

# Beyond the Clinic: A National Health Equity Review

## *Implications for our local safety net*

Health & Medicine  
POLICY RESEARCH GROUP

Wesley Eplin, MPH, Director of Health Equity  
Tiffany N. Ford, MPH, Senior Policy Analyst

### Executive Summary

Safety net systems across the United States are working to improve patient outcomes and improve population health by addressing barriers to quality health and healthcare for their patients. Our local safety net in the Chicago metropolitan area experiences many of the same difficulties as other communities, indicating the need to learn from efforts across the country. Yet, there are few comprehensive studies or reports detailing interventions across localities at both the level of social determinants of health (SDOH) and, more importantly, the structural determinants of health inequities (SDOHI).

Addressing structural determinants has a greater potential for advancing progress on the SDOH—and in larger ways—than direct services in response to inequities. By presenting some opportunities to address both SDOH and SDOHI, this paper seeks to discuss ideas for advancing health equity. For example, in addition to expanding health insurance coverage, the Affordable Care Act (ACA) represents an attempt to recognize that to truly improve patient and population health we have to transform health systems and the ways we address health. The creation of the Center for Medicare and Medicaid Innovation through the ACA, for example, represented a way to begin systems transformation.

This policy and practice review of national work takes us a step further by helping to paint a picture of how the safety net can use this time of health reform opportunity to shift toward addressing social determinants of health, structural determinants of health inequities, and ultimately health equity.

There are ample studies and papers detailing clinical care interventions and programs to provide more services to meet unaddressed needs. Rarely do these

studies focus on the need for large safety net institutions to utilize their individual and collective political power to change the structural inequities that drive the inequitable distribution of social determinants of health.

To make a valuable and new contribution to the trajectory of healthcare's interest in advancing health equity, this paper does not focus on social determinants of health. Rather, it gives some examples of this work to orient readers to research and national efforts. Then the paper pivots to focus on how the power of the health sector—which represents roughly 18% of the U.S. economy—could be better used to influence structural drivers of inequities.<sup>1</sup>

#### In this Brief:

Definitions and Frameworks	p. 2
Intervening on the Social Determinants of Health: A National Scan	p. 4
Health Equity Imperative: Intervening on Structural Inequities	p. 8
Opportunities for the Safety Net to Intervene on Structural Inequities	p. 10
Conclusion	p. 17

*This paper is part of a larger project, Creating Healthy Communities: Helping the Safety Net Navigate the Challenges and Opportunity of Health Reform, examining how the ACA and state level health reforms can support the move toward health equity and stronger communities in the Chicago area. The companion paper, A Qualitative Review of Chicago's West Suburban Safety Net, can be found [here](#).*

## Definitions and Frameworks

### Definitions of Health Equity

The metaphor of a “safety net” as applied to social programs designed to help ensure that people do not “hit the ground” or die when social and economic forces cause them to “fall” likely comes from the use of safety nets in the circus. While safety net programs such as Medicaid, Medicare, Children’s Health Insurance Program (CHIP), Temporary Assistance for Needy Families (TANF), and Supplemental Nutrition Assistance Program (SNAP) help millions of Americans, those working to advance health equity must ask: *Why are some people more likely to fall while others are secure? How do we ensure people do not fall? Why does it remain normal that so many people fall through the gaps—that we don’t have guarantees for basic human rights such as housing, food, and healthcare?*

Generally, the purpose of safety net systems is to serve as a safeguard against poor health outcomes for those who cannot afford other services, and to ensure people receive support for basic human needs. As such, these systems should have the ultimate goal of **health equity**, achievement of which is listed as an overarching goal of Healthy People 2020, the Centers for Disease Control and Prevention’s (CDC) list of national health goals and priorities. But what does “health equity” mean? Many researchers and organizations have created definitions that seek to explain the concept. Below are four examples of definitions of health equity.\*

Throughout the document, the authors have chosen to use the following definition provided by Dr. Camara Jones, a leading public health researcher

---

#### \* Other Definitions of Health Equity:

##### *World Health Organization Definition*

Equity is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically.

##### *CDC Definition*

When all people have “the opportunity to ‘attain their full health potential’ and no one is ‘disadvantaged from achieving this potential because of their social position or other socially determined circumstance’”.

and former President of the American Public Health Association:

#### Dr. Camara Jones’ Definition

Health equity is a process of assurance of the conditions for optimal health for all people. It requires at least three things:

1. Valuing all individuals and populations equally
2. Recognizing and rectifying historical injustices
3. Providing resources according to need

Jones, Camara P. *Social Determinants of Equity and Social Determinants of Health*. (Undated). Presentation on behalf of the Centers for Disease Control and Prevention. Retrieved from: <https://minorityhealth.hhs.gov/Assets/pdf/Checked/1/CamaraJones.pdf>

Dr. Jones’ definition of health equity is especially helpful both because of what it offers to the analysis of equity and the ways in which it can be operationalized. This definition successfully:

- Describes health equity as a process of assurance instead of outcome: This portion of the definition says that health equity is a process instead of an end goal, outcome, or a future state of affairs. Therefore, if we eliminate health disparities (or health inequities), we are still not finished as a field with the process of health equity, because there is a need for ongoing *assurance of the conditions for optimal health for all people*. Dr.

##### *Health Affairs Definition*

Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.

For the purposes of measurement, health equity means reducing and ultimately eliminating disparities in health and its determinants that adversely affect excluded or marginalized groups.

Jones has also pointed out that “assurance” is one of the three core functions of public health named by the National Institute of Medicine in the 1988 report, *The Future of Public Health*, and also adopted by the CDC.

- **Operationalizes what needs to be done:** Often, definitions leave us wondering what steps to take in order to address the issue. Dr. Jones’ definition of health equity provides three concrete actions that can help us to begin the process of health equity. Some of her further presentations on this topic provide additional concrete examples of ways in which members of the safety net can participate in this process.
- **Brings history into the conversation:** While health is impacted by individual behavior, it is also a product of families and communities. If you are born into a family or community that historically has been disadvantaged, it makes sense that we need to acknowledge that starting point as we work toward equity.<sup>2</sup> It is important to understand why these inequities exist in order to redress them. (Ecosocial theory articulated by social epidemiologist Dr. Nancy Krieger may also be helpful in considering how health inequities are in part an embodiment of historic injustice.)

## Definition of Social Determinants of Health

The **social determinants of health** are “the conditions in the environments in which people live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”<sup>3</sup> Social determinants of health are shaped by the distribution of money, power, and resources.<sup>4</sup>

## Definition and Implications of Structural Determinants of Health Inequities

“**Structural determinants of health inequities**, more simply referred to as **structural inequities**, refers to the systemic disadvantage of one social group compared to other groups with whom they coexist and the term encompasses policy, law, governance, and culture and refers to race, ethnicity, gender or gender identity, class, sexual orientation, and other domains.”<sup>3</sup> When thinking about structural inequities, references to these identities are needed to highlight the ways in which

structural inequities not only *disadvantage* some groups of people, but also *advantage* other groups and impact health outcomes and health inequities for everyone.

## Why These Definitions and Frameworks Matter

There is an important distinction between the “social determinants of health” and “structural determinants of health inequities,” a distinction that is often not made in discussion of these topics.

