



# Leveraging the Social Determinants to Build a Culture of Health

## FINAL REPORT

Written for the Robert Wood Johnson Foundation by CommonHealth ACTION  
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CommonHealth ACTION is a national public health organization that aligns people, strategies, and resources to generate solutions to health and policy challenges. We envision an America in which all people have equitable opportunities and neighborhood conditions to achieve their best possible health.

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Since its inception, The Robert Wood Johnson Foundation has dedicated its efforts to improve the health of this nation. The foundation's approach to this work has evolved over time based on emerging issues and lessons learned from both theory and practice.

After many investments in the improvement of healthcare and the realization that the actual health of people living in the United States was not improving – and in some cases they were worsening – the foundation decided to seek solutions outside of the healthcare system.

With the establishment of the Commission to Build A Healthier America in 2008 to 2009, the foundation began shifting its focus to understanding the influences of where people in the United States live, learn, work, and play to identify ways to improve their health outcomes. In 2016, the foundation's President and CEO, Dr. Risa Lavizzo-Mourey, outlined the organization's new vision to build a national Culture of Health that the foundation hopes to achieve by working with many others interested in improving the health of everyone in the nation.

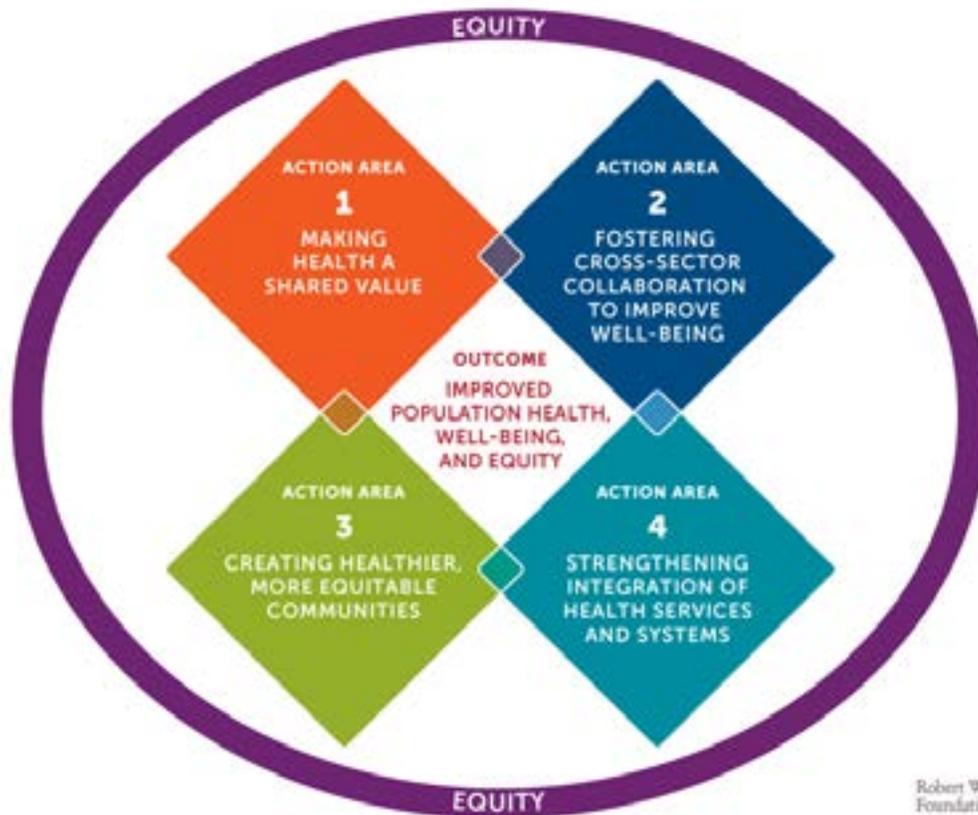
Why a Culture of Health? This excerpt from the foundation's publication *From Vision to Action: A Framework and Measures to Mobilize a Culture of Health*, is the purpose for this framework:

Despite ongoing efforts to improve the health of our nation, positive change is not occurring at a promising pace. ... The Framework offers an integrated, evidence-based, and comprehensive approach to addressing the societal influences of health and well-being. In doing so, it calls for unprecedented collaboration between individuals; organizations in the private and public sectors; and communities representing a range of social, demographic, and geographic characteristics.

By building the Culture of Health on a national level, the foundation seeks to address the urgent need to catalyze improvements in health, well-being, and equity using a broad, cross-sector of collaborative approach.

This is done by identifying opportunities to listen to various stakeholders, to identify ways to translate, package, and disseminate current knowledge, as well as develop tools for local leaders to create healthier and more equitable communities. This listening and learning approach would enable the foundation to identify pressing research needs to advance learning on how to raise awareness, engage and motivate diverse audiences in the implementation of solutions in policy and practice, and ultimately to achieve healthier and more equitable communities.

## CULTURE OF HEALTH ACTION FRAMEWORK



### The Project

In order to tap into the lessons learned from the SDOH field, the foundation envisioned using several approaches. Through a partnership with CommonHealth ACTION—a national public health nonprofit based in Washington, DC—the foundation identified three (3) tools that would aid in the listening and learning agenda: an environmental scan, white papers, and a national convening.

**1. Environmental Scan:** This is a compilation of resources from the SDOH field that are both general and specific to the focus areas identified as key building blocks for this SDOH-informed agenda. The scan provides a synopsis of articles, papers, tools, and/or media that discuss historical and current trends in the social determinants of health field. Also, it identified themes using the lens of readiness, racism/equity, healthcare systems, and others as they emerged. The scan helped to inform other areas of the project, including the identification of participants and resources for the convening agenda. The focus areas for this environmental scan include:

- ▶ Racism (as a social determinant of health)
- ▶ Education
- ▶ Housing
- ▶ Wealth/Economic Stability
- ▶ Occupation/Employment

- 2. White Papers:** The foundation commissioned White Papers to be written by experts in the identified focus areas for this project (see above), asking each writer to tap into their extensive knowledge and background, using an SDOH lens, to identify two to three priority areas for the foundation to address and provided a baseline for the discussion at the national convening as well as helped to inform the development of the convening's activities. The writers included: Dr. Gilbert Gee, UCLA Fielding School of Public Health (Racism); Dr. Katrina Walsemann, University of South Carolina (Education); Drs. Diana Hernandez and Shakira Suglia, Columbia University, Mailman School of Public Health (Housing); Dr. Darrick Hamilton, The New School, and Dr. William Darity Jr., Duke University (Wealth and Occupation).
  
- 3. National Convening:** The convening was a day and a half event that took place in Philadelphia, PA on June 1 – 2, 2016 and was attended by 34 people whose professional background were directly and indirectly aligned with the identified focus areas. These individuals were asked to read the white papers prior to the convening, provide feedback, and share their ideas and thoughts about the current and potential future of health, all of which would help inform the development of an SDOH-informed approach to building a Culture of Health.

This final report serves as a synthesis of the results of all these efforts. However, a significant portion of the document focuses on the thoughts and ideas shared by the convening participants, as well as the suggestions that emerged from their discussions. The Environmental Scan and White Papers are located in the Appendices, along with other materials developed throughout this project for reference. Finally, in the last section of this report, we will outline and discuss the lessons learned from all three efforts, as well as identify specific action items for the foundation to pursue in its quest to build a national Culture of Health.





The participants were very active and engaged thought partners who were invested in not only sharing their thoughts but also learning from each other and the process, which made this a notable convening and valuable experience for everyone who attended. A list of the participants may be found in the Appendices.

## The Process

Understanding the time limitations of a 1.5-day face-to-face meeting, the project team provided participants with materials prior to the convening, which included readings and videos that gave them the background and context for the Culture of Health framework, readiness, culture, health disparities, and inequities. Also, the team asked the participants to read the White Papers thoroughly so that would serve as the baseline for the conversations at the convening. Finally, the participants also completed a short survey that helped the project team understand and prepare for the breadth of perspectives within the group.

After the introductory activities, Dr. David Williams provided background about the social determinants of health and the foundation's work. Dr. Williams serves as an advisor to the foundation on strategies that address building the social determinants of health into the Culture of Health vision, with a focus on racial and ethnic disparities in health. After his presentation, the Jasmine Hall Ratliff (RWJF) gave an overview of the Culture of Health framework, to ground the participants in the content. The White Paper writers did presentations that highlighted the two to three areas they identified as priorities for the foundation to address. The writers then fielded questions as the group began to explore emerging ideas from both the presentations and their discussions.

At the conclusion of the evening, Natalie S. Burke (CommonHealth ACTION) asked the participants to process the information gleaned from the first day's work by responding to three questions and posting their thoughts based on categories provided:

- **STICKY THINGS:** Thinking about the survey responses and the associated themes, as well as the white paper presentations, what stuck with you?
- **COULD HAVE DONE WITHOUT...:** Thinking about the survey responses and the associated themes, as well as the white paper presentations, what left you concerned, disappointed, or uncomfortable?
- **HOPE:** Thinking about the survey responses and the associated themes, as well as the white paper presentations, what do you hope will happen or be different in the future, and what left you hopeful?



While there were a variety of responses to the questions posed (See complete list of responses in the Appendices), there were some notable takeaways:

### **Sticky Things**

- The compounding effect of racism over a lifetime.
- Quality of schools and pathways matters.
- Housing insecurity goes beyond homeless or not [homeless].
- Measurement remains an issue. Life course perspective is important.
- Racial disparities in wealth cannot be overcome only through education and income. Reasons are historic and integrated. What to do?

### **I Could Have Done Without...**

- Again, why [are] the data presented seemingly binary (Blacks vs. Whites)? Little to no data on Asians or American Indians.
- A bit disappointed with the implication that education is the “solution.” Also, disappointed that little attention was given to the fact that health disparities can widen w/ SES.
- Too much thinking of housing as separate, as opposed to a neighborhood anchor.
- Lack of conversation about transportation and impact on opportunity and health
- Cautions about Neo-liberal approaches. I want to know more.

### **Hope**

- More thinking about the intersections of gender, age, sexual minority status and race is important for understanding racism.
- Must be responses to trauma in schools. School discipline, School to prison pipeline.
- This room is full of smart people with power to change the power imbalance.
- Neighborhood determines opportunity; the communication (about employment) must counteract geography.
- The challenges and opportunities of Big Data.

Day two began with a recap of the thoughts posted in the previous day’s exercise in addition to framing the day’s activities. Dr. Dwayne Proctor delved a bit deeper into the concept of a Culture of Health by looking at the foundation’s intention for framing this approach as culture. He spoke about some of the lessons that the Foundation has learned while going through this aspirational journey, including understanding the importance of language, becoming solutions oriented, and the application of race and equity considerations when developing their approach.

Following was Dr. Paula Braveman who began by explored existing definitions of health equity and their connection to the social determinants of health. Dr. Braveman has been working with the foundation on developing a comprehensive definition on health equity for several months, and given the critical connection with building a Culture of Health, the convening served as a great opportunity to both outline and receive feedback about the latest version of the definition. She first discussed the importance of defining health equity, and reviewed a few examples of current relevant definitions, identifying the strengths and weaknesses of each of the definitions. Dr. Braveman then presented the latest working definition of health equity that was a result of the work with the foundation:<sup>1</sup>

1. Dr. Braveman will present a final definition of health equity at the October 29-November 2, 2016 annual meeting of the American Public Health Association.

Health equity means that everyone has the opportunity to live as long and healthy a life as possible. But for many people, obstacles such as poverty, discrimination, and their consequences –including lack of access to good jobs, education, housing, a safe environment, and quality health care– make good health unattainable. Fairness requires dedicated efforts to remove these obstacles to health.

The final presenter of the morning was Natalie S. Burke, who examined the basic concept of culture, which she defined as:

An integrated pattern of learned core values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible.

Using the smoking cessation movement as an example, she illustrated how culture develops, how it changes, and how readiness must be present in order for change to occur. Also, she explained how equity, diversity, and inclusion were important considerations when developing the scope of work and resources necessary to implement culture change.

These three presenters established the foundation for the next phase of the day’s activities, after which it was then time for the participants to break into groups and begin formulating their ideas. This process entailed individual and group thinking in several stages. Participants separated into groups representing each SDOH focus area so that they could do deeper dives into the content, and they were asked to think about, discuss, and share their individual and combined thoughts with the larger group. Outlined below are the phases through which the participants engaged in thought partnership:

- 1. Current Culture Assessment:** Participants wrote their individual appraisals of the culture that is currently demonstrated within their assigned determinant/topic area. They posted their thoughts on a wall and discussed them as a group, with the goal of coming up with a consensus statement about the culture of that determinant/topic area.
- 2. Future Culture Visioning:** After sharing their current culture consensus statements with the group, the participants went back into those groups to discuss what the future culture of the determinant/topic area should be, and generated a vision statement to summarize their thoughts. As they created these statements, the participants had to consider the following:
  - What needs to change to support health in the future?
  - What is the role of equity, individuals, communities, institutions, and systems?
  - What will be true about the culture of health when it exists?
- 3. Priority Areas Identification:** Once each group described the future culture of their assigned determinant/ topic area, they needed to identify two to three priority areas (i.e., the “what”) that would build a Culture of Health, and as they discussed the possibilities they should consider the following factors:
  - What is the potential impact (value) of the priority area?
  - How feasible is it?

- What is necessary, in terms of readiness, to accomplish the priority area?
- Are any of the priority areas dependent on other factors? If so, what are those factors and why?

**4. Strategic Directions Identification:** This phase was particularly important as it was geared towards having the participants provide specific guidance (i.e., the “how”) to the foundation in terms of implementing the priority areas identified. The facilitators asked the participants to create a laundry list of strategic directions and then collectively decide on the top three directions for each priority area they proposed. Once again, they needed to consider certain factors:

- Who will do it (i.e., individuals, communities, institutions/organizations, systems)?
- What resources (i.e., money, human capital, etc.) are needed?
- What are the potential barriers or what needs to be moved out of the way?
- Are there conditions that are favorable to accomplish the “how”?
- How will this create equitable outcomes or contribute to them?
- What is the feasibility for implementation?
- Is there a sequence to specific activities to ensure readiness?





## The Results

The participants engaged in intense thought and idea development throughout the day, from which emerged some very interesting proposals for the foundation. The following is a summary of the results from their various discussions by topic area:

### Education

- **Future Culture:** To have a public that values education for all as a racially, economically integrated, inclusive, safe, supportive, and accessible public good that insures life-long learning, full ... participation, critical thinking, and economic mobility.
- **Priority Areas with Strategic Directions:**
  - Area #1:** De-compartmentalize and move beyond traditional conceptions of education and health.
    1. Cross-sector collaboration within training, research, policy, funding, and advocacy.
    2. Design inquiries, set priorities, and create interventions with all the stakeholders at the table from the very beginning.
    3. Support qualitative research, including but not limited to community-based participatory research and narrative development that will emphasize their value.
  - Area #2:** Develop and embed new methods for understanding structural institutional racism as it impacts and is impacted by education.
    1. Identify and target unlikely allies and potential influencers; essentially, power mapping.
    2. Use data gathered about this issue to conceptualize, design, and implement equitable solutions.
    3. Establish funding for a research to practice collaborative that supports researchers and practitioners in a consistent way to continue their collective efforts to meet, exchange ideas, and test solutions.

**Area #3:** Broaden the ways we think about traditional and social determinants of health to capture inequities in a more direct way.

