlund J. *American Passages: A History of the United States, Volume 2: Since 1865*. Boston, MA: Wadsworth; 2007: 577.

³² Renteln, Alison Dundes. A Psychohistorical Analysis of the Japanese American Internment. *Human Rights Quarterly 17*, no. 4 (1995): 618-48.

³³ Voter Identification Requirements – Voter ID Laws. National Conference of State Legislatures Web site. <http://www.ncsl.org/research/elections-and-campaigns/voter-id.aspx>. Published October, 2015. Accessed 2015

³⁴ Fighting Voter ID Requirements. American Civil Liberties Union Web site.

<https://www.aclu.org/issues/voting-rights/fighting-voter-suppression/fighting-voter-id-requirements>. Accessed 2015.

³⁵ Hanley D. It's time to end racial, religious and ethnic profiling of Americans. *Washington Report on Middle East Affairs*. 2012. <http://www.wrmea.org/2012-june-july/it-s-time-to-end-racial-religious-and-ethnic-profiling-of-americans.html>. Accessed 2015.

³⁶ Insecure Communities: Latino Perceptions of Police Involvement in Immigration Enforcement (2013) https://www.policylink.org/sites/default/files/INSECURE_COMMUNITIES_REPORT_FINAL.PDF

³⁷ Lake C et al. *Insecure Communities: Latino Perceptions of Police Involvement in Immigration Enforcement*. Oakland, CA: PolicyLink; 2013.

³⁸ Page SB, Larner MB. The aids to family with dependent children program. *Welfare to Work*. 1997; 7(1):20-27.

³⁹ Fullilove MT. The Environment and Public Health. In: Hanna KE, Coussens C, editors. *Rebuilding the unity of health and the environment: a new vision of environmental health for the 21st Century*. Washington, D.C.: National Academies Press; 2001.

⁴⁰ Hall P. *Cities of Tomorrow: An Intellectual History of Urban Planning and Design since 1880*. San Francisco, CA: Wiley Blackwell; 2014.

-
- ⁴¹ Plessy v. Ferguson (1896). PBS Web site. http://www.pbs.org/wnet/jimcrow/stories_events_plessy.html. Accessed 2015.
- ⁴² Byrne J, Wolch J. Race, nature and parks in geography: Past research and future directions. Unpublished paper, [nd].
- ⁴³ Mair C, Gruenewald P, Ponicki W, Remer L. Varying impacts of alcohol outlet densities on violent assaults: explaining differences across neighborhoods. *Journal Of Studies On Alcohol & Drugs* [serial online]. January 2013;74(1):50-58 9p. Available from: CINAHL Complete, Ipswich, MA. Accessed June 21, 2016.
- ⁴⁴ Mack R. Bringing down the walls of state pre-emption: California cities fight for local control of alcohol outlets. *Berkeley Journal of African-American Law and Policy*. 1997;3(1).
- ⁴⁵ Kwate, NOA. Fried chicken and fresh apples: racial segregation as a fundamental cause of fast food density in black neighborhoods. *Health & Place*. 2008;14(1):32–44. doi: 10.1016/j.healthplace.2007.04.001.
- ⁴⁶ Unshared Bounty: How Structural Racism Contributes to the Creation and Persistence of Food Deserts <http://www.racialjusticeproject.com/wp-content/uploads/sites/30/2012/06/NYLS-Food-Deserts-Report.pdf>
- ⁴⁷ Zenk SN et al. Interdisciplinary, participatory research on urban food environments and dietary behaviors. In: *Urban Health and Society: Interdisciplinary Approaches to Research and Practice*. San Francisco, CA: John Wiley & Sons; 2009.
- ⁴⁸ Feldstein, L. Zoning and land use controls: beyond agriculture. *Maine Law Review*. 2013; 65(2): 467-90.
- ⁴⁹ Rothstein R. *The Making of Ferguson: Public Policies at the Root of its Troubles*. Washington, DC: Economic Policy Institute. 2014.
- ⁵⁰ Paul Mohai and Robin Saha "Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies (2015). *Environmental Research Letters* 10 125011"
- ⁵¹ ⁵¹ Paul Mohai and Robin Saha "Which came first, people or pollution? A review of theory and evidence from longitudinal environmental justice studies (2015). *Environmental Research Letters* 10 125011"
- ⁵² The Making of Ferguson: Public Policies at the Root of its Troubles. Richard Rothstein. Economic Policy Institute (2014) <http://www.epi.org/files/2014/making-of-ferguson-final.pdf>
- ⁵³ Spivack DR, Yanez E, Bokde A. Creating new urban park space in Los Angeles: An Analysis of the Current Quimby Ordinance and Recommended Improvements. Los Angeles, CA:Los Angeles Neighborhood Land Trust; 2014.
- ⁵⁴ Culver L. *Issue 5: From paradise to parking lot*. Los Angeles, CA: Los Angeles Forum for Architecture and Urban Design; 2010.
- ⁵⁵ Mohl R. *The Interstates and the Cities: Highways, Housing, and the Freeway Revolt*. Birmingham, AL: Poverty and Race Research Action Council; 2002. Department of History, University of Alabama at Birmingham.
- ⁵⁶ Wolcott, VW. *Race, Riots, and Roller Coasters: The Struggle over Segregated Recreation in America*. Pennsylvania, PA: University of Pennsylvania Press; 2012
- ⁵⁷ Ewing R, Meakins G, Hamidi S, Nelson A. Relationship between urban sprawl and physical activity, obesity, and morbidity - Update and refinement. *Health & Place* [serial online]. March 2014;26:118-126 9p. Available from: CINAHL Complete, Ipswich, MA. Accessed June 22, 2016.
- ⁵⁸ Rothstein, R. Modern Segregation. *Economic Policy Institute*. March 6, 2014. <http://www.epi.org/publication/modern-segregation/>. Accessed December 30, 2015.
- ⁵⁹ Jaffe E. Be careful how you refer to the so-called 'great American streetcar scandal'. *CityLab*. June 3, 2013. <http://www.citylab.com/commute/2013/06/be-careful-how-you-refer-so-called-great-american-streetcar-scandal/5771/>. Accessed 2015.
- ⁶⁰ Fractionated Ownership. Indian Land Tenure Foundation Web site. <https://www.iltf.org/land-issues/fractionated-ownership>. Accessed 2015.