The phrase, “structural determinants of health inequities,” is made up of a string of jargon words. What do they mean? Discussions about the “social determinants of health” often include topics like housing, education, transportation, and food systems. Each of these—and other systems, and the policies and practices related to them—are factors that relate to and contribute to health. Inequities in these systems are closely related to health inequities. What determines the degree to which some groups have access to social determinants of health and others do not? In other words, what distributes the social determinants of health inequitably?

As mentioned above, the structural determinants of health inequities are the more causal factor related to the distribution of the social determinants of health. Safety net stakeholders that have a focus on health equity should increasingly focus on structural determinants of health inequities through supporting community-based efforts to build power and demand that money, power, and resources are equitably distributed.

This does not negate the importance of efforts to help mitigate health problems resulting from maldistribution of the social determinants of health through programs like food pantries or housing programs. While these efforts should continue, these actions alone will not advance health equity as defined by Dr. Jones. To amplify such efforts, the structural determinants of health inequities level—the structures, systems, policies, and values that stratify populations’ access to social determinants of health—are a prime area for all safety net stakeholders to engage in. There are a variety of strategies and tactics that safety net stakeholders can

utilize in this work which can also support community health and wellbeing.

**In order for safety net stakeholders to improve the health of the populations they serve and make progress on health equity, they must engage their own power, public voice, lobbying, and advocacy to support the demands for equitable social determinants of health being made by marginalized communities.**

Also, safety net stakeholders should offer resources, such as funding, meeting spaces, and research to community-based groups who are organizing to build power and make demands of government and other systems for equitable resources and opportunities.

## Intervening on the Social Determinants of Health: A National Scan

Safety net system stakeholders including nonprofit and public hospitals, local health departments, free and charitable clinics, federally qualified health centers (FQHCs), and philanthropy have increasingly been more attentive to addressing the social determinants of health.

Hospitals, for instance, have historically been anchors of communities. In recent years, they have begun to further honor their anchor missions by focusing on interventions such as purchasing more goods and services locally; implementing local hiring; and supporting community efforts like providing housing or supporting local schools. The ACA required nonprofit hospitals to both regularly conduct community health needs assessments (CHNA) and to spend community benefits dollars in response to the needs identified in the CHNAs. Also, nonprofit and public hospitals have long provided charity care (to varying degrees) to un- or under-insured patients.

Likewise, other safety net stakeholders have played key roles in community health. For example, FQHCs arose from the community health center movement, in which communities founded health centers where they were needed to provide care to people who did not otherwise have access, often hiring people from the community. Local health departments protect

and promote the health of the public, and grantmakers have provided funds to all types of safety net stakeholders, often serving in other supportive functions such as convening others.

In this section we have identified some examples based on existing national research reports of how safety net stakeholders have intervened on the social determinants of health. While Chicago area safety net systems are still in the early phases of this work, local efforts do exist. For instance, Rush University Medical Center and the Cook County Health & Hospital System have both undertaken serious efforts over the course of the past year to tackle food insecurity and transportation barriers. Many of these more recent examples are not included in our analysis as results have not yet been published. In the next section we will move on to discuss policies and interventions safety net stakeholders can implement to advance health equity.

### Housing

#### Local health department effort | Alameda County, California

“Since their initial meetings in 2010, the Alameda County Place Matters Housing Workgroup has involved residents, community advocates and organizers, housing-related service providers, government agencies, and decision makers to develop, advocate for, adopt, and support implementation of policies to address housing habitability, affordability, and access in Alameda County. The Workgroup’s efforts have primarily been focused in Alameda County’s lowest-income neighborhoods that are most impacted by racial health inequities.”<sup>5</sup>

#### Local health department effort | Chicago, Illinois

The Corporation for Supportive Housing is leading a housing and health effort that includes partnering with the Chicago Department of Public Health. This project includes a flexible, nontraditional funding source to provide supportive housing interventions for people experiencing homelessness, complex health needs, and involvement in multiple systems.<sup>6</sup>

## **Health system effort | New York City, New York**

“SBH Health System in New York City’s Bronx borough sold part of its campus to a developer to build low-income housing. It opened an urgent care center and other outpatient facilities in the new development.”<sup>7</sup>

## **Health system effort | Chicago, Illinois**

The University of Illinois at Chicago Health System (UI Health) has developed a Better Health Through Housing program in partnership with the Center for Housing and Health. The program “aims to reduce healthcare costs and provide stability for the chronically homeless by moving individuals directly from hospital emergency rooms into stable, supportive housing, with intensive case management.”<sup>8</sup>

## **Collaborative effort | Portland, Oregon**

In Portland five hospitals and a nonprofit health plan are donating more than \$20 million to help build nearly 400 housing units for homeless and low-income people.<sup>9</sup>

## **National philanthropic efforts**

“Increased awareness of the social determinants of health has led to a greater focus among funders on the intersections of health and housing. Foundations such as the Kresge Foundation, Missouri Foundation for Health, and HealthSpark Foundation are investing in a variety of strategies to bridge health and housing, including financing the construction or renovation of permanent supportive housing, which combines affordable housing with social services for people experiencing homelessness, and remediating substandard housing to eliminate health hazards.”<sup>10</sup>

## **Local philanthropic efforts**

In Chicago, the Chicago Community Trust has increasingly funded organizations to focus on housing using a portion of its newer GO Grant funding to support organizations focused on advancing healthy and affordable housing. GO grants also address other areas of the Trust’s portfolio including the health sector.<sup>11</sup>

## **Transportation**

### **Health systems efforts**

“MedStar Health, a nonprofit health care system with hospitals in Maryland and the District of Columbia, began a partnership with Uber last year. It allows patients to access the ride service while on the hospital’s website and set reminders for medical appointments. Medicaid patients who might not have access to the Uber app can also arrange the ride by calling the hospital’s patient advocates. Hackensack UMC, a hospital in New Jersey, and Sarasota Memorial Hospital in Florida have also set up similar partnerships.”<sup>12</sup>

## **Food**

### **Health system effort | Boston, Massachusetts**

Boston Medical Center runs a program called ‘Systematic Screening, Therapeutic Food Pantry, and Demonstration Kitchen’: “When patients are found to be hunger positive, physicians write prescriptions for healthy foods like fruits and vegetables. Patients can fill these prescriptions at an on-campus food pantry, which serves 7,000 low-income patients each month through a partnership with the Greater Boston Food Bank. Registered dietetic technicians receive the prescriptions via BMC’s electronic health record system and prepare packages of clinically and culturally appropriate foods. This service extends to whole families rather than just individuals, and patients can visit the pantry up to twice a month. The program serves high numbers of patients with chronic conditions, including cancer, HIV/AIDS, inflammatory bowel disease, diabetes, and obesity. BMC also hosts a demonstration kitchen to teach patients how to prepare the foods they receive from the pantry.”<sup>13</sup>

### **Health center effort | Indiana**

Community Health Network is a nonprofit health system in Central Indiana that actively assesses whether its community benefit programs address social determinants of health. They address food insecurity issues in part through financially underwriting a Community Supported Agriculture (CSA) program and a food cooperative to help connect patients and families with additional food.<sup>14</sup>

## **Collaborative effort | California**

Both Catholic Healthcare West and Kaiser Permanente served as founding members of this California Endowment initiative in 2011, investing \$2.5 million and \$1 million, respectively, to help seed what developed into a \$264 million private-public partnership loan fund. Modeled after Pennsylvania's Fresh Food Financing Initiative, the fund aims to increase access to healthy food in underserved communities.<sup>15</sup>