1. Study the factors that reproduce inequities in education rather than just educational attainment.
2. Place more value on the research being done.
3. Invest in and incentivize cross-disciplinary efforts

## Occupation/Employment

- **Future Culture:** To provide those who choose to join structured and unstructured job markets with the opportunity to do so through job guarantee programs instituted by private and public resources and policies. These individuals should receive just treatment and wages, and consequently sustain communities that will have the capacity to organize and engage in issues to further self-determination and good health.

- **Priority Areas with Strategic Directions:**

**Area #1:** Support reparations for the enslavement of people of African descent.

- Mobilize an uncompromising social movement campaign and lobbying effort that includes economists, political scientists, communications experts, global allies, and colleges/universities (e.g., Georgetown and Brown University)
- Support the design of a fully developed program for reparations.

**Area #2:** Conduct more studies of iterative relationships between health, wealth, race, and gender.

- Support a major research effort using mixed methods of wealth and health, paying attention to intergenerational transmission effects.
- Measure and document lifespan experiences with discrimination and their connection to wealth, health, race, and gender.
- Take action by testing findings on a smaller scale.

**Area #3:** Support financial literacy/routes to wealth programs and priorities.

- Study and build advocacy for effective, sensitive, and innovative models of pedagogy.
- Connect financial literacy programs directly to wealth allocation programs such as baby bonds and reparations, while forging public and private partnerships to require financial literacy and wealth management education in public schools and publicly-funded programs.
- Hold the nation accountable via documentation and monitoring state report cards on financial literacy, including anti-fraud protections.

## Wealth

- **Future Culture:** Where our national priority focuses on all of us reaching our highest human capabilities through equitable access and control of public and private assets, and that as a society, we measure success and how well we are able to provide access to these assets so they can allow people to reach their goals as they determine them.

- **Priority Areas with Strategic Directions:**

**Area #1:** Fund innovations that elevate opportunity and outcomes for minority populations.

1. Fund more demonstration projects that build on ideas, are tied to policy systems and change, and explicitly include the most effective in design and creation of the strategies.
2. Crowd source possibilities for innovations.

**Area #2:** Study the interconnectedness of race, stress, and racism by exploring the puzzling result of rising racial disparity at higher levels of social economic status.

1. Fund data collection and reporting, not only for the black/white dichotomy but also for other racial/ethnic groups, particularly if no data exists.
2. Expand the use of social and behavioral measures of electronic medical health records in this area.

**Area #3:** Support reparations for the slavery of African descent, and disenfranchisement of Native Americans.

1. Through education, make a better case for reparations.
2. Commission a high-profile, selective study group to produce a report on the issues.
3. Implement a demonstration on baby bonds and their potential impact on lives, both in terms of health and economic outcomes.

## Housing

- **Future Culture:** Where investments in the physical environment are aligned and coordinated creating healthy, safe, connected places to live, learn, work and play, leading it to better health for all and eliminating disparities.

- **Priority Areas with Strategic Directions:**

**Area #1:** Invest in an innovative inter-disciplinary project that simultaneously considers how the social determinants of health intersect to produce health and equities.

1. Support multidiscipline and multisector solutions, for example, examine how housing, education, and transportation all connect.
2. Invest in community quarterbacks who would be able to champion the direction of dollars and investments into different organizations within their communities.
3. Build the capacity of local leaders to advocate for more dollars and investments in these types of activities.

**Area #2:** Develop a framework that can help to de-compartmentalize many of these issues.

1. Recognize intersectionality, including racism, over the life course.
2. Support community-based participatory research that is applied and to change these policies to ensure that the voice and needs of the community are heard.
3. Make the framework actionable so that it can be used to hold communities and policymakers accountable.

**Area #3:** Support housing with services particularly for neglected populations.

1. Design utility decisions to include an emphasis on quality, sustainability, and maintenance.
2. Support comprehensive services that are commonly formed, culturally appropriate and responsive to the needs of communities, particularly for those who experience barriers to quality and affordable housing.

## Racism

- **Future Culture:** An ideal culture is one where poverty, illness, and violence are not viewed as individual failings, but a community disgrace and a collective responsibility; [this ideal culture would] consequently, end dehumanization and recognize the humanity of all people.
- **Priority Areas with Strategic Directions:**
  - **Area #1:** Support having social scientists and community members at the forefront of developing the narrative and hypothesis for agendas and strategies to understand and address the implications of racism.
    1. Change organizational policy and requirements for participation and spearheading of the process, as well as allocate resources to support these efforts.
    2. Implement strong and meaningful feedback loops [to ensure that] approaches [can] be modified based on responses to individual experiences and outputs.
    3. Identify ways where all stakeholders can achieve some of their goals through consensus building.
  - **Area #2:** Support an emphasis on intersectionality, life course, and cumulative risks.
    1. Develop new methods of understanding structural, institutional, and internalized racism.
    2. Create a compendium for multiple fields and sectors, mandating institutional data collection that is consistent with protocols to monitor and address racism within these systems.
  - **Area #3:** Learn from the knowledge and expertise derived from people's lived experience.
    1. Recognize that our conceptualization about the ways in which racism plays out in our lives can be informed by a number of different perspectives, through academia as well as lived experiences.
    2. Support the standard collection [of] reporting and sharing across disciplines
    3. Support policy and foreign policy that comes from and supports intersectionality approaches.

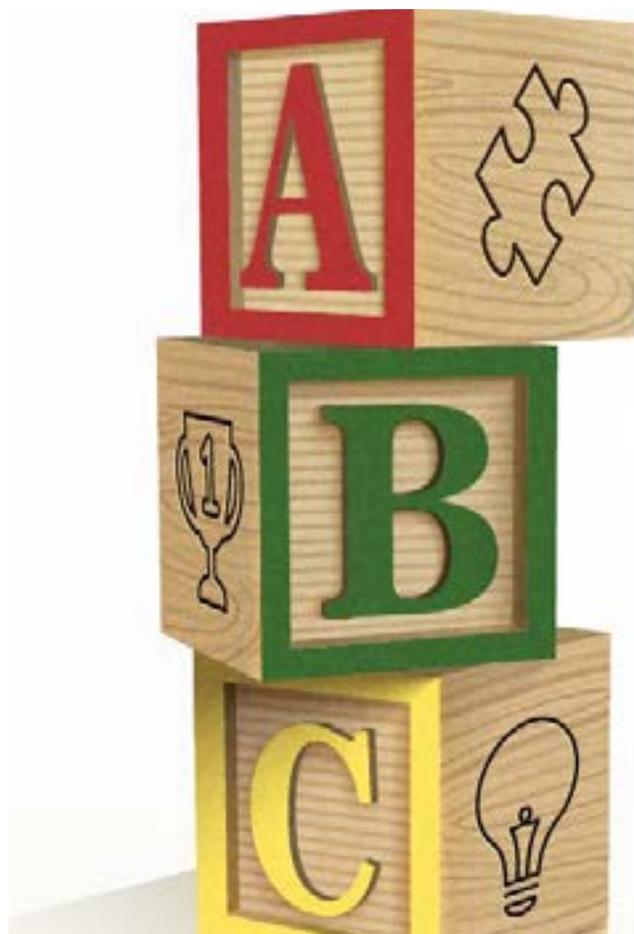




# ANALYSIS & RECOMMENDATIONS

The priority areas and strategic directions provided by the convening participants illustrate the rich and fruitful results that can emerge from cross-sector collaboration. Based on the breadth and variety of perspectives compiled, it is clear that great thought and effort were invested in these deliberations, despite the group having really only one day to accomplish this task of informing this approach to building a Culture of Health.

While the participants would have wanted more time to build on their discussions, the suggestions provided are nevertheless very useful and innovative ideas for the foundation to consider as part of their effort to build a culture of health. To support the review process, the priority areas are re-organized and synthesized below within the following categories:



## EASY LIFT

Priorities and strategic directions that can be easily implemented by the foundation based on current efforts.

## MORE DISCUSSION

Priority areas and strategic directions would require further conversation and development for the foundation to determine how they could be incorporated.

## HARD CONVERSATIONS

Priority areas and strategic directions that would require a fundamental discussion about the internal will at the foundation to engage in these activities.

## Easy Lift

The participants offered priorities and strategic directions across all the SDOH focus areas that can be easily implemented by the foundation as they speak to approaches and strategies in which the foundation has already made investments. Here are some key themes that summarize the suggestions included in this category:

- **Intersectionality:** This term is defined as “the interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power” (Davis, 2008), and it served as the overarching theme for many of the priority areas and strategic directions suggested. The convening brought together individuals with diverse educational and professional backgrounds who had the opportunity to engage in a day and a half of cross-sector knowledge sharing that clearly influenced their thinking about the approach the foundation needs to take when developing the SDOH-informed approach. They determined, for example, that there was a need for more research on the iterative relationships between health, wealth, race, and gender. Essentially, the participants are looking to the foundation to support innovative and diverse types of programs and research methodologies that will encourage more cross-sector relationship building, and possibly even developing a framework for this type of an approach.
- **Race, Stress, and Racism:** Also aligned with the intersectionality theme was the focus on the interconnectedness of race, stress, and racism. During the convening, participants discussed the puzzling incidences of rising racial disparity among individuals at higher levels of social economic status. In order to address this dichotomy, they felt that the foundation could support expanding the ways we think about and study traditional and social determinants of health. For example, understanding that Education is a major indicator of health outcomes, participants thought that more research was needed to determine how structural and institutional racism impact, and are impacted by education.
- **Life Course and Cumulative Risk:** The participants felt that more value and importance should be placed on considerations about individual experiences over the life course, as well as the cumulative risk over a lifetime of inequities. While there is a lot of research about impacts of inequities on individuals at different segments within their lifetime, the collective impact of those inequities is rarely studied.
- **Lived-Experiences:** Another key discussion point that emerged in the convening was the fact that the type of research that tends to be lifted up the most is usually based in quantitative data. Participants felt that placing more value on qualitative data, and in particular lived- experiences, could bring more depth and understanding to the work being done around racism and is resulting inequities.

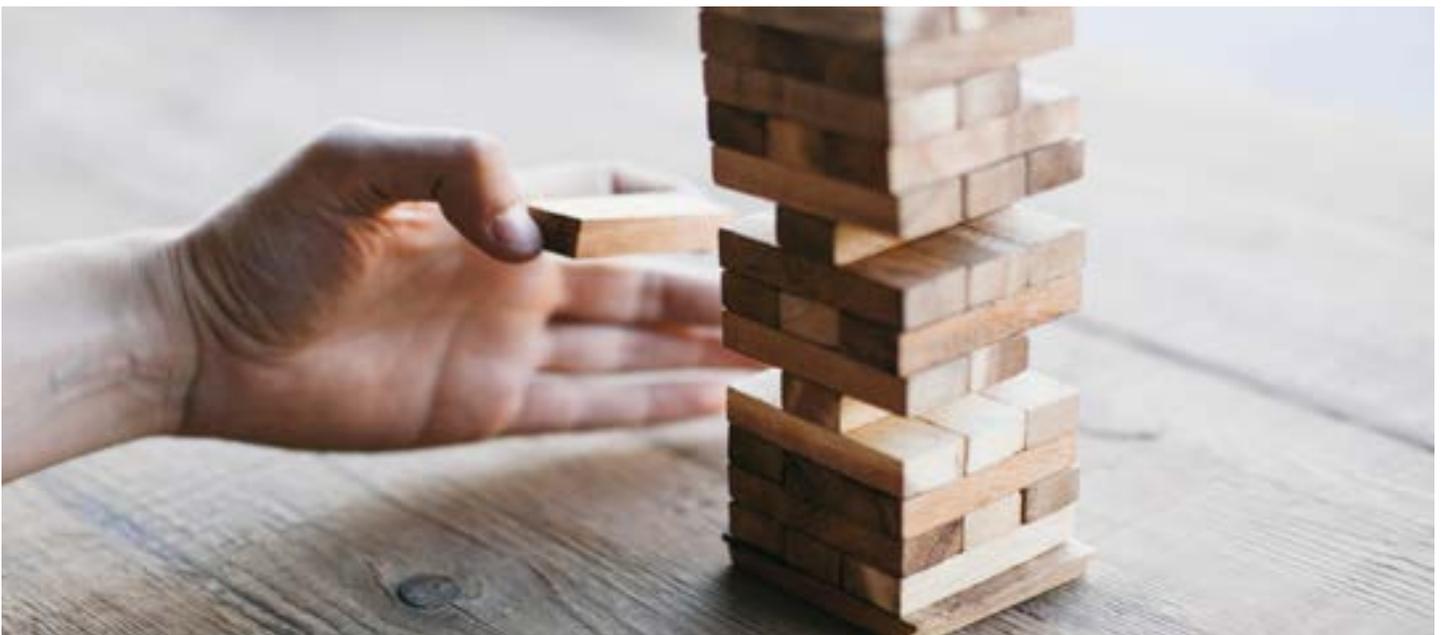
Although these issues have been broken out as key issues, they are all aligned and connected to each other. In addition, the foundation has demonstrated that its work is already tied to these themes; the participants asked for an expansion in the thought process and reach of this work.

## More Discussion

The participants thought that the foundation could potentially invest in some of the following options and incorporate them into their current work. However, these priority areas and strategic directions would require

further conversation and development in order for the foundation to determine how they could integrate the suggestions into their current portfolio.

- **Community Development/Financial Supports:** Incorporated in this theme are the participants' requests that the foundation (1) support financial literacy and routes to wealth programs and priorities, (2) fund innovations that elevate opportunity and outcome for minority populations, (3) support housing with services, particularly for neglected populations, and (4) re-think community development investments. While some of the foundation's work has probably touched on many of these issues, they have been treated more like associated services rather than given direct focus of the foundation's investments. These suggestions will require a lot more discussion about how they could be incorporated into the foundation's community-based work as well as how the foundation would define its role.
- **Interdisciplinary Research:** While the foundation does devote a lot of its resources into research, the priority areas and associated strategic directions incorporated in this theme speak more to how these investments are made. For example, the participants asked for the foundation to invest in the development of an innovative inter-disciplinary project that considers simultaneously how the social determinants of health intersect to produce health and equities. This is of course aligned with the intersectionality theme in the Easy Lift section, but will require the development of this specific approach.
- **Community Participation:** While the foundation has included community members in their programs, they have not typically engaged them in the initial groundwork for these programs. This request asks for the foundation to place community members and social scientists at the forefront of developing the narrative and hypothesis for agendas and strategies, to understand and address the implications of racism. This could be viewed in part as a reaction—one that was justified—to the minimal representation of community members at the convening. There was a very strong message that moving forward, any work that the foundation does related to racism should be influenced by community.



While these suggestions are innovative, they would require more discussions to flesh out what they would encompass and how they could be implemented. Additionally, the foundation would need to be clear about their role in the execution.

## Hard Conversations

The suggestions in this section can be summed up in one word: Reparations. There were significant conversations (particularly in the wealth and occupation/employment focus areas) around supporting efforts to address inequities among the descendants of African slaves and disenfranchised Native Americans through reparations. The participants who put forth these suggestions felt that through proper education, a better case could be made to validate an approach that has typically been dismissed as complicated and explosive.

The following are areas where they felt the foundation's influence could be most useful:

- Commission a high-profile, selective study group to produce a report on the issues (related to reparations)
- Mobilize an uncompromising social movement campaign and lobbying effort that includes economists, political scientists, communications experts, global allies, and colleges/universities (e.g., Georgetown and Brown University)
- Support the design of a fully developed program for reparations.