-
- ⁶¹ Racial Restrictive Covenants. Seattle Civil Rights and Labor History Project. <http://depts.washington.edu/civilr/covenants.htm>. Accessed 2015.
- ⁶² Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. *Economic Policy Institute report*. October 15, 2014. <http://www.epi.org/publication/making-ferguson/>. Accessed October, 2015.
- ⁶³ Racial Restrictive Covenants. Seattle Civil Rights and Labor History Project. <http://depts.washington.edu/civilr/covenants.htm>. Accessed 2015.
- ⁶⁴ Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. *Economic Policy Institute report*. October 15, 2014. <http://www.epi.org/publication/making-ferguson/>. Accessed October, 2015.
- ⁶⁵ Jackson KT. *Crabgrass frontier: The suburbanization of the United States*: Oxford University Press, USA; 1985.
- ⁶⁶ Greer, J. (2013). The Home Owners' Loan Corporation and the development of the residential security maps. *Journal of Urban History*, 39(2), 275-296.
- ⁶⁷ Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. *Economic Policy Institute report*. October 15, 2014. <http://www.epi.org/publication/making-ferguson/>. Accessed October, 2015.
- ⁶⁸ Michael C. Lens & Paavo Monkkonen (2016) Do Strict Land Use Regulations Make Metropolitan Areas More Segregated by Income?, *Journal of the American Planning Association*, 82:1, 6-21, DOI: 10.1080/01944363.2015.1111163
- ⁶⁹ Harrison ML, Phillips DA, Chahal K, Hunt L, Perry J. *Housing, Race and Community Cohesion*. Chartered Institute of Housing; 2005.
- ⁷⁰ Rothstein R. The Making of Ferguson: Public Policies at the Root of its Troubles. *Economic Policy Institute report*. 2014. <http://www.epi.org/publication/making-ferguson/>.
- ⁷¹ Housing Assistance Council. *Housing on Native American Lands: Rural Research Report*. Washington, DC:Housing Assistance Council; 2013.
- ⁷² Conceptualizing the New Urban Renewal: Comparing the Past to the Present *Urban Affairs Review* July 2012 48: 498-527, first published on May 15, 2012 - <http://uar.sagepub.com/content/48/4/498.short>
- ⁷³ Fullilove MT and Wallace R. Serial Forced Displacement in American Cities, 1916-2010. *Journal of Urban Health Bulletin of the New York Academy of Medicine*. 2011;88(3). doi: 10.1007/s11524-011-9585-2.
- ⁷⁴ Gruenstein Bocian, Debbie, Peter Smith, and Wei Li, *Collateral Damage: The Spillover Costs of Foreclosures*. Center For Responsible Lending, October 24, 2012.
- ⁷⁵ Joint Center for Housing Studies of Harvard University. *America's Rental Housing: Evolving Markets and Needs*. Cambridge, MA: Harvard University; 2013.
- ⁷⁶ Causa Justa: Just Cause. *Development without Displacement: Resisting Gentrification in the Bay Area*. Alameda, Ca: Causa Justa; 2014.
- ⁷⁷ Zuk M and Chapple, K. *Case Studies on Gentrification and Displacement in the San Francisco Bay Area*. San Francisco, Ca: Center for Community Innovation; 2015.
- ⁷⁸ Harvard University. *Americas Rental Housing*. Joint Center for Housing Studies: Cambridge, Ma; 2015.
- ⁷⁹ Goffman, Alice. 2008. *On the Run: Wanted Men in a Philadelphia Ghetto*. *American Sociological Review*. 74(3):339-357.
- ⁸⁰ Ding L, Hwang J, Divringi, E. *A Practitioner's Summary: Gentrification and Residential Mobility in Philadelphia*. Philadelphia, Pa; 2015.
- ⁸¹ Zimmerman G, Messner S. Individual, Family Background, and Contextual Explanations of Racial and Ethnic Disparities in Youths' Exposure to Violence. *American Journal Of Public Health* [serial online]. March 2013;103(3):435-442. Available from: Academic Search Complete, Ipswich, MA. Accessed June 24, 2016.