## **Health system effort | Cook County, Illinois**

Cook County Health and Hospitals System (CCHHS) launched a pilot program in 2015 that connected food-insecure patients to fresh produce resources through the Greater Chicago Food Depository. CCHHS uses a two-question food insecurity screening tool during patient intake, and patients who screen positive are given vouchers for fresh produce at mobile produce markets called "FRESH Trucks." CCHHS also connects food-insecure patients in need of permanent assistance to local Supplemental Nutrition Assistance Program and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) resources.<sup>16</sup>

## **Health center efforts nationally**

As early as the 1960s, when community health centers were being developed in the U.S., food security was identified as a fundamental issue for advancing health: "They sought to address the underlying factors that led to many diseases taking root. In Mississippi, malnutrition was one of the overwhelming health conditions. Dr. Jack Geiger and his staff devised an innovative, if fundamentally common-sense, solution: write prescriptions for food. The health center made arrangements with the local grocery so that sick and malnourished children could take their prescriptions for food and have them filled, and the grocer could send the bill to the health center. The health center would then pay those bills using funds from the pharmacy budget. The OEO wasn't keen on this setup initially, saying those funds were only to be used for the treatment of disease, but Geiger made clear that the last time he checked in the book, the treatment for malnutrition was food."<sup>17</sup>

## **Education**

### **Health system effort | California**

Health Policy and Programming Policy (HPPP) staff explored how to move their programmatic work in schools to be more upstream and equity focused. No longer focusing solely on school wellness, but on educational attainment. After learning about the San Francisco School District's restorative justice work and its positive effects on youth mental health, educational attainment, and conflict management, HPPP explored ways to pilot restorative practices in San Mateo County with an eye toward scaling up the program if successful.<sup>18</sup>

### **Health system effort | Minnesota**

"Sean Allen, former Assistant Director of Rochester Area Foundation (RAF), explained that his organization recently collaborated with Mayo on First Steps—an initiative that aims to ensure children start school with proficient literacy skills to succeed. 'It has changed the way we work with them,' he said. Since 2005, Mayo has contributed \$750,000 to this "public-private economic development program" that seeks to reduce the nearly 50 percent of kindergartners who enter school unprepared. Referring to this program as an investment in the community, Susan Ahlquist, former Director of Community Relations for Mayo Clinic (2008–2012), added, 'We recognize the importance of education and early childhood development as key social determinants of health.'"<sup>19</sup>

### **Collaborative effort | Michigan**

"[One] partnership focused on education is the Henry Ford Early College, which is a collaborative effort with the Dearborn Public Schools and Henry Ford Community College (no affiliation to the hospital system). Currently enrolling 250 students, the Early College's intention 'is to take kids, many who are at risk and have a high probability of not completing high school, and get them engaged in a track toward a clinical profession as ninth graders,' according to Schramm. As a result, these students can graduate in as little as five years with their high school diploma, associate's degree, and clinical certificates. Additionally, students will have avoided any tuition costs because state funds support that student for the thirteenth year."<sup>20</sup>

## Employment, Income, and Wealth

### Health systems effort Michigan

“Henry Ford has used its purchasing power to encourage businesses to relocate to Detroit and to actively purchase from existing local businesses to support the revitalization and economic stabilization of the City of Detroit.... Although targeting local purchasing efforts had been part of the culture, Henry Ford, along with Detroit Medical Center and Wayne State, made official a new ‘Buy Detroit’—now Source Detroit—effort in early 2011, leveraging a portion of the three anchors’ nearly \$1.6 billion in annual procurement to help revitalize the city. To date, approximately \$16.5 million in purchasing has been transferred to Detroit-based businesses.”<sup>21</sup>

### Health systems effort | Minneapolis, Minnesota

“Hennepin Health, a patient-centered care program at Hennepin County Medical Center in Minneapolis, works to address the medical and social needs—including unemployment—of low-income patients who have complex or multiple conditions. Hennepin Health has partnered with Rise, Inc., a local organization that offers patients resources to find employment. In addition, the two organizations work together to provide patients with appropriate housing, as increases in wages may displace patients from low-income housing. These efforts have decreased healthcare costs for program participants by 60%.”<sup>22</sup>

### Philanthropic efforts

“The Consumer Health Foundation recently shifted its health justice portfolio to explicitly focus on economic justice as a key social determinant of health. The foundation funds grantees that advocate for policies on workers’ rights, living-wage campaigns, and workforce development. The foundation has also partnered with other local foundations to launch a new community wealth-building initiative in the Washington, D.C. region.”<sup>23</sup>

## Cross-Cutting Efforts

### Health system effort | Chicago, Illinois

Rush University Medical Center, in collaboration with other health systems and local community organizations, is working to develop a screening tool

to identify social determinants of health that may be affecting patient health, and set up a referral system for patients who need assistance.<sup>24</sup>

### Health system effort | Cook County, Illinois

Cook County Health and Hospital System is able to connect patients to community-based services by screening for SDOH, such as food insecurity, as a part of an integrated care system, and connect patients to resources in the community.<sup>25,26</sup>

### Elements of Hospitals’ Efforts:

Below are some elements that were mentioned in hospitals and health systems’ plans and efforts for advancing health in the communities that they serve:

- Focusing procurement, purchasing, contracting on local-, minority-, and women-owned businesses, to keep dollars local and invest them in jobs in the community, including:
  - Assistance to local businesses in learning how to apply and compete for contracts
  - Use of discretionary funds for small businesses that may not yet be ready to take on a large contract
  - Sourcing food locally
- Workforce diversification efforts with regard to both women and people of color
- Efforts focused on hiring from within the communities in which a health institution (hospital, clinic, etc.) is situated
- Neighborhood revitalization and improvements to local infrastructure and transportation
- Encouraging large suppliers to locate to the city in which the health system is placed, to bring new jobs and economic investment
- Investment in business and technology incubators
- Investments in job training and skill development opportunities\*

*\*Zuckerman, David, with contributions from Sparks, Holly Jo, Dubb, Steve, and Howard, Ted. Hospitals Building Healthier Communities: Embracing the Anchor Mission. <http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/Zuckerman-HBHC-2013.pdf>*

## Medical-Legal Partnerships at Hospitals and Clinics

“Attorneys in general—and poverty lawyers in particular—have an in-depth understanding of relevant policies, laws, and systems, and seek out solutions at the individual and policy levels to a range of health-related social and legal needs. When embedded as specialists in a health care setting, lawyers can directly resolve specific problems for individual patients, while also helping clinical and non-clinical staff navigate system and policy barriers and transform institutional practices. Using legal expertise and services, the health care system can disrupt the cycle of returning people to the unhealthy conditions that would otherwise bring them right back to the clinic or hospital.”