Reparation is an extremely difficult topic in and of itself, and it would be even more challenging to create a program or effort based on this issue. This is specifically because it tears open the scabs of wounds inflicted from slavery and the Jim Crow era that are still yet to be healed. To date, any conversations about rectifying the impacts of structural and institutional racism, particularly those involving reparations, have been polarizing and divisive at best. The foundation would have to dig deep to first make a decision about initiating these conversations and then decide if and how it would determine its role and responsibilities in such an endeavor.



## Developing the Social Determinants of Health Approach

As the foundation contemplates these suggested priority areas and strategic directions, it is important to revisit the initial goal of this project, and that is to create a SDOH-informed approach towards building a Culture of Health. While this report provides a lot of information to consider, there is still more to be gathered, synthesized, and incorporated. This approach should be viewed as a circuitous and iterative process that continues to evolve as the foundation applies the knowledge it gains throughout this process. Even as the foundation solidifies its plan to incorporate these suggestions, these steps should be revisited routinely to ensure that the approach continues to integrate the lessons learned from the social determinants of health framework and the experiences of the experts and practitioners in the various fields.

It is therefore important to outline and understand in a very basic way the components that are critical to developing this approach:

### Foundation

- **Porous Silos:** To support the sharing of information across the determinants, the foundation should facilitate and build more cross-sector and inter-disciplinary relationships that could lead to more insights about the production of inequities, their impact, and how they should be addressed.
- **Research & Data:** While this is an easy lift for the foundation, there still needs to be a shift in the investments into more, diverse data collection and analysis that takes into consideration factors such as populations that are inadequately researched, as well as the impact of intersectionality.

### Building Blocks

- **Translation:** It is extremely important to demonstrate how the social determinants of health approach informs and supports the Culture of Health Framework, which will ultimately lead to the desired outcome: health equity.
- **Narrative:** Contiguous to translating the data is “making the case,” which involves determining the voice and strategy for this narrative to be communicated on multiple levels (i.e., individual, societal, institutional, and community).

### Infrastructure

- **Implementation Plan:** The foundation must determine and establish goals, objectives, activities, roles, and responsibilities for this SDOH-informed approach that should include securing buy-in from various stakeholders.
- **Action & Evaluation:** As the foundation implements this approach, it is important to evaluate its success and re-calibrate by conducting periodic reviews of the foundation and building blocks of this process.





## Suggested Next Steps

Given the enormity of this process, the following are suggestions for some initial immediate steps to follow up on the June 2016 convening that would help the foundation begin moving towards the goal of developing this SDOH-informed approach.

- 1. Plan a Series of Convenings:** The June 2016 convening served to bring many ideas and thoughts to the foundation and initiated the development of priorities and strategic directions. While fruitful, a lot more collaborative work will be required to truly flesh out and streamline the suggestions to determine which strategies would be most useful to the foundation's cause. This series of convenings should be an integral part of the developing the SDOH-informed approach and will ensure that the foundation can solicit and receive feedback throughout the development process.
- 2. Incorporate Community Participation:** Although the June 2016 participants were quite diverse given the small size of the group, there is clearly a need for more community-based inclusion in these conversations. The first task should be to define "community" for this activity, as well as determine scope of their input and feedback. In addition, the foundation should seek out individuals and organizations who are not part of the "choir," as those community members will provide them with the best information about how to create the most universally-accepted messages that support a Culture of Health. It is important to note that including community members in this process will require a significant investment in planning time and effort to secure their involvement in the convenings or specific assignments.
- 3. Address the Gaps:** While several topic areas were covered in the convening, certain significant factors that impact equity and health outcomes were not discussed at all or in enough detail. Some of the comments gleaned from the convening's evaluation process indicated that participants felt there needed to be additional components and discussions to generate more comprehensive solutions. While they were touched on during the convening, these are some critical areas that participants felt needed to be explored before finalizing an SDOH-informed approach:
  - Public Safety/Criminal Justice System
  - Transportation
  - Gender
  - Technology
  - Media/Communications

## Conclusion

The convening brought together several experts who outlined for the foundation a path that could be used to leverage lessons learned from the intellects and practitioners in the field. That said, these concepts serve only as the basis for an effort that requires additional discussion and refinement so that they may be used to support the larger effort. We hope that this report provides a framework for tapping into these resources and creating a comprehensive social determinants of health approach that provides reinforcement for the foundation's Culture of Health infrastructure.



## **LIST OF APPENDICES**

- ▶ I. Environmental Scan
- ▶ II. Convening Agenda
- ▶ III. Participant Directory
- ▶ IV. Convening Working Definitions
- ▶ V. White Papers
- ▶ VI. Post-it Notes Exercise Results

# ENVIRONMENTAL SCAN



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## Leveraging the Social Determinants to Build a Culture of Health ENVIRONMENTAL SCAN REPORT

### GENERAL SDOH Resources

Title	Brief Description	Scan Category
<a href="#">Why violence is so contagious</a>	How violence spreads, and how we can stop it. What does being male and having a history of suicide have in common with being a mass murderer? Research on the brain and into violent behavior suggests that exposure to violence either through media or personally is an important factor. Researchers/people who study violence explain recurrence of patterns; they use a simple metaphor, “That violence is contagious and spreads like a disease.”	RP
<a href="#">How Changeable Is Gender?</a>	The narrative about gender is that it is a “social construct;” one can shift from one gender to another and end up with his/her “true identity.” The Journal of Neuroscience states people who identified as transsexuals and wanted a sex reassignment had structural differences in their brains between desired gender and genetic sex. Dr. Kranz has possibly found mismatch between gender identity and physical sex. Transgender people’s brains are structurally different from males and females who are non-transgender. Others theorize the transgender experience might arise from a “quirk of brain development.” Outcome studies suggest that gender reassignment does not give everyone what they really want, or makes them happier. Researchers controlled for baseline rates for depression and suicide – known to be higher in transsexuals; found elevated rates of depression and suicide after sex reassignment.	RP
<a href="#">Being Black Is Bad for Your Health</a>	Seeking health equity in the US; the goal – ensure all people have access and means to live healthy lives. The truth, being a Black person in America – No matter your economic status – it is bad for your health. Researchers use “excess deaths” to explain sad facts if Blacks and Whites had same mortality rate, approximately 100,000 fewer black people would die each year in America. Matching educated African Americans with White peers, they are sicker and die younger than educated White peers; will live three fewer years than Whites with the same income.	T
<a href="#">Website Meant to Connect Neighbors Hears Complaints of Racial Profiling</a>	Nextdoor.com is a website intended to be a virtual neighborhood hangout for the tens of thousands of neighborhoods and hundreds of local police departments that use it to communicate with residents. The social network is testing ways to prevent postings that have led Blacks and Latinos to be seen as suspects in their own neighborhood. However, people still	T

Category Legend:

Gaps/Issues for further Research (G/IFFR); Best Practices/Models That Work (BP/MTW); Trends (T); Public Opinion Polls (POP); Research Polls (RP)



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	use the network to report suspected crimes. Attitudes and actions must change in order to end racial profiling.	
<a href="#">Proof Pilot</a>	The pace of innovation in community health and wellness is such that traditional academic and professional evaluators can't keep up. And, the costs of traditionally run evaluations are beyond the resource availability of all but the most well-funded programs. Therefore, very few evaluations get done. ProofPilot is an online platform that makes it as easy to design, launch, manage and participate in randomized controlled trials and longitudinal outcome studies as it is to manage a blog. The end goal of ProofPilot is to give tools to organizations that haven't been able to run these kinds of studies in the past.	T

### SDOH Focus Area Resources

#### Structural Racism (as a determinant of health)

Title	Brief Description	Scan Category
<a href="#">Darsh Singh: They turned my picture into a racist meme. What happened next is an inspiration.</a>	A racist caption from an online humor site wrongfully identifies a former well-known (Sikh) basketball player as a (Muslim) in a harmful stereotype joke. Friends old and new rallied “around shared values of truth, education, and compassion” and “spoke out against the ignorant meme.”	T
<a href="#">Medical schools don't do enough to fight racism</a>	This article addresses racism in a learning environment, where the student had no recourse because her evaluations would have been in jeopardy. Equity, Diversity, and Inclusion came into play; the author implies that there is great need for this type of training in the medical field. Institutional racism exists in medical learning environments.	T
<a href="#">A Third of Americans Don't Know Their Neighbors</a>	Urban “Think Tank” found that one third of people never spoke/interacted with their neighbors. Forty plus years ago, the percentage was much less with no interactions, while one third of people did interact. Social science and medicine research show that interaction helps health and well-being. Also, it is much easier to stay in touch with people we love through telephone, social media, and other modes of communication; so, it seems less important to reach out to the person next door.	T
<a href="#">Annals of Internal Medicine</a>	This is an essay published to “call out” people in the medical profession, especially trainers and those who are trainees. It is	G/IFFR

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Gaps/Issues for further Research (G/IFFR); Best Practices/Models That Work (BP/MTW); Trends (T); Public Opinion Polls (POP); Research Polls (RP)



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<a href="#">On Being a Doctor: Shining a Light on the Dark Side</a>	<p>the authors hope, and others who participated in this publication, that such an essay will help to ameliorate the disrespectful behaviors, assault, and structural racism from those in higher positions against their patients. The author was teaching a medical humanities course to senior medical students and asked about forgiveness. One student recalls several occasions when patients were sexually assaulted, demeaned while under anesthesia, and racial overtones were used. The hope is that this essay will bring medical educators to the awareness of what really goes on in these institutions and begin to shed light on the dark side of their profession.</p>	
<a href="#">The Privilege of Choice</a>	<p>A 41-year old diagnosed with Type II Diabetes, hypertension, and elevated blood cholesterol...too busy, tired; had many demands on time. The excuses could not continue. Six months later, fortunate enough to have lost 30 pounds, he visits the gym at least five days a week, makes different choices about the food he eats, and takes medication daily. His numbers are now well within the normal range; possibly less. To make a choice, one must have a choice. Are choices made a privilege? His work hours are flexible; allow him to plan week around gym time; employer provides gym membership, which is an employee benefit; he can afford extra monthly charge for childcare while working out; has partner who helps prepare nutritious meals; manages daily tasks of family life; neighborhood has many options; can purchase healthy foods including has large grocery stores, farmer’s markets, and niche markets that specialize in organically grown produce. Cannot cook? He is not stuck with fast foods as only option. He has the ability to run safely in a park, take a leisurely stroll with family; works out using outdoor gyms in addition to the commercial gyms that dot his neighborhood. These are some of the privileges of choice.</p>	G/IFFR
<a href="#">Nixon Aide Reportedly Admitted Drug War Was Meant To Target Black People</a>	<p>"Did we know we were lying about the drugs? Of course we did." Former aide to President Richard Nixon pulls back the curtain on the true motivation of the United States’ war on drugs. John Ehrlichman, who <a href="#">served 18 months in prison</a> for his <a href="#">central role in the Watergate scandal</a>, was Nixon’s chief domestic advisor when the president <a href="#">announced the “war on drugs”</a> in 1971. The administration <a href="#">cited a high death toll and the negative social impacts of drugs</a> to justify expanding federal drug control agencies. Doing so set the scene for decades of <a href="#">socially and economically disastrous</a> policies. The intense racial targeting</p>	RP

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Gaps/Issues for further Research (G/IFFR); Best Practices/Models That Work (BP/MTW); Trends (T); Public Opinion Polls (POP); Research Polls (RP)



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	that's become synonymous with the drug war wasn't an unintended side effect – it was the whole point.	
<a href="#">U.S. police chiefs group apologizes for 'historical mistreatment' of minorities</a>	The president of America's largest police organization on Monday issued a formal apology to the nation's minority population "for the actions of the past and the role that our profession has played in society's historical mistreatment of communities of color."	T
<a href="#">The new book 'The Other Slavery' will make you rethink American history</a>	"It is not often that a single work of history can change the course of an entire field and upset the received notions and received knowledge of the generations but that is exactly what 'The Other Slavery' does." People are enslaved in many ways today, and a flashback of the enslavement of American Indians for the past 500 years can help prove a reality. This book is a "profound" contribution to North American history; we do not have to delve "into history to understand its power."	RP

### Housing and Physical Environment

Title	Brief Description	Scan Category
<a href="#">Creating a Durable Housing Finance System</a>	The report addresses the temporary fixes implemented to support home owners during/after the 2008 financial crisis and makes the case for a more durable approach to fixing the housing finance system.	G/IFFR
<a href="#">Broadband Connectivity in Affordable Housing</a>	NHC – Connectivity Work Group – Discussion was to achieve national goal to reach all Low Income Housing Tax Credit properties with basic/broadband services. Broadband Connectivity will provide economic opportunities and allow residents to move toward self-sufficiency; the achievement of kids in school, businesses reach new markets, and communities build higher skilled workforces.	BP/MTW
<a href="#">NLIHC 2015 - 2016 Public Policy Agenda</a>	Dedicated to federal policy initiatives – achieve socially just public policy; assure individuals with lowest incomes have affordable/decent homes. Goals: preserve existing federally assisted homes and housing resources, expand the supply of low income housing, and establish housing stability as the primary purpose of federal low income housing policy.	BP/MTW
<a href="#">DATA2GO.NYC</a>	NYC Department of Housing and Urban Development – given access to data tools; support to develop interactive data visualization and given opportunity to do demonstrate at the White House. Measure of America empowers community leaders/organizations/families with the user-friendly data	T

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Gaps/Issues for further Research (G/IFFR); Best Practices/Models That Work (BP/MTW); Trends (T); Public Opinion Polls (POP); Research Polls (RP)



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Title	Brief Description	Scan Category
	that gives access to affordable housing, jobs, preschools, and much more.	
<a href="#">We can't forget how racist institutions shaped homeownership in America</a>	Discrimination by race in housing has been a way of life in US society for numerous years. It has been in the DNA of design, development, marketing, and financing of American cities; been promoted by agencies such as real estate boards, neighborhood associations, municipal governments, state and federal courts, mortgage lenders, and others. Distinct neighborhood boundaries have been drawn, people have been denied equal access to markets and places, and there have been ridiculous disparities in wealth, opportunities, and basic quality of life.	POP

### Education

Title (Hyperlinked)	Brief Description	Scan Category
<a href="#">America's Promise Alliance</a>	The organization came about from the Presidents' Summit for America's Future in 1997. It is research/action on helping all youth reach their full potential. It creates conditions for success of all young people, plus millions of those being left behind. Five Promises were set forth; research/data show those who experience at least four were more likely to have successes academically, socially, economically, and civically.	BP/MTW
<a href="#">High School Graduation in New York City</a>	<p>Measure of America – New Report on High School Graduation Rates Released Today</p> <p>On-time graduation depends on community districts; neighborhood influences student's ability to graduate HS in four years. Students from more affluent communities do much better with on-time graduation than do students from lesser affluent communities.</p> <p><b>Findings:</b> More than 95% of students graduate in four years from affluent neighborhoods in NYC. The universal policy of HS choices in the city creates huge benefits, which outweighs costs to students and families.</p> <p><b>Recommendations:</b> City should set time-bound target to cut neighborhood graduation gap, and make necessary changes; more guidance counselors for middle schools, and more good HS options for students, and city should address: a) economic insecurity, b) safe, affordable housing, and c) food insecurity and health challenges.</p>	T