-
- ⁸² U.S. Department of Education. 2013-2014 Civil Rights Data Collection: A First Look, Key Data Highlights on Equity and Opportunity Gaps in Our Nations Public Schools. Washington, DC: Office for Civil Rights; 2016.
- ⁸³ U.S. Department of Education. *Civil Rights Data Collection: Data Snapshot: Teacher Equity*. Washington, DC: Office for Civil Rights; 2015.
- ⁸⁴ U.S. Department of Education. *New Data from the US Department of Education 2009-10 Civil Rights Data Collecting Show Continuing Disparities in Educational Opportunities and Resources*. Washington, DC: Office for Civil Rights; 2011.
- ⁸⁵ Rural schools. National Education Association Web site. <http://www.nea.org/home/16358.htm>. Accessed December, 2015.
- ⁸⁶ Spatig-Amerikaner A. *Unequal Education: Federal Loophole Enables Lower Spending on Students of Color*. Washington, DC: 2012.
- ⁸⁷ Hanna R, Marchitello M, Brown C. *Comparable but Unequal: School Funding Disparities*. Washington DC: 2015
- ⁸⁸ Orfield G, Frankenberg E. Increasingly Segregated and Unequal Schools as Courts Reverse Policy. *Educational Administration Quarterly*. 2014; 50(5):718–734.
- ⁸⁹ Rothstein, R. The racial achievement gap, segregated schools and segregated neighborhoods – a constitutional insult. *Race and Social Problems*. 2014;6(4).
- ⁹⁰ National Institute for Early Education Research, Center on Enhancing Early Learning Outcomes. *Trends in State Funded Preschool Programs: Survey Findings from 2001-2001 to 2011-2012*. New Jersey; 2013.
- ⁹¹ Secretary of Education Arne Duncan et al. Increase access to quality preschool. *The Hill*. June 9, 2015. <http://thehill.com/opinion/op-ed/244485-increase-access-to-quality-preschool>. Accessed December, 2015.
- ⁹² The Executive Office of the President. *Increasing College Opportunity for Low-Income Students*. Washington, DC: The White House; 2014.
- ⁹³ Association of Public and Land-Grant Universities. *Fact Sheet: College Costs*. Washington, DC; 2012.
- ⁹⁴ Campos, P. The real reason college tuition costs so much. *SundayReview*. April 4, 2015. http://www.nytimes.com/2015/04/05/opinion/sunday/the-real-reason-college-tuition-costs-so-much.html?_r=1. Accessed December, 2015.
- ⁹⁵ Marschall D, Clawson, L. *Outsourcing, Sending Jobs Overseas: The Cost to American’s Economy and Working Families*. Washington, DC: Working America and AFL-CIO; 2010.
- ⁹⁶ Lafer, G. (2013). The legislative attack on American wages and labor standards, 2011-2012. EPI Briefing Paper #364. <http://www.epi.org/files/2013/EPI-Legislative-Attack-on-American-Wages-Labor-Standards-10-31-2013.pdf>. Accessed July 13, 2016.
- ⁹⁷ Pager D, Shepherd H. The sociology of discrimination: racial discrimination in employment, housing, credit, and consumer markets. *Annual Review of Sociology*. 2008;34:181-209.
- ⁹⁸ Nunley, J. M., Pugh, A., Romero, N., & Seals, R. A. (2015). Racial Discrimination in the Labor Market for Recent College Graduates: Evidence from a Field Experiment. *The BE Journal of Economic Analysis & Policy*, 15(3), 1093-1125.
- ⁹⁹ Nunley, J. M., Pugh, A., Romero, N., & Seals, R. A. (2015). Racial Discrimination in the Labor Market for Recent College Graduates: Evidence from a Field Experiment. *The BE Journal of Economic Analysis & Policy*, 15(3), 1093-1125.
- ¹⁰⁰ Reeves, RV. Saving Horatio Alger: Equality. Opportunity. And the American Dream. *Brookings Essay*. <http://www.brookings.edu/research/essays/2014/saving-horatio-alger> Published: August 20, 2014. Accessed: October 1, 2015.

