Richmond Health Equity Partnership:
Partnership Project between the City of Richmond, Contra Costa Health Services, and
West Contra Costa Unified School District to advance Health Equity in Richmond

The Richmond Health Equity Partnership (RHEP) is a partnership between the City of Richmond, Contra Costa Health Services, West Contra Costa Unified School District, and local partners including The California Endowment, University of California Berkeley Associate Professor Jason Corburn, and other community-based organizations. RHEP is working to build key institutional partnerships with the goal of cross-sector collaboration to advance health equity and implement the Community Health and Wellness Element (CHWE) of the Richmond General Plan 2030. The partnership will advance health equity for children and families in Richmond through the development of a Health in All Policies strategy, Full-Service Community Schools strategy, and a Health Equity Report Card to measure change overtime. In addition to moving towards health equity in Richmond, we aim to create a model for possible duplication in other cities and areas of west Contra Costa County. Our goal is to build new working partnerships within and between local government institutions – City, County and School District – to facilitate systems change and enable these institutions to respond to and lead with community-based health equity initiatives.

City of Richmond

West Contra Costa Unified School District

Contra Costa Health Services

Health Equity Reader
This is a living document, intended to be updated and used as RHEP moves through the process of developing policies and tools that will help address health equity in Richmond. This document provides an introduction to the concept of health equity, the working definitions and language used by RHEP, and relevant references of academic and popular media articles and reports about health equity. This document can be used as a capacity building tool for RHEP partners and Richmond residents as diverse relevant resources are included.

This document currently includes (in DRAFT form):

Contents

Share your expertise:

Please submit additional resources, references, frameworks etc. as this document is a living document that is accessible to both the RHEP partners and Richmond residents (Email Gabino Arredondo at Gabino_Arredondo@ci.richmond.ca.us and Jen Loy at Jen_Loy@ci.richmond.ca.us).

Health Equity: An Introduction

What is health?

The Richmond Health Equity Partnership has a broad vision and definition of health for both an individual and Richmond community. Good health includes the absence of illness and access to health care services for individual residents, as well as socioeconomic factors like access to education, employment and housing. A community's overall health depends on individual and socioeconomic factors like these, but health is also a function of the environment in which residents live, work and play. The RHEP partnership envisions a healthy Richmond in which these critical determinants of the healthy living environments are made accessible to Richmond community members:
  • Parks and recreational facilities;

  • Healthy foods;

  • Medical services;

  • Walking, bicycling and public transit;

  • High-quality and affordable housing;

  • Walkable neighborhoods with access to services;

  • Safe neighborhoods and public spaces; and,

  • Environmental quality.

This list of healthy determinants is taken from the Richmond Community Health and Wellness Element (CHWE), an element in the Richmond General Plan. Often referred to as a city's "constitution," a General Plan addresses future development goals through a series of general policy statements. Richmond's CHWE targets the social, economic, physical, and environmental causes of health inequities and poor health outcomes. Click here to read more or download the CHWE.

What is health equity?

Health equity is achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices.[i]

In other words, health equity means that all people are healthy, even if it takes more money and effort to support the health of some.
What is the difference between inequality and inequity?
Inequality and equality are dimensional concepts, simply referring to measurable quantities. Inequity and equity, on the other hand, are political concepts, expressing a moral commitment to social justice.[ii]

What is difference between health inequality and health inequity?
In a paper[iii] by the director of the Center on Social Disparities in Health, UC San Francisco, equity in health is defined as:

- As "the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage — that is, wealth, power, or prestige."

- Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is essential to wellbeing and to overcoming other effects of social disadvantage.

- Health inequities refer to those inequalities in health that are deemed to be unfair or stemming from some form of injustice.[iv] And Braveman adds that health inequities result from an uneven distribution (of resources, services, wealth, etc.) is unnecessary, unjust, unfair and avoidable.

- As well, equity is an ethical principle; it also is consonant with and closely related to human rights principles.

Health Equity Definitions and RHEP:

On March 20, 2012, RHEP partner Associate Professor Jason Corburn from University of California, Berkeley presented an introduction to health equity and the work of RHEP. Jason Corburn is an Associate Professor in the Department of City and Regional Planning and a member of the Global Metropolitan Studies initiative at the University of California, Berkeley. A [Robert Wood Johnson Health and Society Scholar](#), his research focuses on the links between environmental health and social justice in cities, notions of expertise in science-based policy-making, and the role of local knowledge in addressing urban environmental and public health problems. To learn more about his work, visit the Department of City and Regional Planning website. Below are several quotes from the March 20, 2012 RHEP [presentation](#):

> What is health equity?
> "Differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions among specific population groups in the Unites States"
> —National Institute of Health (NIH) Working Group on Health Disparities
>
> "...Differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust."
> —Margaret Whitehead, 1946 , Department of Public Health , University of Liverpool
>
> "...Achieving the highest level of health for all people. Health equity entails focused societal efforts to address avoidable inequalities by equalizing the conditions for health for all groups, especially for those who have experienced socioeconomic disadvantage or historical injustices [such as racism]."
> —Virginia Department of Public Health
>
> What do we know about health inequities?
> 1. Health inequities are not natural, genetic or inevitable
>
> 2. Health is more than health care
>
> 3. Health is tied to distribution of resources
>
> 4. Economic & political inequities are bad for health
>
> 5. Racism is a central driver of inequities
>
> 6. Chronic stress can be deadly
>
> 7. Choices we make are shaped by choices we have
>
> 8. Organizational decisions influence inequities