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Title (Hyperlinked)	Brief Description	Scan Category
<a href="#">Socioeconomic Status and Health: How Education, Income, and Occupation Contribute to Risk Factors for Cardiovascular Disease</a>	<p>Discusses the socioeconomic status (SES), measured by income, education and occupation, and how it predicts a person’s mortality and morbidity. A study was conducted to quantify lack of education as the strongest SES measure associated with risk factors for disease. Higher education may be the best SES predictor of good health. However, there are potential limitations to using education as a sole indicator of SES. The question exists of whether degrees or certifications are better measurements/ parameters than years of schooling and the possibility; if other dimensions of SES are more sensitive markers for health in some population subgroups.</p>	RP
<a href="#">Failure to Stimulate Toddlers’ Brains Could Set Them Back for Decades</a>	<p>Figures show that almost 130,000 children a year are falling behind before they reach primary school. These years are a “lightbulb moment” for children and a critical time to develop key skills. Most parents realize the significance of pre-school years as a period of brain development. A new national focus on early learning is necessary to give children the best start in order to tackle the nation’s education gap. In the research, more than half of parents and two-thirds of fathers said they did not get enough help and advice to understand their child’s early learning. There is the notion and misconception that learning can wait, and schools need to be challenged.</p>	RP
<a href="#">How to Graduate More Black Students</a>	<p>The Education Trust is a nonprofit that focuses on improving outcomes for low-income students of color. More black students are graduating from college than a decade ago. More than 50 schools have reduced graduation gaps between black and white students. Black students are often more challenged by serious disadvantages from their earliest years and colleges are being asked to close gaps that they did not directly create. According to the authors, various institutions illustrate that demographics are not destiny and that what colleges do with and for their students play a pivotal role in student success.</p>	RP
<a href="#">White Kids Get Medicated When They Misbehave, Black Kids Get Suspended – or Arrested</a>	<p>Recently, racial discrepancies in American policing has heated up, a subplot has emerged; similar discrepancies in handing out discipline in schools exist. Black students made up just 18 percent of students in the public schools sampled by the <i>New York Times</i> in 2012, but “they accounted for 35 percent of those suspended once,” and 39 percent of those expelled – the Times examined federal data, and noted that “nationwide, more than 70 percent of students involved in arrests or referrals to court are black or Hispanic.” Even Black preschoolers were not exempt. They made up the same 18</p>	G/IFFR

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Title (Hyperlinked)	Brief Description	Scan Category
	<p>percent of the student population. They constituted half of all suspensions.</p> <p>When teachers and children are allowed to learn about each other's different cultural backgrounds and variations, it is possible that common ground may develop. This should not be based on the child's race, gender, ethnicity, or socioeconomic status, but based on a mutual understanding of respect, which fosters a stronger desire for the child who wants to learn and feels as a valued member in his/her class. More research is needed in this topic.</p>	

### Employment/Occupation

Title	Brief Description	Scan Categories
<a href="#">How can we build cities fit for 2036?</a>	<p>Providing adequate and affordable housing is an issue that both the developing and the developed world must address. Virtually nowhere in the US can a fulltime minimum waged employee afford a one-bedroom apartment. Police officers, teachers, hospital workers, and firefighters are being priced out of the very cities that depend on them. When the private, public and social sectors invest in housing, transportation, access to healthy food, education, healthcare, and the like, they help create and support a vibrant workforce and an enabling environment for individuals and businesses to succeed.</p>	T
<a href="#">The Myth of Welfare's Corrupting Influence on the Poor</a>	<p>The belief that government aid for poor people will just encourage bad behavior is deeply ingrained in the American popular imagination. There is little doubt that welfare can discourage employment, particularly when recipients lose benefits quickly as their earnings from work rise. A researcher suggests that, "the spread of welfare aversion around the world might be an American confection." The goal must be to help people move from welfare into work and self-sufficiency.</p>	
<a href="#">Raising the Minimum Wage Is the Key to Improving Mental Health in America</a>	<p>Salary affects much more than buying power or tax status. So suggests a recent study, which states a less costly approach to the improvement of mental health on a huge scale is to raise the minimum wage. In the late 1990s, this was proven in Britain and reported by a British economist and his colleagues, and published in the Journal <i>Health Economics</i>. It is strident and therefore is the moral compelling argument that everyone should be ensured/given the opportunity to earn a living wage.</p>	BP/MTW

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Title	Brief Description	Scan Categories
	Increasing the minimum wage prevents a large number of people from being highly stressed. Good wages provide a preventive benefit, which is the improvement of mental health. Realistically, increase in wages has to be done incrementally and sensibly.	
<a href="#">Why Big Businesses Are Becoming More Progressive</a>	The top financial firms are finally realizing why they should look beyond old white men. Business giants are beginning to stand up for minorities. Approximately 100 companies signed a letter imploring North Carolina’s Governor, Pat McCrory, to repeal the state’s new anti-LGBT law. Other big businesses are taking similar action in other states with similar legislations. “Some of America’s biggest companies are pushing a progressive agenda in the conservative heartland....” There are ventures that aim to illuminate how diversity translates to better performance.	G/IFFR
<a href="#">Why Your Single Minority Candidate Has Statistically No Chance Of Being Hired</a>	A new study found that when companies only interviewed one woman or minority they did not get the job, but luckily there's a simple fix. Diversity initiatives are popping up all over, particularly within technology companies that have a preponderance of white men among executives and staff. Several organizations started by putting measures in place to ensure that new hires were drawn from a more diverse talent pool. A new study from researchers at the University of Colorado aims to show that simply adding one minority candidate to the pipeline does not guarantee a quick fix. In both the NFL and among the tech companies they have tried to use the method; progress has been incremental. Only six of the league’s 32 head coaches are people of color. Studies show that when there is only one woman, she does not stand a chance of being hired; when there were two minorities or women in the pool of finalists, the status quo changed.	G/IFFR
<a href="#">This Interviewing Platform Changes Your Voice To Eliminate Unconscious Bias</a>	Hiring is fraught with unconscious bias, but <a href="#">Interviewing.io</a> aims to change the game at the outset to allow only the skills to shine. Unconscious bias is often hiding in plain sight during the hiring process. Simply by being human, recruiters and managers can fall prey to signals that suggest the candidate is not part of their tribe. Everything from an ethnic-sounding name to checking a gender box on an application can disqualify a candidate at the resume stage, according to several studies. “The way we filter candidates at the very top of the funnel is broken.”	G/IFFR

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### Wealth/Economic Stability

Title	Brief Description	Scan Category
<a href="#">Why Pediatricians Should Screen Their Young Patients for Poverty</a>	Being poor, carries serious lifelong health effects. Learning about children’s lives beyond clinic walls can help doctors provide better care. The author offers up solutions such as Medical-Legal Partnerships but asks who will pay for them.	BP/MTW
<a href="#">Maryland Study Shows Early Childhood Exposure to Medicaid Linked to Better Adult Health</a>	The investment in childhood health could have big payoff in adulthood. UMSPH - <i>Journal of Health Economics</i> states that exposure to Medicaid in early childhood, from conception to age 5 – associated with significant improvements in adult health (age 25 to 54). Health improvement may be linked to early access to healthcare by families who were provided Medicaid.	RP
<a href="#">The Opportunity Project</a>	Open Data Build Stronger Ladders of Opportunity for All – The project is a new open data effort to improve economic mobility for all Americans. It will put data and tools in the hands of civic leaders, community organizations, and families to help them navigate information about critical resources that pertain to the SDOH. Measure of America was honored to take part in this effort to empower local leaders, community organizations, and families with user-friendly data about access to affordable housing, jobs, preschools, and much more.	T
<a href="#">Arkansas governor quietly implements statewide drug tests for welfare applicants.</a>	A Democratic Representative in Arkansas’s House found out “by-the-way” and “after-the-fact” that his state had voted to pass a drug testing program for welfare applicants. Good for him, he voted against such a thing in the vote for the pilot. “He didn’t even realize that a provision inserted at the last minute would give his governor the power to unilaterally expand that project to the entire state.” Other state representatives have found, “that other states that drug test welfare recipients have found incredibly low positive test rates. They have also found that drug testing comes with a big cost – ten states have spent about \$2 million over two years on their programs.”	G/IFFR
<a href="#">Land Grab Duplicity – Pacific Standard</a>	The right-wing land transfer activists are trying to convince the American people that federal public lands belong to the states. To achieve their goal, they are peddling in fiction and deceit. The land transfer movement is made up of extreme conservative legislators, industries, and Koch network operatives...are in resurgent mode. Their goal is to put a majority of our country’s 600 million acres of federal public land, with their eye-popping mineral wealth and scenic	T

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Title	Brief Description	Scan Category
	splendor, into the hands of state governments ruled by right-wing ideologues. Much of the land would likely fall prey to the oil and gas, ranching, and other heavyweight industries. They plan to get rid of public lands and turn them over to the states that can be coerced, unlike the federal government; eventually they will be owned by private ownership.	
<a href="#">The law was supposed to reduce discrimination. But it made hiring more racially biased.</a>	<p>Should employers be allowed to look at your credit history? The unintended consequences of policies and how things don't always go as planned: Have bad credit? Good luck finding a job. According to a <a href="#">2012 survey</a>, 47 percent of employers said they run credit checks on applicants. Many hiring managers believe that a troubled financial history signals untrustworthiness, or a defective work ethic, so they weed out job-seekers with stains on their credit reports. Studies find little evidence that possessing a clean financial record has anything to do being a good worker. Medical debt, not credit card debt, is the <a href="#">top reason</a> that people file for bankruptcy. When employers regularly reject applicants bearing the scars of financial distress, poverty becomes an airtight trap. One of the hottest ideas among lawmakers is to ban employers from running credit checks on job applicants. Chicago, New York City and eleven states have passed such laws. Supporters of these restrictions often frame the issue as a civil rights problem....credit checks impede employment among minorities who disproportionately <a href="#">have low credit scores</a>.</p>	T

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# CONVENING AGENDA

## Leveraging the Social Determinants to Build a Culture of Health

June 1 – 2, 2016 | Hilton Philadelphia at Penn's Landing

### AGENDA

#### Convening goals:

1. Share expertise, research, and tools that may inform the foundation's future work.
2. Identify gaps in research and best practices that the foundation should address.
3. Develop potential priority areas and strategic directions that will help catalyze the Culture of Health framework among communities and their leaders.

#### June 1 – Wednesday (Riverview A)

3:30p – 4:00p	Registration Opens ( <b>Riverview AB</b> )
4:00p – 4:30p	Welcome & Overview
4:30p – 5:00p	Grounding/Why Are We Here?
5:00p – 6:00p	White Paper Overviews
6:00p – 6:15p	Closing/Wrap Up
6:15p – 8:00p	DINNER
8:00p	ADJOURN

#### June 2 – Thursday (Riverview B)

8:00a – 8:30a	Breakfast	11:05a – 12:00p	Future Culture (by Sector/Determinant)
8:30a – 9:00a	Grounding	12:00p – 12:30p	LUNCH
9:00a – 9:45a	Unpacking Culture and Readiness	12:30p – 1:00p	Priority Areas
9:45a – 10:15a	Readiness for Culture Change	1:00p – 2:30p	Strategic Directions
10:15a – 10:30a	BREAK	2:30p – 2:45p	BREAK
10:30a – 11:05a	Current Culture (by Sector/Determinant)	2:45p – 4:15p	Group Report-outs
		4:15p – 4:30p	Closing
		4:30p	ADJOURN

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June 1 – 2, 2016 | Hilton Philadelphia at Penn's Landing  
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# CONVENING WORKING DEFINITIONS



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## Leveraging the Social Determinants to Build a Culture of Health June 1 – 2, 2016 | Hilton Philadelphia at Penn's Landing

### WORKING DEFINITIONS

- **Community:** A group of people who share some or all of the following: socio-demographics, geographic boundaries, sense of membership, culture, language, common norms, and interests (CommonHealth ACTION adapted from Centers for Disease Control and Prevention [CDC], n.d.).
- **Community Capacity:** The interaction of human, organizational, and social capital existing within a given community that can be leveraged to solve collective problems and improve or maintain the well-being of a given community. It may operate through informal social processes and/or organized efforts by individuals, organizations, and the networks of association among them and between them and the broader systems of which the community is a part (Chaskin, 1999).
- **Culture:** An integrated pattern of learned core values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and worldview, are not visible (California Endowment, n.d.).
- **Disproportionality:** Over- or under-representation of a particular group or race in a public system (e.g., the child welfare or criminal justice systems) compared to their representation in the general population (CommonHealth ACTION).
- **Diversity:** The collective mixture of differences and similarities that includes individual and organizational characteristics, values, beliefs, experiences, backgrounds, and behaviors. It encompasses our personal and professional histories that frame how we see the world, collaborate with colleagues and stakeholders, and serve communities (CommonHealth ACTION, adapted from Washington State Human Resources, n.d.).
- **Environmental Change:** A physical or material change to the economic, social, or physical environment (CDC, 2010).
- **Equal:** 1) Of the same measure, quantity, amount, or number as another. 2) Regarding or affecting all objects in the same way (Merriam-Webster, n.d.).
- **Equality:** Equal treatment that may or may not result in equitable outcomes (Xavier University, n.d.).
- **Equity:** Providing all people with fair opportunities to attain their full potential to the extent possible (CommonHealth ACTION, adapted from Braveman and Gruskin, 2003).
- **Equity Lens:** The lens through which you view conditions and circumstances to assess who experiences benefits and who experiences burdens as the result of a program, policy, or practice (CommonHealth ACTION).
- **Health Equity:** Providing all people with fair opportunities to attain their full health potential to the extent possible (Braveman, 2006)



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- **Implicit Bias:** Attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. These biases, which encompass both favorable and unfavorable assessments, are activated involuntarily and without an individual's awareness or intentional control (Kirwan Institute, n.d.).
- **Inclusion:** Active, intentional, and ongoing engagement with diversity, including intentional policies and practices that promote the full participation and sense of belonging of every employee, customer, or client (CommonHealth ACTION, adapted from Riggs, 2012 and Xavier University, n.d.).
- **Inequity:** A difference or disparity between people or groups that is systematic, avoidable, and unjust (CommonHealth ACTION, adapted from CDC n.d.).
- **Intersectionality:** The interaction between gender, race, and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies and the outcomes of these interactions in terms of power (Davis, 2008).
- **Isms:** Systems of privilege and oppression based on social identities, including but not limited to: race (racism), sex (sexism), class (classism), age (ageism), ability (ableism), and sexual identity (heterosexism). All are rooted in doctrines of superiority and inferiority; find systemic expression in individual, institutional, as well as cultural forms; and function through the dynamics of power and privilege. These common elements are often expressed in the equation  $PREJUDICE + POWER = OPPRESSION$ . Systems of privilege and oppression are not discrete and are experienced in interactive and overlapping ways (CommonHealth ACTION, adapted from Xavier University, n.d.).
- **Oppression:** The systematic targeting or marginalization of one group by a more powerful group for the social, economic, and political benefit of the more powerful group (OpenSource Leadership Strategies, n.d.).
- **Perspective Transformation:** The process of becoming critically aware of how and why our assumptions have come to constrain the way we perceive, understand, and feel about our world; changing these structures of habitual expectation to make possible a more inclusive, discriminating, and integrating perspective; and, finally, making choices or otherwise acting upon these new understandings (Mezirow, 1978).
- **Policy:** A law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions (CDC, n.d.).
- **Power:** Access to resources and to decision-makers as well as the ability to influence others and to define reality for yourself and potentially for others (OpenSource Leadership Strategies, n.d.).
- **Practice:** The direct application or use of knowledge or skills specific to a particular profession or job (CommonHealth ACTION, n.d.).