-
- ¹⁰¹ Sommeiller E, Price M. *The Increasingly Unequal States of America*. Washington, DC: Economic Policy Institute; 2015.
- ¹⁰² The American Association of University Women. *The Simple Truth about the Gender Pay Gap*. Washington, DC; 2015.
- ¹⁰³ Gould E, Cooke T, Kimball W. What Families Need to Get By: EPI's 2015 Family Budget Calendar. *Economic Policy Issue*. <http://s4.epi.org/files/2015/epi-family-budget-calculator-2015.pdf> Published: August 26, 2015. Accessed: October 1, 2015.
- ¹⁰⁴ The Fair Labor Standards Act (FLSA). *United States Department of Labor*. <http://www.dol.gov/compliance/laws/comp-flsa.htm>. Published: n.d. Accessed: August 7, 2015.
- ¹⁰⁵ Khazan O. How Welfare Reform Left Single Moms Behind. *The Atlantic*. May 12, 2014. <http://www.theatlantic.com/business/archive/2014/05/how-welfare-reform-left-single-moms-behind/361964/> Accessed: October 1, 2015.
- ¹⁰⁶ Matthews D. Millions of Americans live in extreme poverty. Here's how they get by. *Washington Post*. May 13, 2013. <http://www.washingtonpost.com/news/wonkblog/wp/2013/05/13/millions-of-americans-live-in-extreme-poverty-heres-how-they-get-by/>. Accessed: October 1, 2015.
- ¹⁰⁷ Blank RM. Evaluating Welfare Reform in the United States. *Journal of Economic Literature*. 2002;(XL):1105-1166.
- ¹⁰⁸ Coates TN. The Case for Reparations. *The Atlantic*. June 2014. <http://www.theatlantic.com/magazine/archive/2014/06/the-case-for-reparations/361631/>. Accessed October, 2015.
- ¹⁰⁹ U.S. Department of Housing and Urban Development. *Unequal Burden: Income & Racial Disparities in Subprime Lending in America*. Washington, DC: US Department of Housing and Urban Development HUD USER; 1998.
- ¹¹⁰ Badger, Emily. The Dramatic Racial Bias of Subprime Lending During the Housing Boom. 2013, August 16. <http://www.citylab.com/housing/2013/08/blacks-really-were-targeted-bogus-loans-during-housing-boom/6559/>
- ¹¹¹ Carr J, Anacker K, Mulcahy M. *The Foreclosure Crisis and Its Impact on Communities of Color: Research and Solutions*. Washington, DC: National Community Reinvestment Coalition; 2011.
- ¹¹² Kneebone E. The Growth and Spread of Concentrated Poverty, 2000 to 2008-2012. *Brookings*. July 31, 2014. <http://www.brookings.edu/research/interactives/2014/concentrated-poverty#/M10420> Accessed October 1, 2015.
- ¹¹³ Mishel L. Causes of wage stagnation. *Economic Policy Institute*. January 6, 2015. <http://www.epi.org/publication/causes-of-wage-stagnation/>. Accessed 2016.
- ¹¹⁴ Shaprio T, Meschede T, Osoro S. *The Roots of the Widening Racial Wealth Gap: Explaining the Black-White Economic Divide*. Waltham, MA: Institute of Assets and Social Policy; 2013.
- ¹¹⁵ Kenworthy L, Smeeding T. *Growing Inequalities and Their Impacts in the United States*. Washington, D.C.: GINI Country Report for the United States; 2013.
- ¹¹⁶ Chetty R, Hendren N. *The Impacts of Neighborhood on Intergenerational Mobility: Childhood Exposure Effects and County-Level Estimates*. Cambridge, Ma: Harvard University; 2015.
- ¹¹⁷ Russell Sage Foundation Review. Neighborhood segregation and the concentration of poverty. *Russell Sage Foundation Review*. June 17, 2014. <http://www.russellsage.org/blog/neighborhood-segregation-and-concentration-poverty>. Accessed December, 2015.
- ¹¹⁸ U.S. concentrated poverty in the wake of the Great Recession. Brookings Institute March 31, 2016, Elizabeth Kneebone and Natalie Holmes <http://www.brookings.edu/research/topics/concentrated-poverty>