9. Service decisions influence inequities

10. Social policies influence inequities

Professor Corburn's presentation can be found [here](http://www.ci.richmond.ca.us/DocumentView.aspx?DID=8658):
http://www.ci.richmond.ca.us/DocumentView.aspx?DID=8658

<u>In other words:</u>
Achieving health equity is not just about providing more services; it is also about how those services are developed, prioritized and delivered. What is needed to fundamentally address health disparities is a broad-based coordinated effort among many partners acting to address root causes. The root causes of health disparities are broadly based in inequalities in many aspects of life, including social and economic policies.

Other common phrases related to health equity:

- **Built Environment**: The human-made surroundings as a result of land use/place-making decisions; includes housing, buildings, infrastructure, roads, parks, transportation, etc.[v]

- **Health Disparities**: The preventable difference in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged population. Although the term "disparities" often is interpreted to mean racial or ethnic disparities, many dimensions of disparities exist in the United States, particularly in health. If a health outcome is seen in a greater or lesser extent between populations, there is disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status, and geographic location [educational attainment] all contribute to an individual's ability to achieve good health. It is important to recognize the impact that social determinants have on health outcomes of specific populations.[vi]

- **Health in All Policies (HiAP)**: HiAP considers that policy and program decisions made by "non-health" agencies play a significant role in shaping community environments. HiAP is a collaborative approach that has been used internationally to address just these kinds of issues. A HiAP approach recognizes that health and prevention are impacted by policies that are managed by non-health government and non-government entities, and that many strategies that improve health will also help to meet the policy objectives of other agencies. The World Health Organization,

European Union, South Australia, Finland, and other Western nations are all exploring ways to implement HiAP.[vii]

- **Root Causes of Health Disparities**: An important feature of health disparities as it is defined in the context of health equity and social justice is that the differences in health that certain populations experience are due to factors beyond individual control. The root causes of health disparities are systemic, institutionalized, and many decades or even centuries in the making. The relationships among the root causes of health disparities are multi-directional and cyclical, exacerbating one another and calling for intervention at every level.[viii]

- **Social Determinants of Health**: The conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.[ix]

- Health Impact Assessment:

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PLEASE SHARE YOUR IDEAS: What terms would you like to see identified? Can you suggest preferred sources? What does a useful glossary of terms look like to you? (Email Gabino Arredondo at Gabino_Arredondo@ci.richmond.ca.us and Jen Loy at Jen_Loy@ci.richmond.ca.us).

Selected Health Equity Readings and Resources

Health Equity: The Basics

Unnatural Causes:

There is a wide body of knowledge, literature, and even measurement and training tools related to health equity. *Unnatural Causes*, the acclaimed documentary series broadcast by PBS, offers a database of health equity materials that include fact sheets, videos, quizzes, training tools, journal articles and books, among other things. Below please see a few introductory readings from this and other key sources that consider health equity.

What is Health Equity? (Excerpted from the *Unnatural Causes* Action Toolkit)

http://www.unnaturalcauses.org/assets/uploads/file/What_Is_Health_Equity.pdf

Health equity concerns those differences in population health that can be traced to unequal economic and social conditions and are systemic and avoidable – and thus inherently unjust and unfair. Most of us can readily see how air pollution and toxic waste might harm health. But social structures can also get under the skin and disrupt our biology. Epidemiologist Sir Michael Marmot put it this way: "Real people have problems with their lives as well as with their organs. Those social problems affect their organs. In order to improve public health, we need to improve society." Tackling health inequities requires widening our lens to bring into view the ways in which jobs, working conditions, education, housing, social inclusion, and even political power influence individual and community health. When societal resources are distributed unequally by class and by race, population health will be distributed unequally along those lines as well.

Unnatural Causes
http://www.unnaturalcauses.org/about_the_series.php
This acclaimed documentary series broadcast by PBS is now used by thousands of organizations around the country to tackle the root causes of our alarming socio-economic and racial inequities in health.

The four-hour series crisscrosses the nation uncovering startling new findings that suggest there is much more to our health than bad habits, health care, or unlucky genes. The social circumstances in which we are born, live, and work can actually get under our skin and disrupt our physiology as much as germs and viruses.

Unnatural Causes **Episodes**

http://www.unnaturalcauses.org/episode_descriptions.php?page=1

In Sickness and In Wealth (56 min.) How does the distribution of power, wealth and resources shape opportunities for health?

When the Bough Breaks (29 min.) Can racism become embedded in the body and affect birth outcomes?

Becoming American (29 min.) Latino immigrants arrive healthy, so why don't they stay that way?