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- **Prejudice:** A judgment or opinion, usually but not always negative, formed on insufficient grounds before facts are known or in disregard of facts that contradict it. Prejudices are learned and can be unlearned (CommonHealth ACTION, adapted from American Medical Students Association, n.d.).
- **Priority Area:** An action or activity identified as a potential solution that is given precedence over others based on its value and/or impact (i.e., the “what”) (CommonHealth ACTION, 2016).
- **Privilege:** When one group has something of value that is denied to others simply because of the groups they belong to, rather than because of anything they have done or failed to do. Dominant group members may be unaware of their privilege or take it for granted. (McIntosh, 2000).
- **Program:** A specified set of activities combined according to precise guidance in order to achieve a specific purpose (National Institute of Justice, n.d.).
- **Race:** Race is socially constructed way of grouping people, based on skin color and other apparent physical differences, which has no genetic or scientific basis. This social construct was created and used to justify social and economic oppression of people of color by Whites. An important thing to note is that while race is a social construct with no genetic or scientific basis, it has real social meaning (Boston Public Health Commission).
- **Racism:** 1) A belief that race is the primary determinant of human traits and capacities, and that racial differences produce an inherent superiority of a particular race (Merriam-Webster). 2) Racism = Race prejudice + the misuse of power in systems and institutions (The People's Institute for Survival and Beyond, n.d.).
- **Readiness:** The degree to which individuals or entities are prepared to take action on an issue. It is issue-specific, measurable, may be increased over time, but it can vary across dimensions and sectors. Readiness is essential to the successful development of strategies and interventions (adapted from the Tri-Ethnic Center for Prevention Research).
- **Strategic Direction:** A course of action that leads to the achievement of specific goals (i.e., the “how”) (adapted from [www.businessdirectory.com](http://www.businessdirectory.com), n.d.).
- **Systems Change:** Change that impacts all elements, including social norms of an organization, institution, or system; may include a policy or environmental change strategy. Policies are often the driving force behind systems change (CDC, 2010).



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# WHITE PAPERS

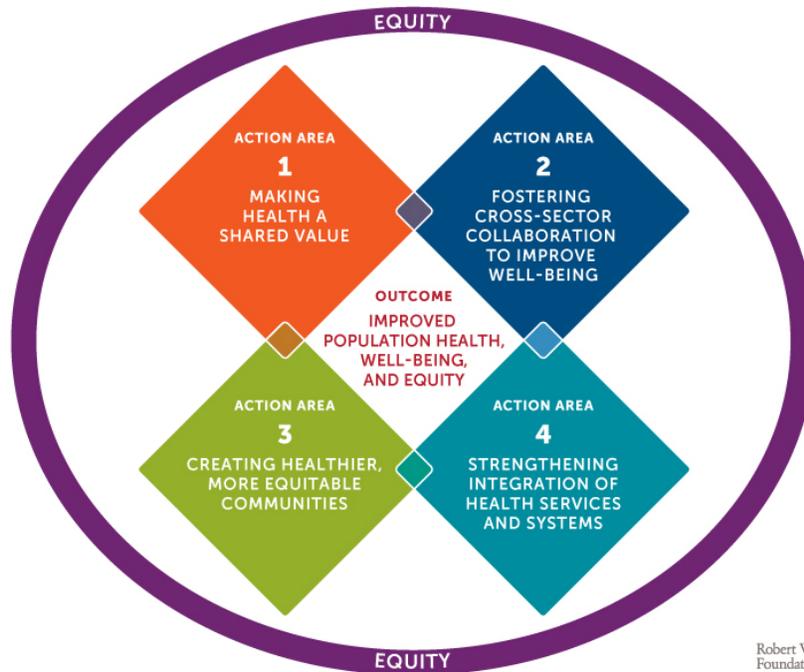


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## Leveraging the Social Determinants to Build a Culture of Health

June 1 – 2, 2016 | Philadelphia, PA

### CULTURE OF HEALTH ACTION FRAMEWORK



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### *Pre-Convening Reading*

## WHITE PAPERS

- Racism as a Social Determinant of Health Inequities
- Education and Health: Complexities, Challenges, and Priorities
- Housing as a Social Determinant of Health
- Socioeconomic Determinants of Health with an Emphasis on Occupation and Wealth

## OVERVIEW

Since 2008 when the *Robert Wood Johnson Foundation (RWJF) Commission to Build a Healthier America (The Commission)* began its work exploring the social determinants of health, or those socioeconomic factors outside of medical care that impact health, The Commission and RWJF have provided an array of resources that have informed both the work of the Foundation and various stakeholders across health and health care. Along with seminal reports, such as *Beyond Health Care* and *Time to Act*, The Commission produced several series of issue briefs on the social determinants of health.

As RWJF advances in its directive to promote a Culture of Health, it remains necessary to continue to explore the social determinants of health in order to move toward health equity, a core component of the Culture of Health framework. As such, RWJF and CommonHealth ACTION (CHA) are collaborating to host *Leveraging the Social Determinants to Build a Culture of Health*, a convening to be held June 1-2, 2016 in Philadelphia, PA.

By bringing together stakeholders in health and health care whether they are from non-profit organizations, community-based organizations, colleges and universities, or philanthropy, RWJF and CHA aim to spark dialogue and cultivate ideas that will inform an action agenda that addresses the social determinants of health while moving toward health equity, and ultimately, a Culture of Health.

A subset of the stakeholders and subject-matter experts invited to the convening were asked to develop white papers across topics in the social determinants of health that would build on the prior work of The Commission and help set the stage for the convening. The researchers drew upon their expertise to write papers that examined the current landscape across social determinants such as racism, education, housing, occupation, and wealth/economic instability. They also explored several emergent areas within the social determinants of health with a focus on health equity and provided recommendations for how to develop an action agenda that could contribute to promoting a Culture of Health.

We present this set of white papers to you as a participant of the *Leveraging the Social Determinants to Build a Culture of Health* convening with the expectation that the papers will help set the stage for the engaging and thought-provoking discussion we have planned for you in Philadelphia. We look forward to hearing your thoughts and perspective as we partner on this important work.

A Robert Wood Johnson Foundation Convening

**Leveraging the Social Determinants to Build a Culture of Health**

June 1 – 2, 2016 | Philadelphia, PA

**Racism as a Social Determinant of Health Inequities**

By:

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## INTRODUCTION

According to Healthy People 2020, our nation's health planning document, *health inequities* are related to “historical and contemporary injustices.” Accordingly, achieving health equity requires that we examine and dismantle the social systems that produce injustice, such as racism.(1-3) A vast and growing body of research consistently shows that racism is a social toxin that is not only morally unacceptable, but potentially lethal.(4-6)

## EVIDENCE LINKING RACISM AND HEALTH

Racism is a system of beliefs and practices that serves to reinforce the power and well-being of whites at the expense of people of color.(7) One visible manifestation of racism is hate crimes. In 2014, the Federal Bureau of Investigation (FBI) reported over 5,479 hate crime incidents, with the majority of these incidents (57%) attributable to racial or ethnic bias.(8)

Yet, federal hate crimes statistics typically underrepresent the actual count of such events since most crimes are not reported to authorities or processed as acts of racial bias. Moreover, hate crimes are only just one form of racial bias. Indeed, a 2015 poll found that an overwhelming 91% of Americans felt that racism remained a problem in the U.S. and that 49% described it as a “big problem.”(9)

An important discovery in the scientific literature is that even small and subtle acts of racial bias, such as being treated with less respect due to one's race, can lead to a large host of health problems.(10) These ongoing and mundane experiences of discrimination are associated with increased risk of health problems such as heart disease, clinical depression, low birth weight infants, poor sleep, obesity, and even mortality.(11-14) The link between experiences of discrimination and illness has been documented among a variety groups,

including African Americans, Arab Americans, Asian Americans, Latinos, and Native Americans.(12, 15-18) Such findings are also seen in other countries, including Australia, Brazil, Japan, and South Africa.(19-22)

Why might racism make people sick? First, racism may hinder one's educational attainment, impede the ability to seek gainful employment, and diminish potential wages.(23) The erosion of these socioeconomic resources may in turn contribute to health outcomes.

Another mechanism by which racism influences health appears to be stress.(24) When stressors are experienced repeatedly, they can contribute to "allostatic load," defined as the "wear and tear" on the body systems, which then lead to a variety of health problems.(25) Experiences of racism are associated with biomarkers of stress, such as cortisol and c-reactive protein.(26, 27) Further, a recent neuroimaging study suggested that discrimination is also associated with the areas of the brain that process social exclusion.(28)

Experiences of racism may also trigger coping mechanisms. Some of these are helpful, such as when people go to church or receive social support from friends. Some of these coping behaviors can also be harmful. Indeed, discrimination is associated with greater use of alcohol, tobacco and other drugs, and risky sexual behaviors.(29, 30) Discrimination may also contribute to avoidance behaviors, such as when patients decide to forgo medications or seek alternative therapies to avoid encountering bias.(31-33)

It is important to recognize, however, that individual experiences of racism are only the "tip of the iceberg" (Figure 1).(34) Below the tip sits a broader foundation of structural racism that is far more difficult to observe, but probably even more important with regard to shaping the well-being of racial minorities.

Structural racism includes the basic operations and norms of a society that serve to maintain a racial hierarchy. These include: segregation of schools, neighborhoods, and workplaces, redlining practices by lending institutions, negative portrayals in the media, mass incarceration, voting restrictions, immigration policies, and many others.(7, 35) The health literature has focused primarily on racial residential segregation. Racially segregated neighborhoods often have greater exposures to environmental toxins, lower tax bases, fewer jobs, and fewer services, such as hospitals.(36, 37) One study estimated that residential segregation was attributable to 176,000 excess deaths in 2000.(38) Other indicators of structural racism have also been associated with illness, including living in areas suffering from redlining by lending institutions, or areas with greater racial animus, as indicated by living in areas with a relatively higher preponderance of racist tweets as compared to other communities.(39-41)

## **WHAT WOULD HEALTH EQUITY LOOK LIKE IN A SOCIETY FREE OF RACISM?**

Health inequities could be considered a marker of the health of race relations. Supposing this is true, then completely eradicating racism would likely dramatically decrease health disparities across racial/ethnic groups. This a very difficult task, however, that goes far beyond sensitivity trainings and diversity initiatives. As long recognized, the elimination of individual prejudicial attitudes and stereotypes would not solve racial inequities because the structural forces that perpetuate racism would remain untouched.(7) Thus, any efforts to eliminate racism must attend to the multiple levels of racism, not simply a single level.(42)

Although it is a difficult task to fix the structural roots of racism, there are reasons to be optimistic. For example, Almond, Chay, and Greenstone noted that the racial disparity in

postneonatal mortality plummeted after the passage of the 1965 Civil Rights acts mandate to desegregate hospitals, resulting in the survival of over 5,000 African American infants in the following decade in the rural south.(43) This analysis did not consider other health outcomes, and it is likely that this study underestimated the potential health benefits of such legislation.

## **OPPORTUNITIES AND CHALLENGES**

Grassroots organizing of local communities has often been at the heart of civil rights activities. Many of these local activities then blossomed into larger initiatives. A good example comes from the area of redlining. Even with the de jure eradication of residential segregation after 1965, many minority communities were thwarted in their attempts to redevelop their communities and to integrate neighborhoods. This is because poor and minority residents were unable to obtain mortgages due to redlining practices by banks. This problem was voiced by local residents in Chicago and elsewhere, which then contributed to a national movement that led legislation such as the Home Mortgage Disclosure Act in 1975 and the Community Reinvestment Act in 1977.(44, 45)

Movements are also happening today with regard to the Black Lives Matter and related organizing efforts.(46) Contemporary organizing is not only happening on the streets, but also in cyberspace. Despite the change in medium, the effects are similar.(47, 48) Individuals are sharing their stories and finding that their experiences are not unique. Moreover, these movements are intertwined with other movements, so that community groups are not only recognizing issues within policing, but other arenas, such as in media representations. Thus, recognizing that racism spans multiple boundaries leads to the strong opportunities for cross-sector collaborations. Collaborations between local community

members, and allies in various sectors, including health and related disciplines, would provide synergies that could benefit all groups.

## **PRIORITY AREAS FOR DEVELOPMENT OF AN ACTION AGENDA**

1. Develop new methods for understanding structural and institutional racism. Much has been learned about interpersonal experiences with racism and health, but much less is known about the role of structural racism.(35, 49, 50) To an extent, the literature has studied segregation, but understudied other forms of structural racism (e.g. mortgage redlining, policing, mass incarceration). In addition, there are yet many untapped forms of institutional discrimination (e.g. within the legal system) that could be further developed conceptually and methodologically within a health equity framework.

2. Consider more fully the role of racism over the life-course. As individuals age, they encounter new social institutions that provide new contexts for racism, such as when young adults exit school and enter the workforce.(51) Research on racism and health must attend to such dynamic change seriously.(52)

3. Attend to cumulative risk. The phrase, “cumulative risk,” usually denotes the increased potential harm that occurs when humans encounter multiple environmental toxicants simultaneously, such as lead, mercury, and arsenic. The idea is also useful for consideration of racism, where we can examine the potential increase in morbidity that occurs when racial minorities encounter everyday discrimination, residential segregation, and occupational segregation *simultaneously*. Relatively little has been done in this regard, but understanding how these exposures may act synergistically should be a high priority. For

example, although research has focused on occupational and residential segregation separately, it is unknown how occupational and residential segregation may act together to produce health inequities.