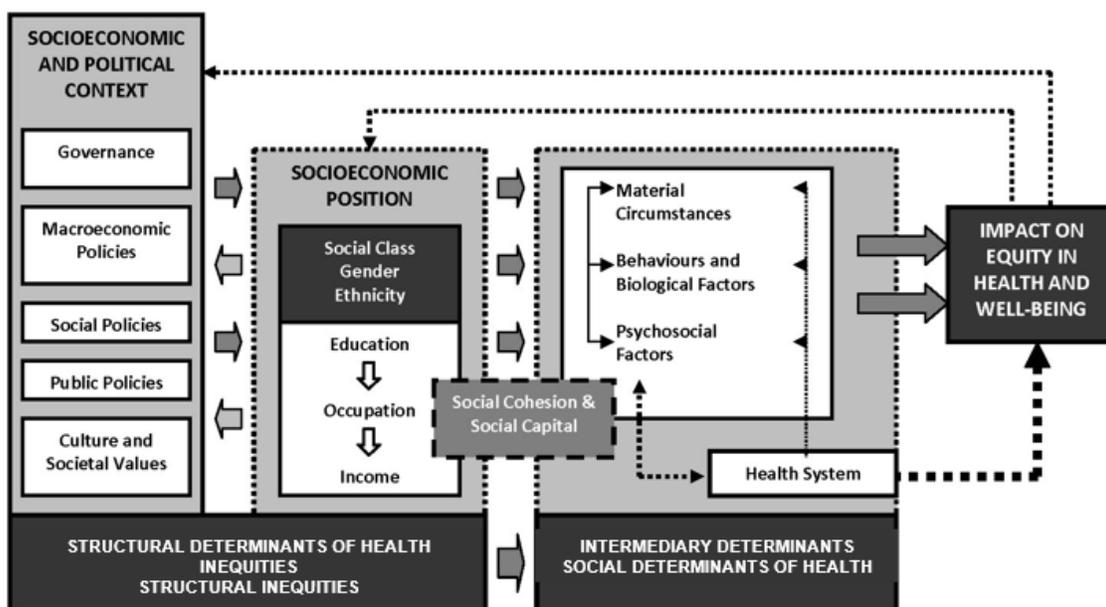
Illinois has dozens of Medical-Legal Partnerships functioning in hospitals, clinics, health schools, and other settings. A list can be found on the National Center for Medical Legal Partnership [here](#).<sup>27</sup>

## Health Equity Imperative: Intervening on Structural Inequities

As defined in the introduction, taking action on the structural determinants of health inequities requires redistribution of power, money, and resources such that they are more equitably distributed.<sup>28</sup>

**Structural inequities** can be marked along the lines of proxy markers for different forms of inequity existing in different policies (at institutional and governmental levels), and in political, economic, social, and cultural contexts. These **proxy measures** include but are not limited to race, ethnicity, sex, gender or gender identity, class, sexual orientation, disability, country of origin, and other demographic or population group domains.<sup>29</sup> The prevalence of structural inequities, manifesting as systems of oppression, such as racism, class inequity, genderism, sexism, heterosexism, ableism, nativism, and other forms of structural oppression is a relevant factor for considering these proxy markers, along the lines of which health inequities may be measured. Belonging to one or more group that is disadvantaged by a particular structural inequity may experience inequities at the personal, institutional, and structural levels as well as across time and in different spaces and contexts. In short, inequities are embedded within policies, systems, in culture (again, to varying degrees), and indeed in U.S. society overall.

Safety net organizations and people working within them can engage positively to counter structural inequities by both looking internally and in society—at policies and systems in particular—for opportunities to help to dismantle and redress the historical and contemporary forms of oppression listed above (and others that may not be listed).



Source: CSDH (2007)

## Use Intersectionality in Your Approach

Another important and complicated facet of inequities, is that people have multiple, interacting identities that expose them differentially to varied and compounding systems of oppression. This means that an **intersectional approach** to understanding and attempting to both ameliorate suffering and work to dismantle structural inequities is required. Intersectionality, a term coined by Kimberlé Williams Crenshaw to describe the experience of Black women, describes the interaction of various systems of oppression and power inequity. Importantly, intersectionality also provides tools for action to counteract oppression and discrimination in all its forms. People working within safety net systems need an understanding that various forms of societal oppression—such as sexism, racism, classism, nativism, and ableism—do not operate independently of one another; rather, they are compounded in the lives of individuals.<sup>30,31</sup>

This is important in order to not only understand how discrimination operates, but also to better understand how to respond to it at individual, institutional, community, systems-change, and policy levels. Important to this understanding is that oppression exists both at the interpersonal level and outside of it, so efforts must transcend tackling individuals' biases and discrimination to also focus on institutional discrimination and structural inequities.<sup>32</sup>

Ultimately, making progress on the social determinants of health requires tackling the social and economic processes that lead to the inequitable distribution of money, power, and resources. Tackling the causes of inequity—the structural inequities—requires engagement in policy at each level of government, including laws and budgets, and in institutional policy in government agencies and in the private sector. This is a political process that includes the engagement of the agency and power of disadvantaged and oppressed communities with the responsibility of their governments.<sup>33</sup>

## Redress Social Stratification and Advance Policies that Support Equity

Structural determinants of health inequities distribute the social determinants of health through

the process of social stratification along such lines as race, ethnicity, class, and education. Working on health equity requires an analysis and intervention on structural inequities in addition to the social determinants of health. Those seeking to advance health equity must consider discrimination in its various forms—at the interpersonal, institutional, and structural level.

Harvard social epidemiologist Dr. Nancy Krieger clarifies this point in a 2012 *American Journal of Public Health* article, *Methods for the Scientific Study of Discrimination and Health: An Ecosocial Approach*, writing:

*At issue is how discrimination, as one form of societal injustice, becomes embodied inequality and is manifested as health inequities.*

*As clarified by ecosocial theory, methods must address the lived realities of discrimination as an exploitative and oppressive societal phenomenon operating at multiple levels and involving myriad pathways across both the life course and historical generations.*

*An integrated embodied research approach hence must consider (1) the structural level—past and present de jure and de facto discrimination; (2) the individual level—issues of domains, nativity, and use of both explicit and implicit discrimination measures; and (3) how current research methods likely underestimate the impact of racism on health.*

Hospitals, health systems, insurers, health departments, community-based organizations (CBOs), and philanthropy should consider their own institutions' policies, practices, and internal systems, and how these may have historically and contemporarily structured opportunity more for some people than others. Health safety net stakeholders should also consider how they can best utilize their lobbying, advocacy, and government affairs staff and resources to help change policies that have historically harmed people suffering from health inequities caused by structural inequities. Notably, the IRS rules for maintaining nonprofit status are such that organizations cannot engage in a substantial amount of lobbying, yet many organizations have the opportunity to do, and there is plenty of room for advocacy focused on issues

rather than specific legislation that is legally allowed. The issues focused on by safety net systems should include policies that advance equity in such areas as economics and taxation, education, housing, transportation, and environmental protection. Also, health safety net institutions can work to ensure that communities being harmed by health inequities are included in policymaking processes both within their institutions and at various levels of government.

## Opportunities for the Safety Net to Intervene on Structural Inequities

Responding to social determinants of health is important work that often produces relatively immediate results. One example is people who are experiencing hunger being given food at a food pantry or soup kitchen. These types of programs have many short-term benefits for society and the impacted individuals, families, and communities. However, none of these SDOH-focused efforts will sustain lasting change in reducing hunger if they do not address the structural determinants of health inequities that systematically stratify access to resources and opportunities, assigning risk and protection to different groups, and causing health inequities.

Below are examples of opportunities for safety net institutions to engage in advancing equity in people's living conditions by intervening at the structural level.

### Internal Policy and Practice

#### Training and education of staff on health equity

Reflecting once again on Dr. Jones' definition of health equity, the first step to addressing structural inequities within organizations is through training and education of staff.

Every staff member should understand the history and contemporary impact of the structural “-isms” (racism, classism, sexism, heterosexism, and others), which can help with both integrating these understandings into practice and broader systemic efforts. Below are two examples of frameworks that

may be helpful for starting on integrating such training.