Bad Sugar (29 min.) What are the connections between diabetes, oppression, and empowerment in two Native American communities?

Place Matters (29 min.) Why is your street address such a strong predictor of your health?

(This episode is available as a stand-alone DVD with English, Lao, Hmong, Vietnamese, Mandarin and Cantonese audio, as well as English and Mandarin subtitles.)

Collateral Damage (29 min.) How do Marshall Islanders pay for globalization and U.S. military policy with their health?

Not Just a Paycheck (30 min.) Why do layoffs take such a huge toll in Michigan but cause hardly a ripple in Sweden?

Ask the Experts Forum #3: Myths About Health Inequities (From *Unnatural Causes*)
http://www.unnaturalcauses.org/assets/uploads/file/Ask_the_Experts_Forum3.pdf
William Dow, Tony Iton, Dennis Raphael, and David Williams discuss diet, universal health care, the economic costs of poor health, the "healthy immigrant effect," and the difference between health disparities and health inequities.

Health Equity Quiz (From *Unnatural Causes*)
http://www.unnaturalcauses.org/assets/uploads/file/quiz.pdf

This quiz includes questions:

How does U.S. life expectancy compare to other countries?

Where did the U.S. rank in life expectancy 50 years ago?

What is the greatest difference in life expectancy observed between U.S. counties?

On average, which of the following is the best predictor of one's health?

A SAMPLE ANSWER: C. Whether or not you are wealthy. The single strongest predictor of health is our position on the class pyramid. Those at the top have the most power and resources, and on average live longer and healthier lives. Those on the bottom are exposed to many health threats over which they have little or no control – insecure and low-paying jobs, mounting debt, poor child care, poor quality housing, less access to healthy food, unreliable transportation, and noisy and violent living conditions – that increase their risk of chronic disease and early death. Even among smokers, poor smokers face a higher mortality risk than rich smokers. Those of us in the middle are still worse off than those at the top.[x]

More Resources (From Unnatural Causes) http://www.unnaturalcauses.org/resources.php

Welcome to our online collection of health equity resources (From *Unnatural Causes*)

This database contains hundreds of articles, Web sites, video clips, charts, datasets, interviews, transcripts, and educational and outreach materials.

- Explore **all** resources by topic, related episode, type, or keyword using the tools to the left.

- Learn more about health equity concepts with our Interactivities, Case Studies, and discussions with top scholars.

Unnatural Causes has also assembled ten key items that were influential in the development of this series. These resources and links will provide information about the key concepts covered in the series and this Web site.

Closing the Gap in a Generation
FINAL REPORT from Commission on the Social Determinants of Health
A project of the World Health Organization (WHO), the Commission on Social Determinants of Health (CSDH) supports countries and global health partners to address the social factors leading to ill health and inequities. It draws the attention of society to the social determinants of health that are known to be among the worst causes of poor health and inequalities between and within countries. The

determinants include unemployment, unsafe workplaces, urban slums, globalization and lack of access to health systems.

The *Unnatural Causes* website also contains final reports from the different knowledge networks, as well as additional background articles and resources.

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The website also contains final reports from the different knowledge networks, as well as additional background articles and resources.

Commission for a Healthier America
WEB SITE The Robert Wood Johnson Foundation Commission to Build a Healthier America looks beyond the medical care system to investigate how factors such as education, environment, income, housing and personal health choices impact the health of all Americans and ultimately provide better opportunities for Americans in every community to grow up and stay healthy. Even with decades of effort to improve America's health care system, too many Americans still die earlier than they should, and too many are suffering from conditions that can be prevented.
The RWJF Commission released a report in February 2008, Overcoming Obstacles to Health, that provides a profile of the current state of health in America.

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Library of Resources on Social Determinants of Health

WEB SITE created and maintained by Dennis Raphael
A great collection of resources on the issues surrounding SDOH, health equity, and the politics of creating real change in the social factors that most affect health outcomes.

See especially Raphael's "Public policies and the problematic USA population health profile," and "The Politics of Population Health: Why the Welfare State is the Key Social Determinant of Health."

Race, Ethnicity, and Health

BOOK edited by Thomas A. LaVeist: This public health reader brings together the best peer reviewed research literature from the leading scholars and faculty in this growing field. This original and much-needed resource will be invaluable to graduate students and researchers alike. The book provides a historical and political context for the study of health, race, and ethnicity, with key findings on disparities in access, use, and quality. This volume also examines the role of health care providers in health disparities and discusses the issue of matching patients and doctors by race.