-
- ¹¹⁹ Profiting from Poverty: How Payday Lenders Strip Wealth from the Working-Poor for Record Profits (2012). National People's Action. http://npa-us.org/files/images/profitting_from_poverty_npa_payday_loan_report_jan_2012_0.pdf
- ¹²⁰ Bourke N et al. *Payday Lending in America: Who Borrows, Where They Borrow, and Why*. Washington, D.C.: The PEW Charitable Trusts; 2012.
- ¹²¹ <https://www.cdc.gov/mmwr/preview/mmwrhtml/su6203a23.htm>.
- ¹²² DuGoff EH et al. Multiple chronic conditions and life expectancy: a life table analysis. *Medical Care*. 2014;52(8):688-694.
- ¹²³ The Commonwealth Fund. Too high a price: out-of-pocket health care costs in the United States. *The Commonwealth Fund*. October, 2014. <http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/out-of-pocket-health-care-costs>. Accessed 2015.
- ¹²⁴ Milliman. *2015 Milliman Medical Index: Will the Typical American Family of Four be Driving a "Cadillac Plan" by 2018?* Seattle, WA: Milliman; 2015.
- ¹²⁵ Stranges E, Stocks C. *Potentially Preventable Hospitalizations for Acute and Chronic Conditions, 2008*. Rockville MD: Agency for Healthcare Research and Quality; 2010.
- ¹²⁶ Smedley BD, Stith AY, Nelson AR. *Unequal Treatment- Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2002.
- ¹²⁷ Thorpe K, Lever J. Prevention: the answer to curbing chronically high health care costs (guest opinion). *Kaiser Health News*. May 24, 2011. <http://khn.org/news/052411thorpelever/>. Accessed December, 2015.
- ¹²⁸ Levi J, Segal LM, Gougelet R, Laurent RS. *Investing in America's Health: A State-by-State Look at Public Health Funding and Key Health Facts*. Washington, D.C.: Trust for America's Health; 2015.
- ¹²⁹ Kinner K, Pellegrini C. Expenditures for public health: assessing historical and prospective trends. *American Journal of Public Health*. 2009;99(10):1780-1791.
- ¹³⁰ Smedley BD, Stith AY, Nelson AR. *Unequal Treatment- Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2002.
- ¹³¹ Radnofsky L. Percentage of uninsured in US dropped in first year of Obama's health care plan. *The Wall Street Journal*. September, 16, 2015. <http://www.wsj.com/articles/percentage-of-uninsured-in-u-s-drops-in-2014-1442416629>. Accessed 2015.
- ¹³² Moy E, Freeman W. Federal Investments to Eliminate Racial/Ethnic Health-Care Disparities. *Public Health Reports*. 2014;129(Suppl 2):62-70.
- ¹³³ Gottlieb L, Sandel M, Adler NE. Collecting and applying data on social determinants of health in health care settings. *JAMA International Medicine*. 2013;173(11):1017-1020.
- ¹³⁴ The Commonwealth Fund. The affordable care act's payment and delivery system reforms: a progress report at five years. 2015. <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/aca-payment-and-delivery-system-reforms-at-5-years>. Accessed 2016.
- ¹³⁵ Rothstein, R. Modern Segregation. *Economic Policy Institute*. March 6, 2014. <http://www.epi.org/publication/modern-segregation/>. Accessed December 30, 2015.
- ¹³⁶ Unshared Bounty: How Structural Racism Contributes to the Creation and Persistence of Food Deserts <http://www.racialjusticeproject.com/wp-content/uploads/sites/30/2012/06/NYLS-Food-Deserts-Report.pdf>
- ¹³⁷ Institute of Medicine. *How Far Have We Come in Reducing Health Disparities?* Washington, D.C.: Institute of Medicine; 2012.