- **Structural Competency:** Health systems can begin teaching such concepts as “structural competency” which “contends that many health-related factors previously attributed to culture or ethnicity also represent the downstream consequences of decisions about larger structural contexts, including health care and food delivery systems, zoning laws, local politics, urban and rural infrastructures, structural racisms, or even the very definitions of illness and health. Locating medical approaches to racial diversity solely in the bodies, backgrounds, or attitudes of patients and doctors, therefore, leaves practitioners unprepared to address the biological, socioeconomic, and racial impacts of upstream decisions on structural factors such as expanding health and wealth disparities.”<sup>34</sup>
- **Roots of Health Inequities:** Health departments and other health system actors can employ the [NACCHO Roots of Health Inequities](#) training.<sup>35</sup> Locally, the Cook County Department of Public Health (CCDPH), as part of its WePlan2020 community health improvement plan, has turned to the Collaborative for Health Equity Cook County (CHE CC) to provide leadership on advancing health equity and working toward elimination of structural racism. CCDPH staff members are currently working to train all of their staff using the Roots of Health Inequity course. Part of CHE CC's leadership on advancing health equity includes building internal capacity of the health department.<sup>36</sup> Other safety net stakeholders can utilize this free online course material for their own staff development.

#### Valuing health equity

- Make *health equity* an official stated value and part of missions within organizations and operationalize it within organizational processes.
- Operationalization may take several forms. Many practitioners, staff, and leadership will likely need training on health equity and related concepts. Also, having health equity as a priority in strategic planning, with a focus on equitable conditions for all staff and for all patients, is essential. Equity can also be integrated into a [trauma-informed](#)

training model, which many health organizations are beginning to use.

### **Diversifying the health workforce**

One way to participate in rectifying historical and contemporary systems of oppression is to ensure that the organization's workforce at all levels mirrors the community served. This means hiring and promoting diverse members of staff, ensuring diverse leadership within the organization among board, executive, and division leadership, and engaging in local hiring practices. As safety net members engage in local hiring, it is important that they acknowledge the many barriers to employment that may exist for our society's historically and contemporarily oppressed populations, including criminal records.<sup>37</sup> Additionally, safety net members can invite community members to serve on the board of directors and ensure that their input is valued at the same or greater level than other board members.

### **Working conditions**

As a sector, health and healthcare is large and growing, with many hospitals and other health systems serving as anchor institutions. Ensuring equitable and fair pay and benefits for employees that support workers' and workers' families' abilities to thrive can be considered a key, material method of valuing equity within health systems. Focusing on workplace conditions can also raise the bar of health, supporting working conditions for other employers in the community. Poverty and poor working conditions make people sick, and health systems should not contribute to this.

Likewise, the working conditions in which health workers provide care have a significant impact on their potential to provide high-quality care. Poverty wages and harsh working conditions can harm both healthcare providers and patients. Healthcare workers can also be affected by their patients' communities' trauma. This stress can add to worker burnout and turnover, reducing overall effectiveness and capacity of the safety net. Thus, a commitment to advancing health equity calls on health safety net institutions to prioritize economic, social, and mental wellbeing and equity in their internal workforce practices. If reimbursements are too low

for a category of worker or particular type of care (homecare, for example), that is likely to contribute to low pay, inadequate benefits, and potentially hazardous working conditions (such as being overworked). In such instances, health systems need to advocate for reimbursement rates that help them provide equitable pay and working conditions for their employees. This is closely related to internal working conditions, and, importantly, includes external advocacy.

In addition to advancing health equity, workforce efforts can have positive impacts on institution's strategic goals. Recruitment and retention of diverse and talented staff is often a high priority, and offering robust, equitable pay and benefits for employees is an important part of such efforts. To ensure equitable pay and benefits, institutions will need mechanisms such as standardizing, regular auditing, and transparency around adjusting pay and benefits. When workers seek to organize a union, health system institutions ought to support these efforts. When workers efforts are supported, everybody wins: workers will have better working conditions, job satisfaction, and remuneration while the organizations will advance economic equality and retain talented staff with less turnover and lower recruitment costs.

A 2016 article in the American Journal of Public Health (AJPH) stated, "Our findings demonstrate that union contract language advances many of the social determinants of health, including income, security, time off, access to health care, workplace safety culture, training and mentorship, predictable scheduling to ensure time with friends and family, democratic participation, and engagement with management."<sup>38</sup> An editorial in the same issue of AJPH highlights the decline in union membership in the U.S. as a threat to public health stating, "It will take a sustained effort to increase the size and strength of unions, and to build a powerful movement aimed at reversing economic inequality and providing safe, secure jobs with adequate compensation and benefits for all."<sup>39</sup> Safety net institutions have a responsibility to engage with unions within workplaces to advance public health.

## Recommendations for Philanthropy

### General operating grants

Philanthropy plays a unique and vital role in supporting the health equity efforts of the safety net. They can advance structural health interventions internally through their funding structure (providing multi-year grants and unrestricted funds) and through funding policy change efforts (including the research, writing, coalition building, and advocacy phases). Multi-year grants can give innovative programs and policy change efforts the opportunity to demonstrate their effectiveness. Unrestricted funds give organizations the freedom to supplement the training of staff on SDOH and SDOHI or to hire staff with this specific expertise.

### Avoid becoming a replacement for a strong public sector

In the face of state and federal budget cuts, demand for philanthropic support is only increasing. While this support has helped preserve vital services, the sector's role is not to replace public money meant to support the safety net—rather, the philanthropic community can fill gaps temporarily while advocating for strong public support for the safety net. Attempting to replace public support can unintentionally absolve the government of its responsibility to fully fund a well-functioning safety net system and places undue burden on philanthropy long-term. The opportunity to provide grants for innovation and general operating expenses can help the safety net have the resources necessary for services that are supported by restricted public sector reimbursements, grants, and other funding mechanisms. It is the responsibility of government to ensure people's human rights, as per the WHO's SDOH framework.<sup>40</sup>

### External Advocacy

Health institutions and providers have a prominent role in our society and their voices are respected and valued by policymakers on topics beyond healthcare. Institutions within the safety net can use their influence to weigh in on local, county, and state policy issues that matter to health, such as school funding, wages, or use of Tax Increment Financing for community development.

Hospitals and other safety net organizations frequently employ government affairs and policy staff to track matters of importance to their institutions. They also frequently belong to larger hospital or safety net associations, which advocate on behalf of the group at different levels of government. Both individual organizations and their membership organizations might provide a larger voice on issues pertaining to structural determinants of health inequities and policy changes that would improve people's lives.

Overall, safety net organizations need to dedicate themselves to pro-equity initiatives by engaging directly with community-based efforts to advance equitable living conditions through policy change, and then utilize their advocacy, voice, and institutional power to advance progress in a variety of areas.

They can do this through advocacy or other material support, for example, providing meeting space or food for meetings can help support organizing efforts by community groups.

### **Below are some areas in which health safety net organizations can be involved with regard to policy change that could help advance health equity through changing the structural determinants of health inequities, with some specific examples following the general principle.**

*Education:* Education is a major social determinant of health.<sup>41,42</sup> Equitable educational opportunities can help people to fully participate in and contribute to our economy, democracy, and society. Safety net institutions should advocate for policies that advance equitable educational funding and opportunities.