Reaching for a Healthier Life: Facts on Socioeconomic Status and Health in the U.S. (pdf)

REPORT from The John D. and Catherine T. MacArthur Foundation Research Network on Socioeconomic Status and Health, 2007
An overview of how socioeconomic status affects health, though consideration of neighborhood, employment conditions, personal behaviors, health care, race and stress. Includes policy implications. The MacArthur Network on SES and Health

brings together many of the world's top researchers on socioeconomic factors in health. Many of these experts were interviewed for *Unnatural Causes.*

More Suggested Readings

The Hot Spotters: Can we lower medical costs by giving the neediest patients better care? (http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande)
ARTICLE by Atul Gawande: This article provides an example of place-based health equity work that is of interest to HREP. In Camden, New Jersey, it was determined that 70 % of emergency room visits were made by residents from one neighborhood. Health equity leaders started to ask questions: Who is visiting? Where exactly are they from? How much do these visits cost the system? What is the illness/ailment that sent them to the E.R? Are these illnesses preventable? And how much would it cost to go into a community to provide services in order to prevent E.R visits and illness. For example, if a single homeless man is determined to experience challenges that lead to E.R. visits, the health equity leaders in Camden would seek out long-term shelter and food solutions.

"Life and Death from Unnatural Causes"
(http://www.acphd.org/media/53628/unnatcs2008.pdf)
Certain groups of people in Alameda County are getting sick and dying prematurely from "*Unnatural Causes.*" In Alameda County, access to proven health protective resources like clean air, healthy food, and recreational space, as well as opportunities for high quality education, living wage employment, and decent housing, is highly dependent on the neighborhood in which one lives. These inequities cluster and accumulate over people's lives and over time successfully conspire to diminish the ultimate quality and length of life in these neighborhoods. Some of the social inequities that are associated with poor health are:
• A retail salesperson would need to work nearly 100 hours per week to afford fair market rent for a 2- bedroom apartment.
• Households earning less than $20,000 per year spend over half of their income on transportation.
• A teacher of poorer students in Oakland Unified School District makes $14,000 less than a teacher of wealthier students in Piedmont Unified School District.
• West Oakland residents breathe air that contains 3 times more diesel particles than in the rest of the Bay area.
• African Americans are sentenced to prison for drug offenses at a rate 34 times that for Whites even though they use illicit drugs at about the same rate.
• Latinos are 5 times as likely as Whites to lack health insurance.

Periodic Health Disparities & Inequalities Report by the Center for Disease Control and Prevention

In 2011, the Center for Disease Control released its first Periodic Health Disparities & Inequalities Report. Below is information from and about the report.

Persistent health disparities in our country are unacceptable and correctable. The problem must be addressed with dual strategies – both universal interventions available to everyone and targeted interventions for populations with special needs.

The *CDC Health Disparities and Inequalities Report, 2011*, is the first in a series of periodic, consolidated assessments that highlight health disparities by sex, race and ethnicity, income, education, disability status and other social characteristics in the U.S.

The report provides analysis and reporting of the recent trends and ongoing variations in health disparities and inequalities in selected social and health indicators, both of which are important steps in encouraging actions and facilitating accountability to reduce modifiable disparities by using interventions that are effective and scalable.

Disparities Examined
The report addresses disparities in health-care access, exposure to environmental hazards, mortality, morbidity, behavioral risk factors, disability status, and social determinants of health at the national level.

Report Supports National Disparities Elimination Efforts
The information provided in the report is of vital importance in achieving the goals of *Healthy People 2020* and the upcoming release of the National Partnership for Action (NPA) to End Health Disparities. CDC's report also complements the annual *National Healthcare Disparities Report* and the periodic reports related to *Healthy People 2020*.

Dual Strategy Necessary to Reduce Disparities
The data presented throughout the report provide a compelling argument for action. Some articles identify promising programs and interventions that have been demonstrated to be effective in reducing the burden of disease or risk factors for a specific health problem. The report recommends addressing health disparities with dual intervention strategies related to health and social programs, and more broadly, access to economic, educational, employment, and housing opportunities.

A dual strategy includes national and locally determined interventions universally available to everyone as well as targeted interventions available to populations with specific needs. CDC and its partners can use the findings in this periodic report to raise awareness and

understanding of which groups are most vulnerable. The findings also can help motivate increased efforts to intervene at the state, tribal, and local levels to best address health disparities and inequalities.

Read more and/or download the report here: http://www.cdc.gov/Features/HealthDisparitiesReport/

Beyond the Basics of Health Equity

Social Determinants of Health: The Canadian Facts
ARTICLE by Juha Mikkonen and Dennis Raphael
The primary factors that shape the health of Canadians are not medical treatments or lifestyle choices but rather the living conditions they experience. This report considers 14 social determinants of health and outlines why they are important; how Canada is doing in addressing them; and what can be done to improve their quality. The purpose of the document is to provide promote greater awareness of the social determinants of health and the development and implementation of public policies that improve their quality.

Tackling Health Inequities Through Public Health Practice: Theory to Action
BOOK edited by Richard Hofrichter and Rajiv Bhatia
Social justice has always been a core value driving public health. Today, much of the etiology of avoidable disease is rooted in inequitable social conditions brought on by disparities in wealth and power and reproduced through ongoing forms of oppression, exploitation, and marginalization. Tackling Health Inequities raises questions and provides a starting point for health practitioners ready to reorient public health practice to address the fundamental causes of health inequities. This reorientation involves restructuring the organization, culture and daily work of public health. Tackling Health Inequities is meant to inspire readers to imagine or envision public health practice and their role in ways that question contemporary thinking and assumptions, as emerging trends, social conditions, and policies generate increasing inequities in health.