-
- ¹³⁸ Tran-Leung, MC. *When Discretion means Denial: A National Perspective on Criminal Records Barriers to Federally Subsidized Housing*. Chicago, IL: Sargent Shriver National Center on Poverty Law; 2015. <http://poverty.org/sites/default/files/images/publications/WDMMD-final.pdf>
- ¹³⁹ Davis R, Rivera D, Fujie-Parks L. *Moving from Understanding to Action on Health Equity: Social Determinants of Health Frameworks and THRIVE*. Oakland, CA: Prevention Institute; 2015.
- ¹⁴⁰ National Network of Public Health Institutes. *THRIVE Empowers Youth to Improve Community Safety: A California Case Example*. Merced, CA: National Network of Public Health Institutes; 2015.
- ¹⁴¹ Personal communication with Tacoma County Health Department, 2015 and 2016.
- ¹⁴² California Department of Parks and Recreation. Assembly Bill No. 31, Chapter 623. Sacramento, CA: California Department of Parks and Recreation; 2008.
- ¹⁴³ Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.
- ¹⁴⁴ CERIN E, CAIN K, SALLIS J, et al. Neighborhood Environments and Objectively Measured Physical Activity in 11 Countries. *Medicine & Science In Sports & Exercise* [serial online]. December 2014;46(12):2253-2264. Available from: Academic Search Complete, Ipswich, MA. Accessed June 26, 2016.
- ¹⁴⁵ Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.
- ¹⁴⁶ Sallis JF, Floyd MF, Rodríguez DA, Saelens BE. The Role of Built Environments in Physical Activity, Obesity, and CVD. *Circulation*. 2012;125(5):729-737. doi:10.1161/CIRCULATIONAHA.110.969022.
- ¹⁴⁷ Bell ML, Ebisu K. Environmental inequality in exposures to airborne particulate matter components in the United States. *Environmental Health Perspectives*. 2012;120(2):1699-1704.
- ¹⁴⁸ Centers for Disease Control and Prevention. *Transportation and Health*. Atlanta, Ga: National Center for Environmental Health; 2014.
- ¹⁴⁹ Cohen L, et al. *Addressing the Intersection: Preventing Violence and Promoting Healthy Eating and Active Living*. Oakland, Ca: Prevention Institute; 2010.
- ¹⁵⁰ Issue Brief Series: The Economic Benefits of Equity Transportation for All: Good for Families, Communities, and the Economy. PolicyLink <https://www.policylink.org/sites/default/files/Transportation-for-All-FINAL-05-10-16.pdf>
- ¹⁵¹ Complete Streets. Mid-Ohio Regional Planning Commission. <http://morpc.org/transportation/complete-streets/index>. Accessed February 11, 2016.
- ¹⁵² Holladay City, Utah: Safe Sidewalks and Safe Routes Work Hand in Hand. Safe Routes: National Center for Safe Routes to School. <http://www.saferoutesinfo.org/program-tools/success-stories/holladay-city-utah-safe-sidewalks-and-safe-routes-work-hand-hand> Accessed February 11, 2016.
- ¹⁵³ Federal Reserve System. Federal Fair Lending Regulations and Statute: The Fair Housing Act. In: *Consumer Compliance Handbook*. Washington, D.C.: Federal Reserve System; 2015.
- ¹⁵⁴ NHC’S Policy Agenda. National Housing Conference Web site. <http://www.nhc.org/#!/policy-agenda/q49db>. Published March 26, 2015. Accessed December, 2015.
- ¹⁵⁵ Blackwell A. A call to action to embrace and enforce the AAFFH rule. *Furman Center*. September 2015. <http://furmancenter.org/research/iri/essay/a-call-to-action-to-embrace-and-enforce-the-affh-rule>. Accessed October, 2015.