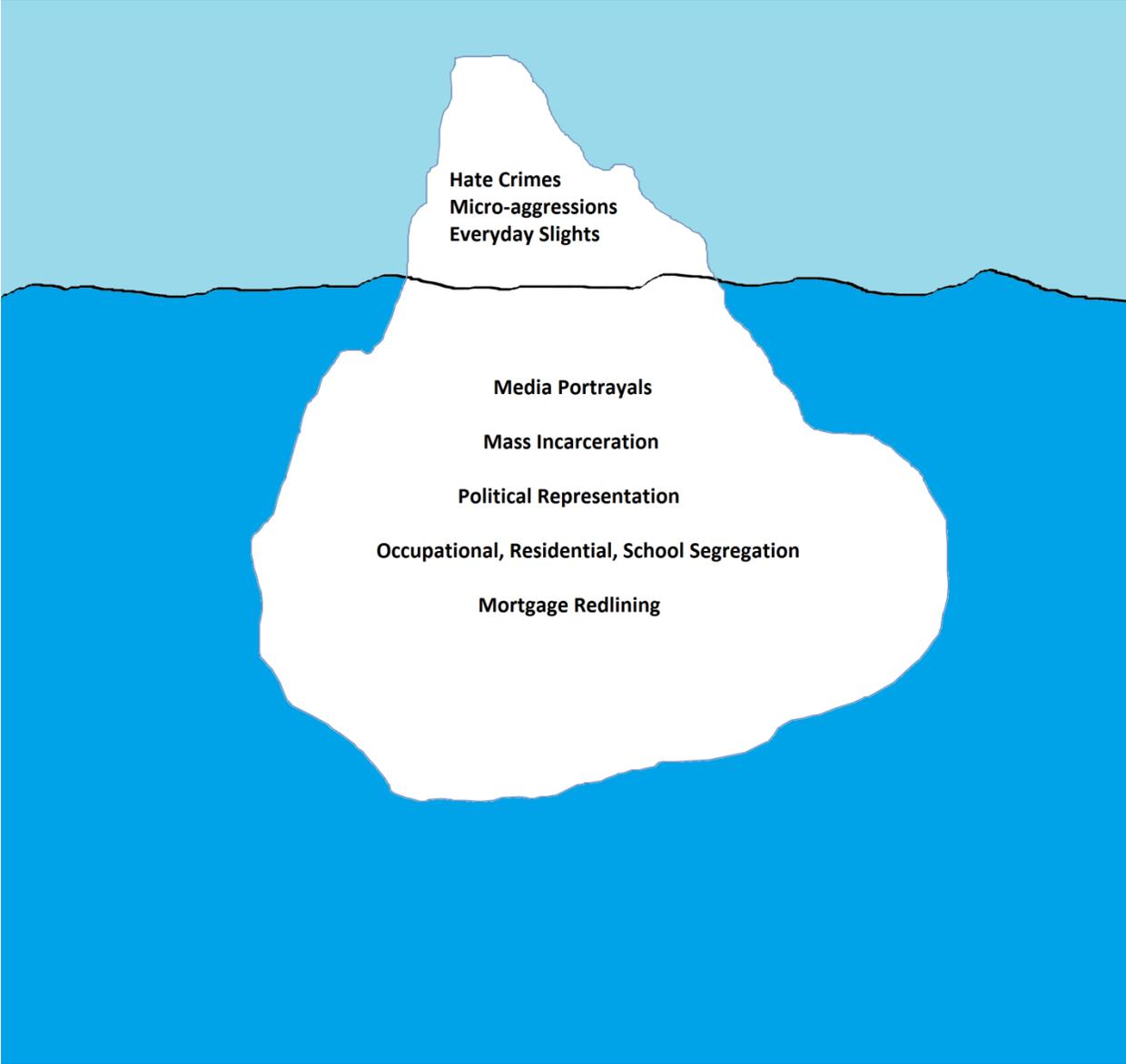
4. Recognize intersectionality. Intersectionality recognizes that experiences of racism are not uniform across social groups, but instead, are contextualized by gender, immigration experience, social class, and many other factors.(53) Numerous accounts denote, for example, how the experiences of racism faced by Black women differ from those of Black men.(54) An emerging literature shows that possession of multiple types of social disadvantages is related to illness.(55) However, this is just the beginning. Intersectionality gets increasingly complex as we begin to recognize other dimensions, such as sexual orientation, age, and social class. We need to strengthen our theoretical understanding of intersectionality and continue to develop the empirical research towards understanding how intersectionality may be related to health inequities.(56)

## **CLOSING**

Racial health inequities have remained entrenched over time and often seem to be intractable. Racism appears to play a key role in generating these inequities. Accordingly, there are good reasons to suspect that health inequities would dramatically decline should we find ways to create a Culture of Health that includes a mandate to foster civil rights and eradicate racism. These actions could include the expansion of new ways to understand and monitor multiple forms of oppression, and further welcome sustained participation by diverse stakeholders. The Civil Rights Act recently passed its 50<sup>th</sup> anniversary, and the actions of that era have resulted in profound changes to the well-being of diverse

communities. Nonetheless, much work remains to fully achieve the vision of full and equal participation of all members of society, and to develop a Culture of Health equity.

Figure 1. The Racism Iceberg (adapted from Gee, et al., 2007).



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**Leveraging the Social Determinants to Build a Culture of Health**

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**Education and Health: Complexities, Challenges, and Priorities**

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Just a few decades ago, most Americans thought that too many people went to college.<sup>1</sup> Today, most Americans view a college education as the key to finding a good job and achieving a middle class lifestyle.<sup>2</sup> This shift in Americans' beliefs has occurred over a period that saw college tuition rise faster than the rate of inflation<sup>3</sup> and government investment in education decline.<sup>4</sup> Though Americans recognize education's importance for employment and income, its importance for health is less commonly known among the American public.

Population health researchers, however, have spent decades documenting the links between education and health. In general, they find that with increasing education, U.S. adults experience more favorable health across a range of outcomes, including lower risk for infant mortality,<sup>5</sup> disability,<sup>6</sup> obesity,<sup>7, 8</sup> depressive symptoms,<sup>9</sup> and cardiovascular disease,<sup>10</sup> as well as better self-rated health<sup>11</sup> and greater longevity.<sup>12-14</sup> The reasons for this education-health link include increased knowledge and coping skills, social support, and engagement in behaviors deemed healthy.<sup>15</sup> Highly educated adults are also more likely to be employed and earn more money, and are less likely to experience chronic stress – such as financial difficulties or prolonged illness – than less educated adults.<sup>16</sup>

The pattern by which more education is associated with better health is often referred to as the *educational gradient* and it is one of the most consistent relationships documented in the health literature.<sup>16</sup> Yet, not everyone in the United States equally experiences the health benefits of education. White men are often more able to translate their education into positive health than are racial/ethnic minorities or women, though the extent to which this is true depends on the health outcome being studied.<sup>5, 7, 13, 17-21</sup> For example, in a longitudinal study of US adults, education was inversely associated with body mass index (BMI) among White men, but was *positively* associated with BMI among Black

men. Among women, more education meant lower BMI for Whites, Blacks, and Latinas, but as women entered their 30s, education was no longer associated with lower BMI for Blacks.<sup>7</sup>

Other studies have also found racial/ethnic and/or gender variation in the educational gradient in health. Braveman and colleagues identified an educational gradient in infant mortality rates; more education was associated with lower infant mortality.<sup>5</sup> The educational gradient was found for White women, but was *not* found for Latinas and was weaker for Black women. Moreover, *college educated* black women had higher rates of infant mortality than White or Latina women with *less than a high school diploma*. Two studies documented weaker educational gradients in mortality for women than men,<sup>20, 22</sup> but one of these studies only found this effect among Whites.<sup>20</sup> The educational gradient in health also appears to be weaker among the foreign-born than among the US-born,<sup>19, 23</sup> particularly for immigrants who received their education abroad.<sup>24</sup>

### **Beyond Attainment: Emerging Areas of Research in Education and Health**

These examples highlight an important finding; the basic relationship between education and health is not equally experienced across social groups in the United States. One of the biggest challenges to fully understanding why this is the case is our reliance on traditional measures of educational attainment – that is, degrees or years of schooling – when studying the impact of education on health.<sup>25-28</sup> This rather narrow focus on quantity or credentials does not adequately capture inequities in school quality, content, or context that can ultimately reduce or increase individuals' educational attainment. These other aspects of education may also be directly related to health and mortality.

## School Quality, Content, and Context

Children in the United States attend vastly different types of schools as a function of their SES and race/ethnicity.<sup>2, 29, 30</sup> For example, most white and Asian children attend low-poverty schools, whereas most black or Latino child attend high-poverty schools.<sup>29</sup> High-poverty and predominantly minority schools are more likely to be under-resourced and employ less-qualified teachers than low-poverty or predominantly white schools.<sup>2, 31</sup> Such inequities are important to consider because school resources are tied to academic achievement, independent of personal and family resources<sup>32-34</sup> and academic achievement in high school is related to college enrollment and persistence.<sup>35</sup> Thus, these inequities often serve to select students into different levels of educational attainment, which given the educational gradient in health, ultimately results in health disparities.

Educational inequities can also influence health directly. Indeed, there is an emerging body of research that investigates how different aspects of educational quality, content, and context are related to health and health behavior not only during childhood/adolescence, but also in adulthood.<sup>36-40</sup> Some have found that average pupil-teacher ratio, teacher wages, and length of school term strengthen the association between education and adult self-rated health,<sup>41, 42</sup> premature mortality,<sup>41, 43</sup> smoking, and obesity.<sup>41</sup> One study found that individuals enrolled in college preparatory coursework had fewer depressive symptoms as adults than individuals enrolled in general course work, independent of childhood and adult socio-economic status.<sup>9</sup> Other studies have shown that the physical and social environments of schools are important for health. For example, improvements in schoolyard designs are associated with short-term and long-term increases in children's physical activity during and after school,<sup>44, 45</sup> whereas school racial/ethnic composition is associated with better health for some students. Specifically, black

adolescents educated in predominantly minority schools tend to fare better in terms of their health and health behavior – they are less likely to initiate daily smoking,<sup>46</sup> report fewer depressive and somatic symptoms,<sup>47</sup> and experience better self-rated health in early adulthood<sup>48</sup> – than black adolescents educated in predominantly white schools. Attending predominantly minority schools might protect blacks from racial discrimination<sup>47</sup> or improve their sense of control,<sup>49</sup> which is associated with better health.

### **Opportunities and Challenges in the Area of School Quality, Content, and Context**

A focus on early educational experiences could lead more researchers to investigate how schools reproduce social and racial inequalities and how such processes ultimately work to impact health throughout the life course. In turn, more researchers might include measures of early educational experiences in their data collection efforts. Currently, few population-based health studies include these measures, and even fewer follow respondents over time to assess the long-term health implications of these early educational experiences.

### **Educational Pathways**

A narrow focus on educational credentials also does not account for variations in how people attend and complete school – or what can be referred to as *educational pathways*. This is particularly concerning because an increasing number of US adults are progressing through school in decidedly more complex ways; about a third of college students experience interruptions in their college career<sup>50</sup> and 37% attend part-time.<sup>51</sup> Educational pathways considered “non-normative” may be another marker of stratification that uniquely contributes to health over and above educational attainment by increasing the cost of college and reducing the economic and social benefits typically associated with a college degree.<sup>52-54</sup> Differences in educational pathways may also help to explain racial and gender

heterogeneity in the educational gradient in health given that non-normative educational pathways are more common among recent cohorts,<sup>55</sup> racial/ethnic minorities,<sup>56</sup> and women.<sup>53</sup>

Few health researchers have attempted to interrogate this question, though there seems to be growing interest. For example, Miech and colleagues investigated how the sequencing of a college degree in relation to the sequencing of other roles, such as marriage and parenthood, was related to obesity.<sup>57</sup> They found that young adults who married prior to completing college had a higher risk of obesity than young adults who married after completing college. A similar pattern was found among black men who became parents prior to versus after completing college. Another approach is to consider the age when someone attains their college degree given that delayed attainment is associated with lower lifetime earnings and less wealth accumulation than on-time attainment.<sup>52</sup> In a national study, adults who returned to college after age 25 and earned at least a bachelor's degree reported fewer depressive symptoms and better self-rated health at mid-life than their counterparts who did not attain a higher degree after age 25.<sup>58</sup>

### **Opportunities and Challenges in the Area of Educational Pathways**

Rarely have health researchers recognized the dynamic nature of education or attempted to measure it. This could be due, in part, to the type of data that is available. Most population-based studies do not collect detailed information on education, but rather ask individuals about their current educational attainment. A more informative approach would be to ask individuals to report the year they attained their highest degree and if they experienced interruptions or delays in their education. Such additions would have minimal impact on survey length, but could allow for a more nuanced examination of the role of education for health.

## **Student Debt**

The inflation-adjusted cost of higher education in the U.S. has soared by over 250% since the 1970s.<sup>3</sup> Yet, wages for the average family have stagnated or declined,<sup>59</sup> making borrowing for college essential for many families. Indeed, over the past decade, the amount of student debt held by Americans has tripled to over \$1.3 trillion.<sup>60</sup> In 2012-13, the average student loan balance among recent graduates who borrowed loans was \$27,300, with 60% holding some student debt.<sup>4</sup> Additionally, black and middle-income students are more likely to borrow to pay for college compared to white and either low-income or upper-income students.<sup>61, 62</sup>

Although parents, policymakers, and scholars have voiced concerns regarding rising student debt, it is only recently that empirical evidence has documented some of the potential health implications of student debt. Several studies demonstrate that greater student debt is associated with diminished health among student borrowers, including poorer mental health and increased sleep problems.<sup>63-66</sup> This association persists even after adjusting for other forms of debt, such as credit card debt.<sup>66, 67</sup> The independent effect may occur because student debt has unique features, such as not being discharged in most bankruptcy proceedings.<sup>68, 69</sup> Student debt, therefore, can carry a greater psychological burden than other forms of debt because borrowers may not be able to avoid paying on this debt, even if under considerable financial strain.

## **Opportunities and Challenges in the Area of Educational Debt**

The effects of student debt are potentially far-reaching since it shapes many decisions, big and small, ranging from choice of job to choice of mate.<sup>62, 70-76</sup> Student debt, therefore, may not only impact health through heightened stress or financial strain, but also through the life decisions that people make about how to save for retirement, what careers

to pursue, whom to marry, and when (or if) to have children. Such an acknowledgement requires a multi-faceted approach to understanding the full implications of student debt for population health and identifying evidence-based solutions for addressing the financial burden that many Americans face due to student debt. This means that we must traverse disciplinary boundaries and communicate the importance of studying the social and health implications of student debt for health equity.

### **Priority Areas for Achieving Health Equity and Promoting a Culture of Health**

The gap between Americans with less versus more education is widening,<sup>77-81</sup> suggesting that education will become a *more* important determinant of health for the next generation than it was for their parents. Inequities in early educational experiences, educational pathways, and emergent issue areas such as student debt, can impact health trends and contribute to widening health inequities. To move toward health equity we must ensure that quality education is accessible to all students, not only to the privileged. This requires increased federal and state investment in education – from pre-kindergarten through college – and the delinking of public school funding from local property taxes, which can serve to concentrate poor and minority students in failing schools.<sup>45</sup>

To achieve this vision of health equity and promote a Culture of Health, we need to:

**Priority Area # 1: Broaden the way we think about, measure, and study education and its relationship to health.** Education is more than just degrees. Education includes where we go to school, what we learn, and how we attend and complete school. Without a broader conceptualization of education, we unduly limit the types of questions we ask and the solutions we develop. Such a reframing could foster better cross-sector collaborations between education and neighborhood researchers, for example, given that decisions to live in certain neighborhoods are often informed by a school’s racial composition.<sup>82</sup> It could also

lead to synergies between education policymakers and population health scientists.

**Priority Area # 2: Support data collection efforts and cross-sector collaborative studies that move beyond traditional investigations of education and health.** New data collection efforts are needed to assess many of the issues raised here. Such efforts will require sustained financial commitment from funding agencies. Additionally, given that many educational inequities inform and are informed by other social processes, such as residential segregation and wage discrimination, funding agencies should encourage proposals from interdisciplinary teams of social scientists and population health researchers that consider these intersections.

### **Conclusion**

It is clear that educational attainment does not adequately capture the breadth of students' experiences within the school system or the social processes that result in some individuals benefiting more from their education than others. To achieve health equity, we need to move beyond assessments of individual educational attainment and pay attention to those facets of the educational experience that perpetuate and reproduce social, racial, and health disparities.

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A Robert Wood Johnson Foundation Convening  
**Leveraging the Social Determinants to Build a Culture of Health**  
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## **Housing as a Social Determinant of Health**

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## Overview

This issue brief highlights our current knowledge on the connection between housing and health, describes what health equity looks like in this domain, and identifies both challenges to achieving health equity in housing and the necessary strategies to change the existing narrative as we move toward health equity.

## Housing and Health

In this report we conceptualize housing as a social determinant of health with three main but intersecting constructs: adequate housing conditions, affordability, and residential stability. Inadequate housing conditions are associated with both physical and mental illnesses through direct and indirect pathways. Structural features of the home (e.g., mold, pest infestation, peeling paint, drafts and energy inefficiencies, physical crowding) directly impact health, while affordability (e.g., fear of eviction, housing costs, overcrowding) and stability, defined as frequent moves or in its most extreme form, homelessness, may indirectly impact health.