The Biology of Disadvantage: Socioeconomic Status and Health
JOURNAL Nancy E. Adler and Judith Stewart, eds. *Annals of the New York Academy of Science*
How does socioeconomic status get under the skin? This book summarizes the decade of research by the MacArthur Foundation Research Network on Socioeconomic Status and Health "exploring the pathways and mechanisms that contribute to the gradient relationship between socioeconomic status and health."

The Status Syndrome: How Social Standing Affects Our Health and Longevity
BOOK by Sir Michael Marmot, 2004

Marmot, advisor to the World Health Organization and one of the premiere scholars on social determinant of health, presents the results of his own 30 year study into the effects of class on health, together with a comprehensive overview of current theory and research. He highlights how a sense of autonomy and control over our lives can be a key factor in our ability to live long, thriving lives.

"**Where you live may signal life expectancy**"
ARTICLE by Angela Hill, Oakland Tribune Posted: 04/17/2008
http://www.contracostatimes.com/ci_8966052
 "Social inequity is health inequity," [Tony] Iton said. "Education policy is health policy. Transportation policy is health policy. All these things are connected, and we need to harmonize these strategies across the board because — right now — years of life are lost due to social conditions."

Health Equity: Reports and Resources from Local Partners

Selected Readings from PolicyLink
PolicyLink is a national research and action institute advancing economic and social equity by Lifting Up What Works.® Guided by the belief that those closest to the nation's challenges are central to finding solutions, PolicyLink relies on the wisdom, voice, and experience of local residents and organizations. Lifting Up What Works is PolicyLink's way of focusing attention on how people are working successfully to use local, state, and federal policy to create conditions that benefit everyone, especially people in low-income communities and communities of color. PolicyLink was a partner in creating the Richmond Community Health and Wellness Element (http://www.ci.richmond.ca.us/index.aspx?nid=2412) and continues to be partner in creating health equity for all.

The PolicyLink Center for Health Equity and Place is committed to achieving health equity as an essential component of a society that protects and promotes the wellbeing of all people. Specifically, the Center for Health Equity and Place seeks to eliminate the unjust and unfair social and economic conditions that have caused disparities in health outcomes; particularly for low income people and communities of color. They recognize that factors in the environment – including economic, social, and physical characteristics – directly and indirectly impact health outcomes, and we are committed to making changes needed in policy, practice and research to reduce the disproportionate impact on those most affected. Recognizing that systemic changes involve long-term strategies, the Center for Health Equity and Place begins by broadening an understanding of the root causes of health disparities and working strategically with others to insert a health equity lens in the

creation of new policies and practices. Our center's emphasis on framing is a critical element of our work, as we shift the focus from the individual to the environment and from primary clinical solutions to broad-based community change. The PolicyLink Center for Place and Health employs a variety of strategies to achieve their vision of healthy communities of opportunity including advocacy, technical assistance, research and data analysis, convenings, and communications.

Below are a few recent PolicyLink reports related to Health Equity:

[Why Place & Race Matter: Impacting health through a Focus on Race and Place](#)
This report builds on our earlier work to look more intentionally and explicitly at race and ethnicity and what they mean in the context of building healthy communities. Our research and our conversations with people working in the field have reaffirmed our belief that place matters. By the same token, race matters—a lot. Race is an overarching consideration that affects where and how we all live. Race continues to fracture our society, compounding disadvantage and perpetuating it across generations. Download the report [here:](#) [http://www.policylink.org/atf/cf/%7B97c6d565-bb43-406d-a6d5-eca3bbf35af0%7D/WPRM%20FULL%20REPORT%20(LORES).PDF](#)

[California's Tomorrow: Equity is the Superior Growth Model](#)
Long at the cutting edge of the nation's demographic transformation, California continues to grow more racially and ethnically diverse. This diversity will be the key to the state's future economic success—if its leaders take immediate and decisive action to increase fairness and opportunity. Read more and/or download [this report](#): [http://www.policylink.org/site/apps/nlnet/content2.aspx?c=lkIXLbMNJrE&b=5136581&ct=11635213](#)

[Healthy Food, Healthy Communities: Expanded Version](#)
By Lifting Up What Works,® this report will help advocates, policymakers, community-based organizations, residents, and other stakeholders replicate and create successful models for ensuring that all communities have access to healthy food and the wide range of benefits it brings. Read more and/or download [this report:](#) [http://www.policylink.org/site/apps/nlnet/content2.aspx?c=lkIXLbMNJrE&b=5136581&ct=10958405](#)

[Fostering Equitable Foreclosure Recovery](#)
This report provides essential information to inform policy discussions about foreclosure recovery. It presents information about the foreclosure crisis and its consequences, describes the federal program created to help communities recover

from the impacts of foreclosures, shares case studies of foreclosure recovery efforts in three regions in the Northwest – Minneapolis-St. Paul, Portland, and Seattle. Read more and/or download this report: http://www.policylink.org/site/apps/nlnet/content2.aspx?c=lkIXLbMNJrE&b=5136581&ct=11622025