*Healthcare access:* Healthcare is a human right. Universal access to high quality, culturally humble healthcare is necessary to support people's health. Members of the health safety net should advocate for policies that advance more universal health coverage, such as single-payer healthcare or improved Medicare for all. As mentioned above, reimbursement rate improvements can also improve access to and quality of care and the health of

healthcare workers, so health systems should support these policy changes as well.

In Illinois, there are a number of campaigns and efforts that safety net institutions can join to advance and protect healthcare access.

- Supporting single payer: [Illinois Single Payer Coalition](#) and [Physicians for a National Health Program](#)
- Supporting expansion of quality, affordable healthcare coverage for all people in Illinois: [Healthy Illinois Campaign](#)
- Supporting the Affordable Care Act, Medicaid, and healthcare access: [Protect Our Care Illinois](#).

### Taxation

Taxes should be sufficient to fund public education, healthcare, social services, public safety, and infrastructure. Illinois has the fifth biggest state economy in the U.S., indicating that there is robust economic activity that if taxed at appropriate levels would adequately fund our public sector.<sup>43</sup> To raise sufficient revenues, a progressive tax structure that uses a graduated income tax is needed. Also, taxing the parts of the economy that are growing, such as services, would help provide necessary revenue.<sup>44</sup> It is in the interests of safety net stakeholder to support policy efforts such as:

- A **progressive income tax** at the state level could allow Illinois to invest more into public schools, Medicaid, and infrastructure, as well as pay down its legacy debts.
- To enable a progressive income tax, Illinois would need a constitutional change as it currently requires that the income tax be a flat rate for all income earners in the state. Periodically an effort to advance a “Fair Tax” gains momentum and safety net stakeholders can help support this movement.
- Also, a state-wide coalition, the [Responsible Budget Coalition](#), engages in ongoing efforts to raise “adequate revenue to support state priorities and make smart investments,” ensure “no more cuts to vital programs and services”; and advance “fairness in raising revenue”.<sup>45</sup> Illinois health and social service organizations are generally welcome to join this effort.

### Housing

Safety net members should acknowledge that housing is a basic human need fundamental to health and support policy changes that advocate for safe, healthy, accessible, and affordable housing for people of all incomes and without discrimination. Here are two advocacy opportunities for safety net institutions:

- In Chicago, a collaborative effort of stakeholders has developed a recommendation to require proactive rental inspections for rental housing units.<sup>46</sup>
- A group of advocates is working to lift the statewide ban on rent control, which would help ensure affordable housing.<sup>47</sup>

### Community development

Community development can have significant positive impacts on community health by providing amenities, green space, and new jobs or negative impacts by pricing out and displacing residents. Safety net stakeholders should advocate for equitable community investment and development, with strong policies that protect people who already live in an area.

- Examples of policies to protect against displacement include rent control, and legacy protections against rent and property tax increases for long-term, low-income, and fixed income residents.

### Transportation

Equitable and accessible transportation is a necessary lifeline for connectivity to jobs, educational opportunities, and to the broader community. Members of the safety net should support equitable transportation system investments serving people and places with unsafe or unreliable transportation options.

### Thrivable jobs

Wages that allow people to thrive and save, paid sick leave, safe working conditions, steady work, and upward mobility all fundamentally support people’s well-being. Safety net stakeholders should support public policies that support workers’ health and wellbeing. Example policies include:

- **Earned sick leave:** Both the City of Chicago and Cook County have joined other parts of the U.S. in passing ordinances that ensure workers are able to earn paid sick leave (although some local municipal governments are opting out of Cook County’s ordinance). Paid sick leave supports people’s ability to seek healthcare when needed, to remain home and care for oneself or a family member for health reasons, and to do this without giving up income, which supports people’s health.
- **Fight for Fifteen** is an international campaign demanding \$15 an hour and a union, advocating significant raises to workers’ wages to advance toward a more livable or even *thrivable* wage as income is one of the most important determinants of health. Likewise, supporting unionization of workers and unions, helps workers to be able to advocate for themselves and their families economic wellbeing, which ultimately supports their health.
- **One Fair Wage** is a campaign led by Restaurant Opportunity Center United to eliminate the tipped minimum wage, a sub-minimum wage that makes workers dependent upon tips. Working in tipped minimum wage jobs exposes workers and their families to worsened economic precariousness because a worker cannot predict their income.
  - As noted on the campaign’s webpage, “Seventy percent of people who work in the restaurant industry are women. Since a living base wage is not guaranteed, and women are instead forced to depend on tips, they frequently have to put up with sexual harassment from customers, co-workers, and management. The EEOC has targeted the restaurant industry as the single largest source of sexual harassment charges filed by women with a rate five times higher than any other industry.”<sup>48</sup>

### Green space and clean environment

Health systems can be strong advocates for public policies and practices that advance clear air, water, land, green spaces, and parks to enable physical activity to support physical and mental health. Given the global threat of anthropomorphic global warming—and the resulting negative health impacts—members of the safety net should advocate

for policies that both seek to reduce climate change and encourage a clean environment overall.

### Policing

Systematic and structural racism, transphobia, class inequity, and other discrimination—as well as violence—in policing are rampant and must be eliminated to advance health equity.<sup>49, 50</sup> As an institution, policing has a problematic history in the U.S., having begun with slave patrols and never equitably applied to all people. This inequity has resulted in dire health impacts.<sup>51</sup> Safety net stakeholders should support policies and procedures that advocate for restorative justice practices and programs that protect against violations of civil and human rights, police violence, and inequities in policing committed against any group of people.

- One example of a safety net stakeholder prioritizing reduction of injustice in policing that others can replicate was undertaken by the Chicago Department of Public Health in 2016 when they launched Healthy Chicago 2.0, the City’s plan to advance community health and health equity. The plan set a goal to “[r]educe mass incarceration and inequitable police attention in communities of color” as part of its broader anti-violence strategy.<sup>52</sup>

### Immigration

All people, regardless of immigration status, deserve human rights, dignity, protection, and good health. Members of the safety net can work on their own internal policies, practices, training, signage, and brochures to ensure that they are fully supportive of helping immigrants and any other marginalized group feel safe, affirmed, and welcomed within their buildings. Health systems should also support local, state, and national policies that support immigrant protections and freedoms.

Examples and resources:

- The Department of Public Health Seattle-King County passed an internal department policy focused on establishing clear boundaries for Designated Private Areas at Public Health – Seattle & King County sites, and authorized access to those areas, outlining appropriate signage and staff protocols for being served a legal document such as a warrant.<sup>53</sup>

- In early 2017, Public Health Awakened, a group convened by Human Impact Partners, developed the Public Health Actions for Immigrant Rights (PHAIR) guide. It was created for “people working at local health agencies who are looking to protect and support undocumented residents and their families” and may be useful to health safety net stakeholders seeking guidance for how to advance policies in their institutions to protect immigrants.<sup>54</sup>
- In Cook County, a coalition of organizations known as Public Health Woke has advocated that hospitals implement the PHAIR guide.<sup>55</sup> The six demands that Public Health Woke has made of the Cook County Health & Hospitals System are listed below, and safety net system institutions can work to advance these within their own institutions.<sup>†</sup>
  1. Placing abundant and clear signage in multiple languages assuring a welcoming institution
  2. Giving staff training and resources addressing needs of marginalized patients and families
  3. Establishing referral systems for legal services, know your rights information and other resources needed by immigrant and other marginalized communities.
  4. Clarifying, revising and strengthening policies and procedures that focus on protecting immigrant and marginalized patients.
  5. Identifying and monitoring indicators and neighborhood stress in immigrant and marginalized communities.
  6. Designing and implementing best practices for clinical and public health providers to deliver appropriate care.
- According to a June 8, 2017 article in the New England Journal of Medicine (NEJM), “Research also suggests that anti-immigrant policies and initiatives can trigger hostility toward immigrants that can lead to perceptions of vulnerability, threat, and psychological distress among both immigrants who are personally targeted and other

members of the group who are not direct targets.”<sup>56</sup> Safety net institutions can use their institutions’ information and data to communicate about the negative impacts of harsh immigration public policy and practice on immigrants’ health. Also, institutions can help advocate to protect and expand the rights of immigrants within local, state, and national policies by sharing the health and social justice cases for inclusive immigration policies and practices directly with policymakers and more broadly through narrative change.