Poor housing quality and instability have been associated with numerous physical health conditions, including respiratory conditions due primarily to poor indoor air quality, cognitive delays in children from exposure to neurotoxins (e.g., lead) and accidents and injuries as a result of structural deficiencies.(Evans, 2006; Leventhal & Newman, 2010) The mental health consequences of poor housing quality and instability have also been noted.(Chambers, Fuster, Suglia, & Rosenbaum, 2015; Suglia, Duarte, & Sandel, 2011) Housing instability disrupts work, school, and day care arrangements, as well as social networks of both parents and children. Worries over the stability of one's housing situation and poor control over the conditions of one's home can result in distress and subsequent

mental disorders. Children and adults experience poor housing quality and instability differently, with further variations among children depending on their developmental stage. As housing conditions are tied to economic factors, vulnerable populations (i.e., racial/ethnic minorities, families with young children, the elderly, and low-income households) are most likely to be housing insecure and suffer health consequences related to poor housing conditions, residential instability and unaffordable housing expenses. (Rauh, Landrigan, & Claudio, 2008)

### **New Directions**

Recent studies have focused on the impact of remediation of housing conditions and within the context of the great recession and the foreclosure crisis of 2008, more research has focused on the impact of residential stability. For example, mortgage delinquency and foreclosure has been associated with depressive symptomatology as well as lack of use of health services.(Alley et al., 2011; Cannuscio et al., 2012) Newer studies have evaluated the impact of interventions and/or remediation moving the discourse beyond the housing and health connection to evaluate the potential benefit of improving housing conditions. A 2013 systematic review of studies focusing on warmth and energy efficiency interventions concluded that investing in improving thermal comfort can improve general health, respiratory health, and mental health.(Thomson, Thomas, Sellstrom, & Petticrew, 2013) Lastly, emerging work has begun to explore the health impact of displacement or the forced movement of people from their homes and neighborhood. As neighborhoods change more vulnerable individuals/populations, who should benefit from positive neighborhood developments, face greater threats of displacement and missed opportunities to benefit from positive neighborhood developments.

## **Existing housing narrative**

From a social determinants of health perspective, housing is often viewed as a dichotomous issue: one is either homeless or housed, a perspective which omits the various precarious housing situations that people, especially vulnerable populations, may experience. These in-between states of housing include residing in homeless shelters, living in doubled- and tripled-up circumstances with multiple families in one unit and moving frequently between places. As “precariously-housed” populations are considerably harder to reach, their experiences are not well documented in the literature thereby leaving the full continuum of housing and its consequences on health underexplored. Further, the interplay between housing affordability and the conditions of housing are often neglected. In the lived experience, families often afford housing at the expense of health whereby they sacrifice conditions for affordability (Hernández 2014). Further dichotomies ensue between new and existing housing stocks as well as luxury versus affordable housing. New and luxury housing offer the best options for health whereas older units and those constructed for lower-income residents often lack healthful conditions and amenities. Also, despite what is known regarding the links between social capital and health, residential instability is often overlooked as a determinant of health even though the disruptions in the formation and continuation of social and institutional ties that occur due to instability are quite evident (Carpiano 2006).

## **Health Equity and Housing**

Health equity in housing would entail opportunities for all individuals, regardless of race/ethnicity, socioeconomic status, household composition or zip code, to benefit from developments in modern building science, fair maintenance practices and creative uses of

space through programming to form a culture of health and social connections. Homes and buildings would be newly built or renovated to reflect standards such as energy efficiency, adequate space, appropriate ventilation and good lighting. Hazards such as lead paint, asbestos, mold and pest infestation would be permanently remediated. Dependable and timely maintenance responses would be afforded to all. Amenities such as green space, community rooms, play areas, quiet zones along with active design elements such as well-lit and easily accessible stairways and walkways would be standard practice rather than luxury items afforded to market-rate and higher income residents. Smoke-free housing policies would be effectively enforced alongside the implementation of designated smoking areas. Health equity in housing would also involve development subsidies to expand affordable housing at a wider range of income levels. Lastly, land use and zoning policies would support health-promoting institutions and recreational opportunities while also retaining stability of local residents and small businesses as new developments are introduced.

Among the challenges in achieving health equity in housing are a lack of imagination and policy deficiencies that limit the reach of housing to better promote health and equity. For example, as a key social institution, residential settings present an opportunity to connect neighbors via health promoting initiatives such as gardening, walking groups, tenant advocacy, resident watch groups, family activities, emergency preparedness drills and intergenerational cooking classes to demonstrate healthy food preparation and life skills. As it were, housing units are constructed without thought to creating and programming space to cultivate social cohesion. This is important since neighbors that know each other are more likely to feel safe, supported and connected—all important concomitants of health. More imaginative approaches are needed to leverage housing as a convening entity with rich programming potential.

Regarding policy, affordable housing development has largely emphasized providing housing to the very poor in historically disadvantaged communities. In order to achieve equity, affordable housing ought to also be more widely available in high resource neighborhoods, so that the poor benefit from enhanced educational, workforce and health opportunities. Meanwhile, providing decent housing opportunities for moderate-income families, who would also benefit from housing subsidies, can interrupt the concentration of poverty in low-resource neighborhoods, albeit careful attention to the displacement risks of gentrification is critical.

### **Priority Areas for Achieving Health Equity in Housing**

Health equity can best be achieved by focusing on three domains of housing: 1) encouraging the physical design and programming of residential space to promote health; 2) preserving, improving and better connecting existing affordable housing; and 3) expanding supportive housing options for special populations.

*Designing and programming housing for health.* The physical infrastructure of housing should capitalize on modern building practices that emphasize high performance metrics in energy efficiency, ventilation, lighting, thermal comfort and the use of environmentally sound materials. Doing so is increasingly aided by certifications such as LEED, Enterprise Green Communities, Energy Star and Passive House, among others. Nevertheless, these certifications and the corresponding building practices are often cost-prohibitive for affordable housing developers. Therefore, in order to achieve health equity, more incentive programs need to be developed that apply best practices to all sectors of housing, but especially housing that targets low and moderate-income residents. Once built, the physical spaces should be programmed by management staff and engaged residents to

encourage social connections and resident health through education and the enactment of health-based activities. Such shifts in design and programming practices will improve the structure and culture of residential buildings.

*Preserving, improving and connecting affordable housing.* The preservation of existing affordable housing along with its modernization, adequate maintenance and connectivity to the broader neighborhood landscape are essential to creating health opportunities for populations most impacted by housing-related health disparities. At a time when the affordable housing stock is dwindling in number and in quality, it is imperative to maintain existing public and privately-held housing and enhance its value and functioning by investing in major capital improvements. Ensuring that affordable housing is integrated into the social fabric of communities and available in a wide array of communities is essential for socioeconomic inclusion rooted in housing.

*Expanding supportive housing to neglected populations.* Supportive housing for special populations including those affected by mental illness and substance abuse have demonstrated positive results in stabilizing these co-morbid conditions (Padgett et al, 2006). Also, women and children are best supported by the shelter and transitional housing systems as well as by housing subsidies that offer opportunities for permanent, affordable housing. However, there are key populations that are left behind—namely, formerly incarcerated men. In light of the disproportionate impacts of incarceration borne by certain communities, formerly incarcerated populations, especially men who are non-custodial fathers, face many challenges reentering communities and establishing a stable home environment. Further, federal guidelines prohibit any householders with a felony record from residing in public housing. These factors need to be reconsidered in pursuit of health equity

for populations most affected by mass incarceration where housing can be used as an important stepping-stone in starting over.

## **Conclusion**

While existing evidence points to a clear relationship between housing and health, as well as the emergence of research noting the impact of improving housing conditions on health, there are challenges in enacting strategies that would achieve health equity in this domain. Strategies to achieve health equity in housing will need to address multiple constructs: adequate housing conditions, affordability, and residential stability. Paramount to achieving health equity in this sector is the fact that as a multi-sectorial field, housing is not always recognized as an important source of health and well being by stakeholders beyond public health. There is a need to shift our understanding from housing luxuries to housing amenities, which are necessary to foster health, well-being and a sense of community. This shift in narrative will require interdisciplinary collaboration of clinicians, public health practitioners, city and regional planners, developers and architects in considering the health impact of housing conditions.

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**Leveraging the Social Determinants to Build a Culture of Health**

June 1 – 2, 2016 | Philadelphia, PA

**Socioeconomic Determinants of Health  
with an Emphasis on Occupation and Wealth**

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The relationship between socioeconomic status (SES) – usually measured by educational attainment, occupational status, and/or income – and health is well documented across time and place (see for instance Kitgawa and Houser 1973; Marmot, 1994; E. Rogot et al., eds, 1992; Deaton, 2002). The relationship between SES and health is often referred to as the “gradient.” Generally, the expectation is, if SES rises, health improves. Individuals and family members with higher SES are expected to have longer and healthier lives.

SES is commonly thought to affect health via three mechanisms: better access to quality health care, to healthier environments, and to healthier behaviors. What is less studied is the relationship between health and *wealth*. This white paper will delve into the health-wealth connection, while addressing other aspects of SES, such as employment and income volatility, as well as the general social determinants of health.

Although there are threshold effects associated with poverty, whereby those with the least resources may be particularly vulnerable to acute illness, unhealthy environments, and inferior health care access, there is also a gradient effect where health is known to vary with SES in a more gradual manner. For instance, the black rate in both neonatal (within the first 27 days of birth) and perinatal (after the first 27 days, but within the first year of birth) mortality was more than twice the white rate. Furthermore, the black/white ratio of infant mortality increases with higher levels of both education and income (Singh and Yu 1995; David and Collins 1991; Schoendorf, et al 1992). This suggests that socioeconomic status alone cannot explain racial and ethnic differences in the infant mortality gap. There are differences in the manner in which the socioeconomic status of mothers from different racial and ethnic groups translates into the production of healthy infants.

It is vital to determine the casual pathway and mechanisms by which SES affects health. Simple correlations are not enough. For instance, unhealthy behaviors themselves, such as smoking, alcohol abuse, drug abuse, poor eating habits and risky sexual activity may be directly related to stress and stigma associated with both racial position and class status. These endogenous relationships between the behaviors described above, SES and health make it difficult to control for behavioral factors in a stochastic (inferential statistic) context.

In short, existing statistical models that presume a causal pathway should be interpreted with extreme caution. There are often problems with “identification” when trying to estimate a causal relationship between two choice variables that very well may influence one another. Stochastic models are hampered by the classic “chicken and egg” problem. For instance, we may observe higher alcohol use among low-income individuals with poor health, but what may be lurking underneath is exposure to “societal stress” associated with low-income status in the first place. This may reinforce poor health and cumulatively produce higher alcohol use, which in turn is associated with a desire self-medicate stress related to social status. In this way, stress may a latent variable related to both income and health.

## **Wealth and Health**

Wealth refers to the total stock of savings that an individual or family possesses at any given moment. It is most commonly measured by net worth: the value of total assets minus debts. Simply put, income is a flow of payments that comes to an individual or family periodically, usually based on the individual’s participation in the labor market, while wealth is the net value of the stock of assets that an individual or family can access (whether or not income is

being earned). Assets are what you “own” (Hamilton and Chiteji, 2013); debts are what you “owe”. Thus, net worth or wealth is the different between what you own and what you owe.

Wealth is important because it represents a pool of resources, beyond income, that individuals or families can use to sustain themselves and to provide support for their offspring. It can be used to cushion against financial shocks that a family experiences. For example, when a family has a disruption to its normal income flow due to a family member suddenly becoming unemployed, the family can use its savings.

Similarly, if a family faces an unexpected and unavoidable rise in its expenditures, *often due to someone needing major medical attention*, the family can dip into its savings. Anirudh Krishna’s *One Illness Away* (2010), a study that examines movements into and out of poverty across the globe, finds that the expenses associated with health related problems are the most significant contributor to descent into poverty.

As such, wealth is a primary indicator of economic security. Moreover, wealthy families are better positioned to: finance elite independent school and college education, access capital to start a business, purchase homes in “good” neighborhoods with lots of amenities, exert political influence through campaign financing, purchase better counsel if confronted with the legal system, leave a bequest, and withstand financial hardship resulting from any number of emergencies, medical or otherwise. The ways that wealth provides advantages to families who have more of it are numerous. There is perhaps no other economic indicator in which Americans are so disparate nor where the black-white divide is so large (Hamilton and Darity, 2010).

**Research and public policy traditionally has focused on education and income as drivers of upward mobility and healthy outcomes.** There is compelling evidence, however, that education alone may be limited in explaining the source of different levels of economic well-being, especially across race. In their report entitled *Umbrellas Don't Make it Rain: Why Studying and Working Hard is Not Enough for Black Americans*, Hamilton et al. (2015) demonstrate that observing an association between higher levels of educational attainment and higher levels of net wealth and concluding that education produces wealth is tantamount to observing an association between the presence of umbrellas during rainfalls and concluding that umbrellas cause the rain. It is more likely that the relative wealth of different racial explains educational attainment differences across groups.

The coauthors conclude that, for black families, studying and working hard is not associated with the same levels of wealth amassed among whites. Black families whose heads graduated from college have about 33 percent less wealth than white families whose heads dropped out of high school. The poorest white families—those in the bottom quintile of the income distribution—have slightly more wealth than black families in the middle quintiles of the income distribution. The average black household would have to save 100 percent of their income for three consecutive years to overcome the obstacles to wealth parity by dint of personal savings activity.

### **Identification Issues**

Meer, Miller and Rosen (2001) use inheritance or substantial gifts as an instrument to identify the impact of the change in wealth over a five-year period on the self-reported changes in health over that same period using the Panel Study of Income Dynamics (PSID).

They ultimately find a small effect of a change in wealth on a change in health, but a few difficulties should be noted. First, their model includes initial period wealth (which is endogenous) and initial health as controls; inheritances or *in vivo* transfer might be anticipated and affect health outcomes. Moreover, both types of intergenerational transfers, themselves, are components of wealth, and cannot be treated legitimately as exogenous boosts to individual or family resources. Indeed, wealth as stock of resources, rather than a flow, may be more relevant with regards to duration/cumulative effects on health/long-term health.

### **Employment/Occupation and Health Insurance**

Even after the passage of the Patient Protection and Affordable Care Act, the vast majority of Americans remain covered through an employer-sponsored health insurance. However, even with the ACA mandates requiring more firms to offer coverage, as well as minimum required that have to be offered by this coverage, there is still considerable variability in jobs that offer health insurance, and the quality of care offered across jobs.

Hamilton (2006) finds that over 85 percent of U.S. occupations are characterized by racial over-representation (typically blacks in low earning occupations and whites in high earning occupations), even after accounting for occupational educational attainment requirements. In terms of job sectors, blacks, Latinos and immigrants are more likely to be employed in industries that offer less insurance and lower quality of coverage. For example, blacks, Latinos and immigrants have a substantially higher proportional representation in service occupations and a lower proportional representation in managerial and professional

occupations than their white and native-born counterparts (Crow, Harrington and McLaughlin, 2002).

Workers may sort themselves into occupations and industries in part based on their demand for health insurance. But that is only part of the story. Employer decisions and institutional factors unrelated to employee choice may force members of “vulnerable” populations into certain occupations and industries, which ultimately affect their health insurance coverage. Finally, this job sorting may affect the labor market experiences and/or expectations of these groups, which in turn may influence their decisions to search for certain jobs or any jobs at all.