For more other PolicyLink materials, visit the Center for Health Equity and Place on their website: http://www.policylink.org/site/c.lkIXLbMNJrE/b.5136633/k.F267/PolicyLink_Center_for_Health_and_Place.htm

Prevention Institute

As a national non-profit organization, the Prevention Institute is committed to preventing illness and injury, to fostering health and social equity, and to building momentum for community prevention as an integral component of a quality health system. Prevention Institute synthesizes research and practice; develops prevention tools and frameworks; helps design and guide interdisciplinary partnerships; and conducts training and strategic consultation with government, foundations, and community-based organizations nationwide and internationally. Prevention Institute brings cutting-edge research, practice, and analysis to today's pressing health and safety concerns. Determined to achieve health and safety for all, to improve community environments equitably, and to serve as a focal point for primary prevention practice, the Institute asks what can be done *in the first place*, before people get sick or injured. Prevention Institute has inspired a broad, comprehensive approach to systematizing prevention as a distinct discipline—not simply an educational message.

Below are selected readings from PolicyLink:

Leading the Way: California's Approach to Health and Equity in Tough Times
Despite tough economic times, California must remain in the forefront as a national leader in health, environmental protection and community prevention. Doing so will maximize federal resources flowing into California, while maintaining a focus on effective governance and good solutions. Priorities for action are summarized in this report in the following categories: 1.Administrative Actions; 2. Legislative Priorities; and 3. Federal Leverage Points. Read more and/or download the report here: http://www.preventioninstitute.org/component/jlibrary/article/id-308/127.html

Prevention is Primary: Strategies for Community Wellbeing
From its inclusion in the economic stimulus to its role in the Affordable Care Act,

prevention has unprecedented national recognition and newly dedicated resources. The updated and revised second edition of *Prevention is Primary* arrives on bookshelves in time to prepare public health advocates, the primary care workforce, and community-based organizations to fully participate in this new national conversation, equipping readers with best-practices, concrete prevention tools, and strategies to strengthen community efforts. Read more and/or download [the report here:](http://www.preventioninstitute.org/component/jlibrary/article/id-102/127.html) http://www.preventioninstitute.org/component/jlibrary/article/id-102/127.html

[Recipes for Change: Healthy Food in Every Community](#)
Recipes for Change: Healthy Food in Every Community was originally developed as a learning document for the Convergence Partnership. The paper outlines organizational practices and public policies to expand access to healthy foods in support of healthy eating and better overall health. Now we are pleased to share the findings with the field. We hope to spur action to make healthy goods widely available, particularly in low-income communities and communities of color, and to build a healthier food system in the United States. Read more and/or download [the report her](http://www.preventioninstitute.org/component/jlibrary/article/id-266/127.html)e: http://www.preventioninstitute.org/component/jlibrary/article/id-266/127.html

Pacific Institute

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[Measuring What Matters](#)
Published by the Pacific Institute and seven local partner organizations, "Measuring What Matters: Neighborhood Research for Economic and Environmental Health and Justice in Richmond, North Richmond, and San Pablo" quantifies how serious, avoidable problems have become chronic and offers solutions for a better, more equitable way of life in West County. The West County Indicators Project was launched in 2006 to work with local residents and organizations to build power to achieve a vision for healthy communities in West Contra Costa County. The individuals and groups who have worked on the issues in the resulting report have produced action plans to identify and address the concerns they feel most impact their quality of life and health. The bottom line is that a healthy community requires environmental and economic justice. Read more or download the [report here:](http://pacinst.org/reports/measuring_what_matters/index.htm) http://pacinst.org/reports/measuring_what_matters/index.htm

Health Equity: A Few Key Academic Articles

Social conditions as fundamental causes of disease

ARTICLE by Link and Phelan

Link and Phelan (1995) developed the theory of fundamental causes to explain why the association between socioeconomic status (SES) and mortality has persisted despite radical changes in the diseases and risk factors that are presumed to explain it. They proposed that the enduring association results because SES embodies an array of resources, such as money, knowledge, prestige, power, and beneficial social connections that protect health no matter what mechanisms are relevant at any given time. In this article, we explicate the theory, review key findings, discuss refinements and limits to the theory, and discuss implications for health policies that might reduce health inequalities. We advocate policies that encourage medical and other health-promoting advances while at the same time breaking or weakening the link between these advances and socioeconomic resources. This can be accomplished either by reducing disparities in socioeconomic resources themselves or by developing interventions that, by their nature, are more equally distributed across SES groups.[xi]

More Link and Phelan: Link, B. G., & Phelan, J. 1995. "Social conditions as fundamental causes of disease." *Journal of Health and Social Behavior*. Spec No, 80-94.