### **Support policy change to advance health equity**

Progressive policy changes in any of the above areas can help to advance toward equitable opportunity for all members of society. In order to address structural inequities, safety net members must recognize and utilize their power for advancing such policy changes.

When considering health equity policy agendas to support or advocacy coalitions to join, safety net stakeholders should ask themselves the following critical questions:

- Will this policy lead to more equitable distributions of money, power, and resources?
- How are disadvantaged or marginalized groups of people who will be impacted by this policy change being engaged?
- How can disenfranchised or marginalized groups be better, more purposely engaged by those making decisions to provide input on the policy debate?
- How could this policy help the health of oppressed or marginalized groups?

Hospitals, clinics, CBOs, and other safety net organizations are positioned to sign on to such campaigns and offer their expertise on the negative impact of inequities in people’s living conditions on individuals’, families’, and communities’ health. Safety net institutions are well-positioned to speak on matters that pertain to health, and their policy staff can lend the voice of their institution to support

---

<sup>†</sup> Health & Medicine Policy Research Group is a member of the Public Health Woke coalition and one of the authors is involved in this campaign.

the efforts of communities to advance more equitable conditions that will support their health. The advocacy efforts of safety net organizations can and should be well beyond the confines of policies and systems that impact the organizations themselves. Additionally they should focus attention on what matters to advance health equity, changing structural determinants of health inequities in the policy areas discussed above and beyond.

## Conclusion

The authors of this paper did not set out to do a comprehensive review of safety net interventions on social determinants of health. Instead, we have provided a collection of approaches that have been employed across the nation at the SDOH level and can serve as models for other systems plus a critical analysis of what safety net stakeholders should be doing to move toward health equity, with a focus on policy change to reduce structural inequities.

Social determinants of health and structural determinants of health inequities shape the course of people's lives. Most safety net systems are understandably focused on social determinants of health; however, they could be doing more at the preventive level of structural determinants of health inequities. Members of the safety net could and should be using their institutional power to redress health inequity by intervening at the structural level where they can have the most impact on the health and wellbeing of their patients and local communities. In order to be most effective, stakeholders must also venture to understand the ways in which these different structures overlap and influence the lives of patients and communities differently.

Responding to the structural determinants of health inequities rather than the social determinants of health can be difficult and time consuming. Addressing the SDOHI requires an investment that may take years to pay off; however, if members of the safety net are committed to the health of their patients and to the process of health equity, responding to inequity at the structural level is the best way to make change. This paper makes the case for safety net stakeholders to step beyond healthcare

silos to challenge the structures that shape inequities in health status and outcomes.

### About Health & Medicine Policy Research Group

Health & Medicine is a Chicago based non-profit working to improve the health of all people in Illinois by promoting health equity. Founded in 1981 by Dr. Quentin Young, it was formed as an action-oriented policy center—nimble, independent, and focused on regional health issues. Health & Medicine's mission is to promote social justice and challenge inequities in health and health care. It conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people.

*This policy brief is made possible through the support of the Community Memorial Foundation. For more information, contact us at 312.372.4292 or [info@hmprg.org](mailto:info@hmprg.org), or visit [hmprg.org](http://hmprg.org).*

## Endnotes

---

- 1 Center for Medicaid and Medicare Services. National Healthcare Expenditures 2016 Highlights. Retrieved from: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>.
- 2 Krieger, Nancy. Epidemiology and the web of causation: has anyone seen the spider? (October 1994). Social Science and Medicine. <https://www.ncbi.nlm.nih.gov/pubmed/7992123>.
- 3 National Academies of Sciences, Engineering, and Medicine. 2017. Communities in action: Pathways to health equity. Washington, DC: The National Academies Press. doi: 10.17226/24624. Retrieved from: <https://www.nap.edu/download/24624>.
- 4 Solar O, Irwin A. A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). World Health Organization. 2010. Retrieved from: [http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH\\_eng.pdf](http://www.who.int/sdhconference/resources/ConceptualframeworkforactiononSDH_eng.pdf).
- 5 Alameda County Advances Equitable Housing Policies. Human Impact Partners. Health Equity Guide. Undated. <https://healthequityguide.org/case-studies/alameda-county-advances-equitable-housing-policies/>
- 6 Trotter, Joanna. Housing Solutions to Education, Health and Criminal Justice Challenges. October 9, 2017. Chicago Community Trust. <http://cct.org/2017/10/housing-solutions-to-education-health-and-criminal-justice-challenges/>
- 7 Lee. Social determinants of health: How are hospitals and health systems investing in and addressing social needs?
- 8 Better Health Through Housing. UI Health. Accessed online on 11/27/17 at <http://hospital.uillinois.edu/about-ui-health/community-commitment/better-health-through-housing>
- 9 Lee. Social determinants of health: How are hospitals and health systems investing in and addressing social needs?
- 10 Doykos, Patricia. Gray-Akpa, Kristina. Mitchell, Faith. New Directions For Foundations In Health Equity. August 2016. Health Affairs. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.026>
- 11 GO Grants Turn One: A Year of Funding, Listening and Learning. Chicago Community Trust. September 4, 2017. Accessed online on November 27, 2017 at <http://cct.org/2017/09/go-grants-turn-one-a-year-of-general-operating-funding-listening-and-learning/>.
- 12 Lee. Social determinants of health: How are hospitals and health systems investing in and addressing social needs.
- 13 Susman, Katherine. Food Insecurity, Health Equity, and Essential Hospitals. Essential Hospitals Institute. June 2016. <https://essentialhospitals.org/wp-content/uploads/2016/06/Food-Insecurity-Health-Equity-Essential-Hospitals.pdf>
- 14 Zuckerman, David, with contributions from Sparks, Holly Jo, Dubb, Steve, and Howard, Ted. Hospitals Building Healthier Communities: Embracing the Anchor Mission. <http://community-wealth.org/sites/clone.community-wealth.org/files/downloads/Zuckerman-HBHC-2013.pdf>
- 15 Zuckerman. Hospitals Building Healthier Communities: Embracing the Anchor Mission.
- 16 Cook County Health & Hospital System. CCHHS Launches New Pilot Program to Address Patients' Food Insecurity. September 24, 2015. <http://www.cookcountyhhs.org/press-releases/cchhs-launches-new-pilot-program-to-address-patients-food-insecurity/>
- 17 D. Brad Wright. Social Justice and Community Health Centers: Commitment to One Gave Rise to the Other. Journal of Health Care for the Poor and Underserved. 2005. <https://publichealth.gwu.edu/departments/healthpolicy/ggprogram/press/16.4wright.pdf>.
- 18 <https://healthequityguide.org/case-studies/san-mateo-county-funds-community-implementation-projects-to-advance-equity/>
- 19 Zuckerman. Hospitals Building Healthier Communities: Embracing the Anchor Mission.
- 20 Zuckerman. Hospitals Building Healthier Communities: Embracing the Anchor Mission.
- 21 Zuckerman. Hospitals Building Healthier Communities: Embracing the Anchor Mission.
- 22 Lee. Social determinants of health: How are hospitals and health systems investing in and addressing social needs?
- 23 Doykos, Patricia. Gray-Akpa, Kristina. Mitchell, Faith. New Directions For Foundations In Health Equity. August 2016. Health Affairs. <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2016.0256>.
- 24 RUSH Community Health Improvement Plan 2017-2019. <https://www.rush.edu/sites/default/files/community-health-implementation-plan.pdf>
- 25 Impact 2020. Cook County Health and Hospitals System (CCHHS) Strategic Plan 2017-2020. Cook County Health & Hospital System. July 29, 2016. <http://www.cookcountyhhs.org/wp-content/uploads/2016/01/CCHHS-Strategic-Plan-2017-2019-Impact-2020-approved-07-29-16.pdf>
- 26 Mason, Terry. Informing the CCHHS Strategic Plan: Community Health Planning Initiatives. Cook County Health & Hospital System. April 22, 2016. <http://www.cookcountyhhs.org/wp-content/uploads/2011/12/12.-Community-Health-Planning-Initiatives-04-22-16.pdf>
- 27 National Center for Medical Legal Partnerships. Accessed online on 11/27/17 at <http://medical-legalpartnership.org/need/>.