-
- ¹⁵⁶ Bodaken M, Hoffman EL. A fair approach to fair housing. *Rooflines*. October 21, 2015. http://www.rooflines.org/4287/a_fair_approach_to_fair_housing/. Accessed December, 2015.
- ¹⁵⁷ Who We Are. Purpose Built Communities Web site. <http://purposebuiltcommunities.org/>. Published 2015. Accessed 2015.
- ¹⁵⁸ Home. Dudley Street Neighborhood Initiative Web site. <http://www.dsni.org/>. Published 2015. Accessed 2015.
- ¹⁵⁹ NHC'S Policy Agenda. National Housing Conference Web site. <http://www.nhc.org/#!/policy-agenda/q49db>. Published March 26, 2015. Accessed December, 2015.
- ¹⁶⁰ Barkan, A. Presented in: Prevention Institute Determinants of Health Interviews; October 2015; Oakland, CA.
- ¹⁶¹ Semuels A. Affordable housing, always. *The Atlantic*. July 6, 2015. <http://www.theatlantic.com/business/archive/2015/07/affordable-housing-always/397637/>. Accessed October, 2015.
- ¹⁶² Housing. PUSH Buffalo: People United for Sustainable Housing. <http://pushbuffalo.org/housing> Published 2012. Accessed February 11, 2016.
- ¹⁶³ Red Feather Development Group. <https://www.redfeather.org/> Published 2016. Accessed February 11, 2016.
- ¹⁶⁴ Food Chain Workers Alliance. The hands that feed us. *Food Chain Workers Alliance Web site*. June 6, 2012. <http://foodchainworkers.org/?p=1973>. Accessed October, 2015.
- ¹⁶⁵ Prevention Institute. *Community Farm Alliance: Bridging Rural Farm Policy with Urban Food Access*. Oakland, CA: Prevention Institute; n.d.
- ¹⁶⁶ What We Do. Community Farm Alliance. <http://cfaky.org/what-we-do/>. Accessed February 11, 2016.
- ¹⁶⁷ Prevention Institute. *Piñeros Y Campesinos Unidos Del Noroeste: Farmworkers' Union improves healthy food access and physical activity opportunities*. Oakland, CA: Prevention Institute; n.d.
- ¹⁶⁸ Prevention Institute. *Blueprint for Action: Preventing Violence in Minneapolis*. Oakland, CA: Prevention Institute; 2011.
- ¹⁶⁹ City of Minneapolis. *Minneapolis Blueprint for Action to Prevent Youth Violence*. Minneapolis, MN: City of Minneapolis; 2013.
- ¹⁷⁰ City of Minneapolis. *Results: State of Youth*. Minneapolis, MN: City of Minneapolis; 2012.
- ¹⁷¹ Success Court: Working to Break the "School to Prison Pipeline." *Kansas City PBS*. 2013. <http://kcpt.org/education/success-court-is-one-tool-being-used-to-break-school-to-prison-pipeline/> Published 2013. Accessed February 11, 2016.
- ¹⁷² Kansas City Public Schools and Department of Elementary and Secondary Education. Regional School Improvement Team Meeting. Presented at: Regional School Improvement Team Meeting; November 20, 2014; Kansas.
- ¹⁷³ Who We Are: History. Purpose Built Communities: Changing neighborhoods. Changing lives. Purpose Built Communities Web site. <http://purposebuiltcommunities.org/who-we-are/history/> Accessed February 11, 2016. Published n.d. Accessed October, 2015.
- ¹⁷⁴ What is the national network of sector partners. National Network of Sector Partners Web site. <http://www.insightccd.org/our-areas-of-focus/workforce-development/national-network-of-sector-partners-nnsp/>. Published n.d. Accessed October, 2015.