About 40 years ago Barbara Bergmann (1971) hypothesized that labor market discrimination against black males is manifest in a “crowding” effect, which results in lower earnings for them. White employers’ refusal to hire blacks in certain occupations forces them to cluster and creates crowding in less desirable jobs, which reinforces a condition of lower earnings in those occupations. An extension of Bergmann’s thesis is that there is a link between occupation or job crowding and the sub-par health insurance coverage for vulnerable populations.

However, even within occupational categories, the health insurance type for blacks and Latinos may be of lower quality than that of their white peers, suggesting that actions across specific firms and firm types may be a source of their subpar coverage. Hamilton, Goldsmith and Darity (2010) provided a new explanation for these health insurance disparities, hypothesizing that firms with predominantly non-white workforces (non-white firms), those

with largely black and Latino workforces, are less likely to offer health insurance than comparable firms with predominantly white workforces (white firms).

Prior to ACA, we uncovered evidence that the racial composition of firm workforce influenced whether it offers employees health insurance coverage. We found that employment at firms with predominantly white workforces is associated with higher likelihood of employer sponsored health insurance, and employment at firms with predominantly non-white workforces is associated with a lower likelihood, both relative to racially diverse firms, even after controlling for a large set of known determinants of employer sponsored health insurance. In addition, firms with large male workforces have a greater proclivity to offer health insurance than those that are largely female. It would be useful to update these results to examine whether the racial composition of firm workforce continues to be associated with quality of health insurance coverage.

There are a number of explanations for why comparable non-white workforce firms might offer different coverage than white firms. Among the possible explanations are (1) higher premiums faced by firms to cover workers from non-white groups due to lower health status, (2) lower profitability of these non-white firms, (3) lower collective bargaining power to negotiate health insurance coverage for workers at firms that employ relatively more black and Latino employees, (4) lower demand for coverage from predominantly black and Latino workforces, and, lastly, (5) workers employed at firms with large shares of non-white workers may be more susceptible to structural barriers unrelated to their work characteristics such as labor market discrimination and as a result be offered less insurance coverage.

The large racial disparity in quality and quantity of health insurance coverage in conjunction with the heightened vulnerability and financial insecurity of black Americans due to low levels of wealth, particularly liquid wealth, are important when understanding the social determinants of health. There are well-documented explanations for health insurance coverage disparities, but they tend to focus on differences in individual socioeconomic and demographic characteristics of group members (see Crow, Harrington and McLaughlin, 2002). Hamilton, Goldsmith and Darity (2010) offer an alternative perspective, that the racial composition of a firm's workforce influences the likelihood and quality of coverage that firms offer employees.

We provide evidence that employment at firms with predominantly white workforces is associated with a higher likelihood of employer sponsored health insurance, and firms with predominantly non-white workforces are associated with a lower likelihood, both relative to racially diverse firms, even after controlling for a large set of known determinants of employer sponsored health insurance. In addition, we find that firms with predominantly male workforces have a greater proclivity to offer insurance than those that are largely female. This finding persists even after controlling for a myriad of factors that influence a firm's health insurance offers.

Given the link between the racial composition of firms and their provisions for health insurance, we need to acknowledge the limitations of a health insurance system so heavily reliant on employer-sponsored health insurance as its cornerstone. In the midst of the Great Recession, the January 2010 unemployment rates for whites stood at 8.7 percent, and at

16.5 percent– nearly twice as high–for blacks (based on the U.S. Census’ Current Population Survey).

In addition, there are large racial disparities among those workers who have dropped out of the workforce altogether, due to discouragement from prolonged bouts of unemployment. Finally, the systemic structures that lead to racial sorting with respect to occupations also highlight the limitations of reforms that maintain an employer sponsored system as its core.

### **SES Volatility and Health**

Unemployment lasting several weeks has mental health consequences (Diette, Goldsmith, Hamilton, and Darity, 2012; Paul and Moser 2009; McKee-Ryan et al. 2005). Diette, Goldsmith, Hamilton, and Darity (2012) use a retrospective mental health diagnosis indicator and data from two large nationally representative data sources – the National Comorbidity Survey Replication (NCS-R) and the National Latino and Asian American Study (NLAAS) – to identify and estimate the impact of both short-term and long-term unemployment on measures of emotional health.

Involuntary joblessness is associated with feelings of “helplessness” (Seligman 1975), which damages mood (i.e., depression, anxiety) and self-perception. As a result, unemployment relates to psychological distress (Jackson and Warr, 1984). The effects of unemployment can be cumulative – each additional week of unemployment leads to more emotional damage – such that long-term unemployment is more damaging than short-term unemployment (Eisenberg and Lazarsfeld 1938; Harrison 1976).

As is the case with other literature examining the impact of SES on health, it is difficult to tease out the casual effect of unemployment on mental health given the simultaneous relationship between the two variables. On the one hand unemployment may cause poor mental health; on the other hand, poor mental health may increase the odds of unemployment.

Diette, Goldsmith, Hamilton, and Darity (2012) attempt to shed further light on the question of causality by examining whether psychologically resilient persons (i.e., individuals who have always exhibited sound emotion well-being) exposed to unemployment in the past year are more likely to experience their first spell of poor emotional well-being than persons employed throughout the past year. The paper finds that long-term unemployment— but not short-term unemployment—promotes psychological distress among “resilient (e.g. those with no prior episodes of mental health disorders)” persons. Negative psychological consequences of long-term unemployment exist even within various other demographic and socioeconomic mental health buffers.

Diette, Goldsmith, Hamilton, and Darity, (2015) perform an intersectional analysis by formally evaluating whether the deleterious impact of unemployment on mental health increases as skin shade (an indicator of Afrocentric phenotype) darkens for black women in the U.S. The colorism literature characterizes societies that have experienced European colonization as allocating privilege and disadvantage according to the lightness or darkness of one’s skin, with favoritism granted to those with lighter skin. Thus, this construct posits that pooling all blacks together may mask intra- and inter-racial differences in outcomes associated with complexion.

In general, the higher exposure to low incomes, which are associated with poorer health, along with exceptional altruistic obligations to support kin due to larger network of family and friend poverty rates, can operate to place a unique burden of stress and strain on black women in the United States. In addition, in major part due to the shortage of “marriageable black males” (Wilson 1987, Darity and Myers 1992, Hamilton et al. 2009), less than three-fifths of black women are married by the age of 30, which leads to single-family households that further reduces time, income and asset inflows for black women. These conditions arise in the context of the ever present threat of both race and gender discrimination in labor and other financial markets. Thus, black women rely heavily on a discriminatory labor market to obtain income, while simultaneously having to do homework including raising children, often without support of a partner (Chiteji and Hamilton 2002, Brown and Keith 2003).

As a consequence of this array of pressures, Brown and Keith (2003) argue that black women are especially vulnerable to mental health consequence, and, thus, unemployment is even more likely to cause income insecurity relative to women from other groups. Unemployment may simply overwhelm their strained adaptive and coping capabilities, resulting in harm to their emotional well-being. Moreover, Brown and Keith (2003) assert that black women with more Afrocentric features, who have historically been subject to poorer treatment than black women with more European phenotypes, may be, quite justifiably, particularly fearful and anxious about unemployment. Thus, unemployment fosters substantial stress for black women, especially among those with more Afrocentric appearances.

Diette, Goldsmith, Hamilton, and Darity, (2015) finds strong evidence of a gradient on depression between skin shade and unemployment for black women. Unemployed black women with darker complexions are significantly more likely to suffer their first onset of depression than unemployed black females with lighter skin shade. Moreover, the findings are robust to various definitions of skin shade.

### **Income volatility**

Problems of income and work hour volatility are gaining attention, alongside existing concerns with wealth and income inequality, but a comprehensive picture is missing, especially as it relates to health. It would especially be important to better understand these variations by race and ethnicity (Hardy and Ziliak, 2014 and Tippett, et al, 2014).

It is noteworthy that all income volatility is not the same. The swings of investment income accrued by high-worth individuals, for example, are likely to be buffered by ample stocks of wealth. But income volatility for low income individuals with low levels of wealth tends to leave costly coping strategies, which may include use of predatory financial products and greater exposure to health risks and foregone healthy input consumption/utilization.

In an upcoming paper, Darity, Hamilton, Hardy and Morduch stratify across wealth and income, and examine the role of race and determinants of income volatility as well as associated economic vulnerabilities.

In some preliminary analysis Darity, Hamilton, Hardy and Morduch have found that income volatility is widely felt but disproportionately experienced by lower income households; black

and Latino households are disproportionately likely to have low income and low wealth, and are also disproportionately likely to face high income volatility; most households exposed to high levels of volatility report having weak financial cushions; those least likely to be equipped to manage income volatility - i.e., those most likely to face both low income and low wealth - tend to be black or Latino; and controlling for income and wealth, black and Latino households are not more likely to face high income volatility than others. A useful extension of the analysis would incorporate health outcomes to examine the interaction between income, wealth, race and volatility as they translate into health.

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# POST-IT NOTES EXERCISE RESULTS

## POST-IT NOTES EXERCISE: FEEDBACK ON THE WHITE PAPERS

### STICKY THINGS

Thinking about the survey responses and the associated themes, as well as the white paper presentations, *what stuck with you?*

#### Racism

- Beginning to show evidence based research supporting the fact that race matters.
- The compounding effect of racism over a lifetime.
- How does color blind ideology impact our ability to address structural racism?
- Very, very appreciative of the notion that prejudicial beliefs are just the tip of the iceberg. I would submit that they are produced by the submerged iceberg.
- Long-term impact of life course discrimination.
- Changing individuals' attitudes won't change structured inequality
- Call out racial bias in the institutions where it exists.

#### Education

- Quality of schools and pathways matters.
- "Opportunity Hoarding" and white parents
- Sticky things education is not measured adequately. (but is the expanded conception really proxying for wealth).
- Racial bias within academia is a problem
- College debt and the stress it induces long term

#### Housing

- Intersection of built and social environments.
- Housing not placed in context of built environment and health
- Only time criminal justice system mentioned -Reentry and housing.
- Housing insecurity goes beyond homeless or not.
- Housing neighborhood adequacy must be considered substantially
- Housing as in "Home" is a place to convene and be the backbone of a new health care system.

#### Occupation/Employment

- Sure the data reality sucks but there seems to be a great deal of deficit thinking. A great deal of conversation about community-created solutions.
- Measurement remains an issue. Life course perspective is important.
- All of the "in" prefixes. "in" adequate, "In" secure, "in" cremental improvement.

#### Wealth/Economic Stability

- Racial disparities in wealth cannot be overcome only through education and income. Reasons are historic and integrated. What to do?
- Mortgage tax benefits- Perfect example.
- It's frustrating that we can't isolate wealth as a variable or predictor to be able to make causal claims



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## **POST-IT NOTES EXERCISE: FEEDBACK ON THE WHITE PAPERS**

### **Wealth/Economic Stability-Cont.**

- An important aspect of the SES construct. What currently predicts movement from instability to stability.
- I guess I feel about a study on wealth (similarity?) to those on racism. Why do we need studies to confirm this?
- Educated blacks still have less accumulated wealth than lesser educated whites. More on routes to wealth and how the integration transfer of wealth is created.



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# POST-IT NOTES EXERCISE: FEEDBACK ON THE WHITE PAPERS

## I COULD HAVE DONE WITHOUT...

Thinking about the survey responses and the associated themes, as well as the white paper presentations, *what left you concerned, disappointed, or uncomfortable?*

### Racism

- The fact that a college educated African American male, who has the longest life expectancy among African Americans, still has a lower life expectancy than high-school educated white males.
- Again, why is the data presented seemingly binary (Blacks vs. Whites)? Little to no data on Asians or Amer. Indians.

### Education

- “Missing” Cradle to Prison Pipeline.
- Victim Blaming “Some parents don’t care”. Maybe they aren’t given the opportunity to care.
- Teacher Bias=Accountability
- A bit disappointed with the implication that education is the “solution.” Also disappointed that little attention was given to the fact that health disparities can widen w/ SES.
- Desegregated schools can still have segregated education via racialized tracking.
- Overemphasis on benefits of segregated schools for Black children w/o unpacking why- and what to make of evidence.
- Data in white paper was binary (Black and White). Where are the NDN’s and Asians?

### Housing

- Too much thinking of housing as separate as opposed to a neighborhood anchor.
- Deficit thinking, surveys and studies. Treat ghettoization of folks of similar culture living in the same neighborhood as a bad thing. No talk of social safety nets, extended family, etc.
- Assumes good actors, we still need accountability and enforcement.

### Occupation/Employment

- Employment has even more adverse effects.
- Discrimination in the labor market for particular groups (formerly incarcerated) living wage discussion as a corrective policy option
- Lack of conversation about transportation and impact on opportunity and health
- How do we combat Neoliberal ideology as a structuring force in the labor market?
- The barriers to employment are myriad- education does not correlate to employment-insecurity of.

### Wealth/Economic Stability

- Cautions about Neo-liberal approaches- I want to know more.



## **POST-IT NOTES EXERCISE: FEEDBACK ON THE WHITE PAPERS**

### **HOPE**

*Thinking about the survey responses and the associated themes, as well as the white paper presentations, **what do you hope will happen or be different in the future, and what left you hopeful?***

### **Racism**

- Use of institutional racism frame on health.
- Calling out racism as a determinant of health.
- Racism as a public health issue.
- I am hopeful that we will actually address racism as a social determinant rather than trying to explain it away by other causes.
- More cross-discipline scholarship to strengthen the evidence base for equity actions.
- Narrative = Voice with a strategy.
- More thinking about the intersections of gender, age, sexual minority status and race is important for understanding racism.
- Current honest/open dialogue and acknowledgement of racism.
- Build of body of environmental justice + built environment + health research and policy work.
- Prospects for better research on the nexus between discrimination, stress and bad health.
- Opportunities to name racism as a determinant of health!

### **Education**

- Unfinished conversation about tension between poverty and education.
- Time to revisit public education financing
- Must be responses to trauma in schools. School discipline, School to prison pipeline.

### **Housing**

- Maybe the fact that the middle class is being stripped of its assets at an alarming rate will wake folks up.
- This room is full of smart people with power to change the power imbalance.
- Intersection of health outcomes and housing policies.
- We need renewed efforts to dismantle the racial stereotypes that support segregation.
- Prospects for changing neighborhoods without displacement.

### **Occupation/Employment**

- Neighborhood determines opportunity-the communication must counteract geography.
- Looking at studies -like those recently released by the Assoc. for Enterprise Opportunity - shows the hope that simple preparation and small business can provide for full employment.
- We will begin to bring race into the conversation and the approach and be intentional about reducing disparities.
- 2 policies proposed for future advancement.



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## **POST-IT NOTES EXERCISE: FEEDBACK ON THE WHITE PAPERS**

**HOPE- Cont.**

### **Wealth/Economic Stability**

- Baby Bonds- Appreciate the idea of being able to invest in a variety of assets. Interesting/Hopeful corrective strategy.
- A weird hopefulness- that poor whites are being affected by loss of wealth and may be beginning to realize that the game is not race.
- How do we quantify/measure “Black Tax”?
- The challenges and opportunities of Big Data.
- Baby Bonds.
- Social Impact Bonds. “Pay for Success” programs.
- Greater mobility pipelines that don't rely solely on “The Market”
- Bonds or trusts for people.
- Recognition of endless connections is hopeful.
- Can we think around policy change or is it too big of a hurdle?