Health inequalities among British civil servants: the Whitehall II study

ARTICLE by Marmot, Michael, et al

The Whitehall study of British civil servants begun in 1967, showed a steep inverse association between social class, as assessed by grade of employment, and mortality from a wide range of diseases. Between 1985 and 1988 we investigated the degree and causes of the social gradient in morbidity in a new cohort of 10,314 civil servants (6900 men, 3414 women) aged 35-55 (the Whitehall II study). Participants were asked to answer a self-administered questionnaire and attend a screening examination. In the 20 years separating the two studies there has been no diminution in social class difference in morbidity: we found an inverse association between employment grade and prevalence of angina, electrocardiogram evidence of ischaemia, and symptoms of chronic bronchitis. Self-perceived health status and symptoms were worse in subjects in lower status jobs. There were clear employment-grade differences in health-risk behaviours including smoking, diet, and exercise, in economic circumstances, in possible effects of early-life environment as reflected by height, in social circumstances at work (eg, monotonous work characterised by low control and low satisfaction), and in social supports. Healthy behaviours should be encouraged across the whole of society; more attention should be paid to the social environments, job design, and the consequences of income inequality.[xii]

A glossary for health inequalities

ARTICLE by I Kawachi, SV Subramanian, and N Almeida-Filho

In this glossary, the authors address eight key questions pertinent to health inequalities: (1) What is the distinction between health inequality and health inequity?; (2) Should we assess health inequalities themselves, or social group inequalities in health?; (3) Do health inequalities mainly reflect the effects of poverty, or are they generated by the socioeconomic gradient?; (4) Are health inequalities mediated by material deprivation or by psychosocial mechanisms?; (5) Is there an effect of relative income on health, separate from the effects of absolute income?; (6) Do health inequalities between places simply reflect health inequalities between social groups or, more significantly, do they suggest a contextual effect of place?; (7) What is the contribution of the lifecourse to health inequalities?; (8) What kinds of inequality should we study?[xiii]

Defining equity in health
ARTICLE by P Braveman, S Gruskin

For the purposes of measurement and operationalisation, equity in health is the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage—that is, wealth, power, or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health; health is an essential to wellbeing and to overcoming other effects of social disadvantage. Equity is an ethical principle; it also is consonant with and closely related to human rights principles. The proposed definition of equity supports operationalisation of the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group. Assessing health equity requires comparing health and its social determinants between more and less advantaged social groups. These comparisons are essential to assess whether national and international policies are leading toward or away from greater social justice in health.[xiv]

More Paula Braveman, a leader in health equity thinking

Defining equity in health. Journal of Epidemiology and Community Health

Monitoring Equity in Health and Healthcare: A Conceptual Framework. Journal of Health, Population and Nutrition

Health Disparities and Health Equity: Concepts and Measurement Annual Review of Public Health

Key Readings about the Relationship between Public Health and Urban Planning

[Confronting the Challenges in Reconnecting Urban Planning and Public Health](#)
ARTICLE by Jason Corburn
Although public health and urban planning emerged with the common goal of preventing urban outbreaks of infectious disease, there is little overlap between the fields today. The separation of the fields has contributed to uncoordinated efforts to address the health of urban populations and a general failure to recognize the links between, for example, the built environment and health disparities facing low-income populations and people of color. Doctor Corburn reviews the historic connections and lack thereof between urban planning and public health, highlight some challenges facing efforts to recouple the fields, and suggest that insights from ecosocial theory and environmental justice offer a preliminary framework for reconnecting the fields around asocial justice agenda.[xv]

[Toward the Healthy City: People, Places, and the Politics of Urban Planning](#)
BOOK by Jason Corburn
In distressed urban neighborhoods where residential segregation concentrates poverty, Liquor Stores outnumber supermarkets, toxic sites are next to playgrounds, and more money is spent to prisons than schools, residents also suffer disproportionately from disease and premature death. Recognizing that city environments and the planning processes that shape them are powerful determinants of population health, urban planners today are beginning to take on the added challenge of revitalizing neglected urban neighborhoods in ways that improve health and promote greater equity. In *Toward the Healthy City,* Jason Corburn argues that city planning must return to its roots in public health and social justice. The first book to provide a detailed account of how city planning and public health practices can reconnect to address health disparities, *Toward the Healthy City* offers a new decision-making framework called "healthy city planning" that reframes traditional planning and development issues and offers a new scientific evidence base for participatory action, coalition building, and ongoing monitoring. To show healthy city planning in action, Corburn examines collaborations between government agencies and community coalitions in the San Francisco Bay area, including efforts to link environmental justice, residents' chronic illnesses, housing and real estate development projects, and planning processes with public health. Initiatives like these, Corburn points out, go well beyond recent attempts by urban planners to promote public health by changing the design of cities to encourage physical activity. Corburn argues for a broader conception of healthy urban governance that addresses the root causes of health inequities.

Deficit Thinking: An Introduction and Selected Readings

<u>What is deficit thinking?</u>
Deficit thinking posits that individuals or entire communities are unsuccessful, and/or suffer the effects of social and health equity do so because of internal deficiencies. This model does not consider the root causes of failures at school, health disparities, etc. As well, the deficit thinking paradigm does not seek assets (either of the individual or community), missing opportunities to identify protective factors that lead to resilience (see following section) or identify "what works." when individuals succeed or when communities are safe and healthy despite assumptions of failure. When thinking about school leadership and changing school environments, identifying and replacing deficit thinking is particularly important.