-
- ¹⁷⁵ The State of Health Equity Research: Closing Knowledge Gaps to Address Inequities. Association of American Medical Colleges: Health Equity Research and Policy. Available at: <https://members.aamc.org/eweb/upload/The%20State%20of%20Health%20Equity%20Research%20-%20Closing%20Knowledge%20Gaps%20to%20Address%20Inequities.pdf>. Accessed August 3, 2016.
- ¹⁷⁶ National Congress of American Indians. *Indian Country Budget Request FY 14*. Washington, DC: National Congress of American Indians; 2015.
- ¹⁷⁷ Green Jobs Central Oklahoma: Philosophy. It's My Community! Green Jobs Central Oklahoma Web site. <http://www.itsmycommunity.org/green-jobs.php> Accessed February 11, 2016.
- ¹⁷⁸ Archi's Acres: Small Scale Organic Farming. Archi's Arces Web site. <http://archisacres.com/> Accessed February 11, 2016.
- ¹⁷⁹ <http://greenlining.org/issues-impact/economic-equity/diverse-small-businesses/> Minority-owned businesses and supplier diversity. The Greenlining Institute Web site. <http://greenlining.org/issues-impact/economic-equity/diverse-small-businesses/>. Updated 2015. Accessed October, 2015. Minority-owned businesses and supplier diversity. The Greenlining Institute Web site. <http://greenlining.org/issues-impact/economic-equity/diverse-small-businesses/>. Updated 2015. Accessed October, 2015.
- ¹⁸⁰ Estola, C. Presented in: Prevention Institute Determinants of Health Interviews; October 2015; Oakland, CA.
- ¹⁸¹ Lee E. *Economic Development Program Area 3*. San Francisco, Ca: San Francisco Controller; n.d.
- ¹⁸² Regulatory Accountability. The Greenlining Institute Web site. <http://greenlining.org/issues-impact/economic-equity/diverse-small-businesses/>. Updated 2015. Accessed October, 2015.
- ¹⁸³ Hipp JS. Presented in: Prevention Institute Determinants of Health Interviews; October 2015; Oakland, CA.
- ¹⁸⁴ Hillsborough County Violence Prevention Collaborative. *2014-2015 Strategic Plan*. <http://www.hillsboroughcounty.org/safeandsoundplan/> Published August 2014. Accessed February 11, 2016.
- ¹⁸⁵ CDC of Tampa. The Corporation to Develop Communities of Tampa, Inc. Web site. <http://www.cdcoftampa.org/> Accessed February 11, 2016.
- ¹⁸⁶ Mayor Landrieu Announces Economic Opportunity Strategy for Disadvantaged Job Seekers and Businesses. City of New Orleans Web site. <http://www.nola.gov/mayor/press-releases/2014/20140909-economic-strategy/> Published September 9, 2014. Accessed February 11, 2016.
- ¹⁸⁷ It's All in the Data: Cincinnati Children's Hospital Gets Wonky to Transform the Health of Its Community. Forbes Web site. <http://www.forbes.com/sites/robwaters/2013/11/26/its-all-in-the-data-cincinnati-childrens-hospital-gets-wonky-to-transform-a-communitys-health/#6d23c5366c67> Published November 26, 2013. Accessed February 11, 2016.
- ¹⁸⁸ Cantor J, Cohen L, Mikkelsen L, Pañares R. *Community Centered Health Homes: Bridging the gap between health services and community prevention*. Oakland, CA: Prevention Institute. 2011. <http://www.preventioninstitute.org/component/jlibrary/article/id-298/127.html>.
- ¹⁸⁹ Gopal S, Kania J. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ¹⁹⁰ Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner's Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.
- ¹⁹¹ LaVeist T et al. *The State of Racial Inequalities in Health*. Princeton, NJ: Robert Wood Johnson Foundation; 2001.

-
- ¹⁹² Unshared Bounty: How Structural Racism Contributes to the Creation and Persistence of Food Deserts <http://www.racialjusticeproject.com/wp-content/uploads/sites/30/2012/06/NYLS-Food-Deserts-Report.pdf>
- ¹⁹³ Krieger N. Discrimination and Health Inequities. *International Journal of Health Services*. 2014;44 (4): 643 – 710.
- ¹⁹⁴ Gee GC, Ford CL. Structural racism and health inequities: Old Issues, New Directions. *Du Bois Review: Social Science Research on Race*. 2011;8(1):115-132.
- ¹⁹⁵ Krieger N. Discrimination and Health Inequities. *International Journal of Health Services*. 2014;44 (4): 643 – 710.
- ¹⁹⁶ Pinderhughes H, Davis R, Williams M. *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community-Level Trauma*. Oakland, CA: Prevention Institute; 2015.
- ¹⁹⁷ Structural Violence. Structural Violence Web site. <http://www.structuralviolence.org/structural-violence/>. Updated 2015. Accessed 2015.
- ¹⁹⁸ Pinderhughes H, Davis R, Williams M. *Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community-Level Trauma*. Oakland, CA: Prevention Institute; 2015.
- ¹⁹⁹ Gopal S, Kania. Fostering Systems Change: Five Simple Rules for Foundations Seeking to Create Lasting Social Change. *Stanford Social Innovation Review*. 2015.
- ²⁰⁰ Centers for Disease Control and Prevention – Division of Community Health. *A Practitioner’s Guide for Advancing Health Equity: Community Strategies for Preventing Chronic Disease*. Atlanta, GA: US Department of Health and Human Services; 2013.
- ²⁰¹ Cohen L, Iton A. *Closing the loop: Why we need to invest—and reinvest—in prevention*. Washington, DC: Institute of Medicine; 2014.
- ²⁰² Davis R. *Measuring What Works to Achieve Health Equity: Metrics for the Determinants of Health*. Oakland, CA: Prevention Institute; 2014.