---

28 Solar & Irwin. A conceptual framework for action on the social determinants of health.

29 Solar & Irwin. A conceptual framework for action on the social determinants of health.

30 Bowleg, L. (2012), The problem with the phrase women and minorities: Intersectionality—an Important Theoretical Framework for Public Health. *American Journal of Public Health*, vol 102, no. 7

31 National Collaborating Centre for Health Public Policy. (March 2016) Policy Approaches to Reducing Health Inequities. Retrieved from: [http://www.nchpp.ca/docs/2016\\_Ineq\\_Ineq\\_ApprochesPPIneqalites\\_En.pdf](http://www.nchpp.ca/docs/2016_Ineq_Ineq_ApprochesPPIneqalites_En.pdf).

32 Lisa F. Berkman, Ichiro Kawachi, and M. Maria Glymour. *Social Epidemiology*, Second Edition. 2014. Oxford.

33 Solar & Irwin. A conceptual framework for action on the social determinants of health.

34 MetzL, Jonathan M., Roberts, Dorothy E., Structural Competency Meets Structural Racism: Race, Politics, and the Structure of Medical Knowledge. *American Medical Association Journal of Ethics*. September 2014. <http://journalofethics.ama-assn.org/2014/09/pdf/spec1-1409.pdf>

35 Root of Health Inequity. National Association of City and County Health Officials (NACCHO). <http://rootsofhealthinequity.org/>

36 Cook County Partners with Community to Tackle Structural Racism and Build Community Power. Human Impact Partners. Health Equity Guide. Undated. <https://healthequityguide.org/case-studies/cook-county-partners-with-community-to-tackle-structural-racism-and-build-community-power/>

37 Nzinga-Johnson, Sekile, Ford, Tiffany N., Powell, Sharon. Introduction to Issue Brief Series: Criminalization of People of Color as a Barrier to Diversifying the Health Workforce. Health & Medicine Policy Research Group. 2017. <http://www.hmprg.org/Blog+Posts/AHECIntro>

38 Hagedorn, J, Paras, CA, Greenwich, H, Haopian, A. The Role of Labor Unions in Creating Working Conditions That Promote Public Health. *American Journal of Public Health*. June 2016. <https://www.ncbi.nlm.nih.gov/pubmed/27077343>.

39 Wright, MJ. The Decline of American Unions Is a Threat to Public Health. *Americna Journal of Public Health*. June 2016. <https://www.ncbi.nlm.nih.gov/pubmed/27153008>.

40 Solar & Irwin. A conceptual framework for action on the social determinants of health.

41 Solar & Irwin. A conceptual framework for action on the social determinants of health.

42 Lisa F. Berkman, Ichiro Kawachi, and M. Maria Glymour. *Social Epidemiology*, Second Edition. 2014. Oxford.

43 United States Bureau of Economic Analysis. Gross domestic product (GDP) by state (millions of current dollars). Retrieved from:

<https://www.bea.gov/iTable/iTable.cfm?reqid=70&step=10&isuri>  
Page 18 • Beyond the Clinic: A National Health Equity Review

=1&7003=200&7035=-1&7004=sic&7005=1&7006=xx&7036=-1&7001=1200&7002=1&7090=70&7007=-1&7093=levels#reqid=70&step=10&isuri=1&7003=200&7004=n aics&7035=-1&7005=1&7006=xx&7001=1200&7036=-1&7002=1&7090=70&7007=-1&7093=levels

44 Center for Tax and Budget Accountability. It Is All About Revenue: A Common Sense Solution for Illinois' Fiscal Solvency. September 9, 2015. Retrieved from: <http://ctbaonline.org/reports/it-all-about-revenue-common-sense-solution-illinois%E2%80%99-fiscal-solvency>

45 Responsible Budget Coalition. About Page. Retrieved December 20, 2017: <http://www.responsiblebudget.org/about>

46 Proactively Addressing Substandard Housing: A Working Group. Retrieved February 8, 2018: <https://www.luc.edu/chrc/events/proactivelyaddressingsubstandardhousingaworkinggroupmeeting/>

47 Elizabeth King. Inside Chicago's Activist Efforts to Secure Rent Control. *Pacific Standard*. November 8, 2017. <https://psmag.com/social-justice/inside-chicagos-activist-efforts-to-secure-rent-control>

48 One Fair Wage. About Page. Restaurant Organizing Centers United. <http://onefairwage.com/about/>

49 Alexander, Michelle. (2010) *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York, NY. The New Press.

50 United States Department of Justice Civil Rights Division and United States Attorney's Office Northern District of Illinois. January 13, 2017. Investigation of the Chicago Police Department. Retrieved from: <https://www.justice.gov/opa/file/925846/download>

51 Cooper, Hannah LF. War on Drugs Policing and Police Brutality. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4800748/>

52 Dirksen JC, Prachand NG, et al. Healthy Chicago 2.0: Partnering to Improve Health Equity. City of Chicago, March 2016. <https://www.cityofchicago.org/content/dam/city/depts/cdph/CDPH/Healthy%20Chicago/Hc2.0Udp4152016.pdf>

53 Tools and Resources. Equity and Social Justice. King County, Seattle. Retrieved on December 22, 2017: <https://www.kingcounty.gov/elected/executive/equity-social-justice/Immigrant-and-Refugee/Tools-and-Resources.aspx>

54 <https://publichealthawakened.com/guide-for-public-health-to-protect-immigrant-rights/>

55 Protect Immigrant Health Now! Public Health Woke Coalition webpage of the Collaborative for Health Equity Cook County. <https://www.checookcounty.org/publichealthwoke-call-today>

56 Williams, David R., Medlock, Morgan M., Health Effects of Dramatic Societal Events — Ramifications of the Recent Presidential Election. June 8, 2017. *New England Journal of Medicine*. <http://www.nejm.org/doi/full/10.1056/NEJMms1702111>