Deficit Thinking: Selected Readings

Displacing deficit thinking in school district leadership. Education and Urban Society
ARTICLE by Skrla, L. and Scheurich, J.J
The deficit thinking paradigm, as a whole, posits that students who fail in school do so because of alleged internal deficiencies (such as cognitive and/or motivational limitations) or shortcomings socially linked to the youngster-such a familial deficits and dysfunctions .... The popular "at-risk" construct, now entrenched in educational circles, views poor and working class children and their families (typically of color) as predominantly responsible for school failure.

Valencia argued, further, that such deficit thinking is deeply embedded in educational thought and practice and that it pervades schools that serve children from low-income homes and children of color. That is, even though virtually every u.s. school has a mission statement containing some form of the aphorism "all children can learn," actual practices and programs in these same schools are suffused with deficit views of the educability of children of color and children from low-income homes. The result of this pervasive deficit approach is that students from low-income homes and students of color routinely and overwhelmingly are tracked into low-level classes, identified for special education, segregated based on their home languages, subjected to more and harsher disciplinary actions, pushed out of the system and labeled "dropouts," underidentified as "gifted and talented," immersed in negative and "subtractive" school climates, and sorted into a plethora of "remedial," "compensatory," or "special" programs.[xvi] [xvii]

Deconstructing deficit thinking: Working with educators to create more equitable learning environments

ARTICLE by Garcia, S.B. and Guerra, P.L.

Studies of comprehensive school reform suggest that such efforts often fail because of educators' unwillingness to examine the root causes of underachievement and of failure among students from low-income and racially or ethnically diverse backgrounds and because of their tendency to locate the problem within students, families, and communities. Reform efforts are undermined by educators' deficit views and by their beliefs about the children who become the targets of reform.[xviii] They believe that the students and the families are at fault because, from their perspective, "these children" enter school without the necessary prerequisite knowledge and skills and that so-called uncaring parents neither value nor support their child's education.[xix] Because these educators do not view themselves as part of the problem, there is little willingness to look for solutions within the educational system itself.[xx]

Additional Selected Readings about Deficit Thinking:

"Deficit thinking"
http://www.learnnc.org/lp/pages/990
Contemporary deficit thinking falls into three distinct categories: neohereditarianism, the culture of poverty paradigm and the theses of cultural and environmental deficits. Each category represents a modern form of thought that has roots as far back as the 17th century. Each also has a long history of being suited to a particular historical period's socially acceptable ways of talking about race, immigration and education**.**

"Challenging Deficit Thinking"
http://www.english.iup.edu/hcs/Rural%20Literacy%20Readings/Challenging%20Deficit%20Thinking.pdf

Valencia, R. R. Dismantling Contemporary Deficit Thinking: Educational Thought and Practice (The Critical Educator)

Valencia, R. R. & Black, M. S. (2002). " Mexican Americans don't value education!" – On the basis of the myth, mythmaking, and debunking. Journal of Latinos and Education, 1(2), 81-103.

Valencia, R. R . The Evolution of Deficit Thinking: Educational Thought and Practice (Stanford Series on Education and Public Policy)

Resilience: An Introduction and Selected Readings

What is Resilience?

In a succinct distillation, Cohen and Schuchter[xxi] define resilience as the ability to withstand negative external stressors and it is determined by psychosocial and environmental factors. On the psychosocial level, they offer, resilience refers to how people respond to stress[xxii] and is conceptualized as normal development under difficult or adverse conditions.[xxiii] On the environmental level, resilience entails adaptation and accommodating change gracefully and without catastrophic failure.[xxiv]

Resilience can be defined as both the "the capacity of a child to deal effectively with stress and pressure, to cope with everyday challenges, to rebound from disappointments, mistakes, trauma, and adversity, to develop clear and realistic goals, to solve problems, to interact comfortably with others, and to treat oneself and others with respect and dignity", *and* as the "ability to meet life's challenges with thoughtfulness, confidence, purpose, responsibility, empathy, and hope". Resilience can be understood as a process or an ability (not a personality trait); it can be measured at the individual or community level; and resilience can be supported by both psychosocial and environmental factors.

Potentially, an understanding of what makes residents and communities "resilient" can inform and influence the design of policy and interventions that seek to support and maintain that which makes residents and their neighborhoods "resilient."

Resilience: Selected Readings

The construct of resilience: Implications for interventions and social policies
ARTICLE by Luthr and Cicchetti

The focus of this article is on the interface between research on resilience—a construct representing positive adaptation despite adversity —and the applications of this work to the development of interventions and social policies. Salient defining features of research on resilience are delineated, as are various advantages, limitations, and precautions linked with the application of the resilience framework to developing interventions. For future applied efforts within this tradition, a series of guiding principles are presented along with exemplars of existing programs based on the resilience paradigm. The article concludes with discussions of directions for future work in this area, with emphases on an enhanced interface between science and practice, and a broadened scope of resilience-based interventions in terms of the types of populations, and the types of adjustment domains, that are encompassed.[xxv]

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