



**THE  
COLORADO  
TRUST**

*A Health Equity Foundation*

DEDICATED TO ACHIEVING HEALTH EQUITY FOR ALL COLORADANS

FEBRUARY 2016

**2015** *Health Equity*  
**LEARNING SERIES**

*Creating Paths to Opportunity*  
Advancing Health Equity by Understanding  
Structures and Organizing for Power

*Prepared for The Colorado Trust by Carie Sherman*

A SUMMARY OF THE COLORADO TRUST'S  
**2015 HEALTH EQUITY LEARNING SERIES**

**In 2015**, The Colorado Trust invited experts in health equity to share their knowledge and raise awareness of the issues that lead to health disparities. In this report, we examine the structures, policies and systems that unintentionally marginalize vulnerable communities. We learn how race impacts health, and the changes needed to improve the health status of all Americans. And we demonstrate how organizations have effectively used their resources to give community members a voice, and improved the health of their own communities.

**2015 Health Equity Learning Series Speakers**



FEB. 5, 2015

"HEALTH EQUITY  
AND COMMUNITY  
ENGAGEMENT"

**Doran Schrantz**  
*Executive Director,*  
*ISAIAH*

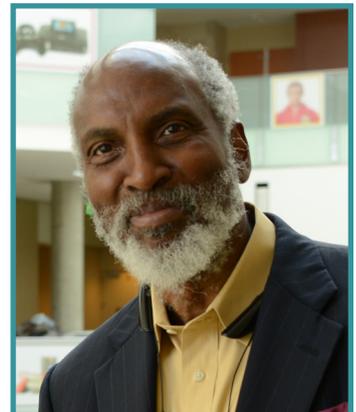


JULY 23, 2015

"HEALTH EQUITY IN RURAL COMMUNITIES"

**Susan Wilger** (left)  
*Director of Programs,*  
*National Center for Frontier Communities*

**Denise Gonzales** (right)  
*Program Director,*  
*Con Alma Health Foundation*



SEPT. 17, 2015

"OPPORTUNITY,  
COMMUNITY, AND  
HEALTH EQUITY"

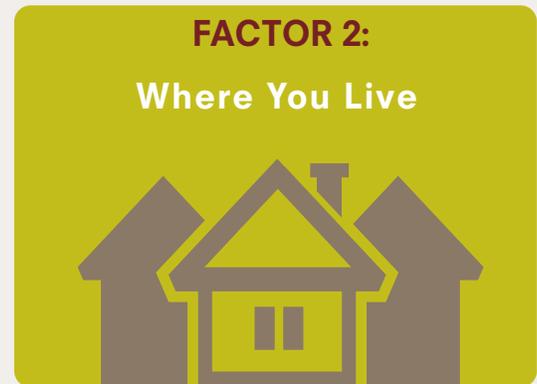
**John A. Powell**  
*Director, Haas Institute*  
*for a Fair and Inclusive*  
*Society, University of*  
*California, Berkeley*

## » Social Determinants of Health

In the United States, there are two factors in particular that influence the health status of individuals, according to Denise Gonzales, program director of the Con Alma Health Foundation in New Mexico:<sup>1</sup>



**TWO FACTORS THAT INFLUENCE HEALTH STATUS**



These social determinants of health have more of an impact than access to health care, behavior and genetics (see figure 1), says Gonzales.<sup>2</sup>

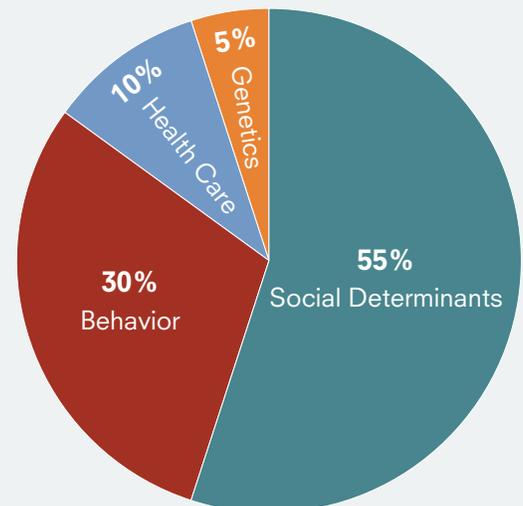
Consider this: According to University of California, Berkeley professor John A. Powell,<sup>3</sup> when compared to whites:

- African Americans have higher death rates for 12 of the 15 leading causes of death.
- African Americans and American Indians have higher age-specific death rates from birth through the retirement years.
- Although Latinos tend to live longer than whites,<sup>4</sup> Latinos have higher death rates for diabetes, hypertension, liver cirrhosis and homicide.<sup>5</sup>

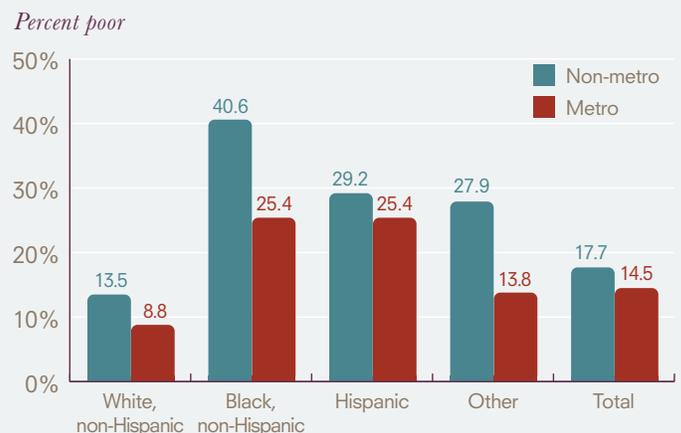
People of color are far more likely to live in opportunity-deprived communities.<sup>6</sup> These high-poverty areas occur in our cities, rural areas and even in the suburbs (see figure 2). They experience:

- Low rates of employment.
- Schools that underperform.
- A lack of adequate housing.
- Crime and other safety risks.
- Impaired access to basic services, such as grocery stores and banks.

People living in these communities experience poorer life outcomes when compared with those who live outside these areas.<sup>7</sup>



**Figure 1: What Determines Health Status** (quoted by Gonzales)



**Figure 2: U.S. poverty rates by race and location** (quoted by Gonzales)

## » Changing Demographics Underscore the Need for Change

In 1980, 80 percent of the U.S. population was white. Today, people of color represent the fastest growing demographic—by 2043, the majority of the U.S. population will be people of color. They will represent the bulk of our workforce, and their social and economic well-being will likely determine the country's success and prosperity.<sup>8</sup>

Improving the health status of all Americans is necessary, but the need is even greater for people of color. According to Gonzales, we need to look at what's fair and leverage the right resources to improve health equity.

## » Current Approaches to Public Health Fail to Improve Outcomes

As director of Berkeley's Haas Institute for a Fair and Inclusive Society, powell has seen many attempts to reduce health disparities.

"We have all kinds of programs aimed at reducing poverty in America. Yet looking at the new census data, we see that not much has changed," powell said.

Powell believes the current use of universal programs—social-service efforts that treat every participant equally—favors the majority and keeps minorities at a disadvantage.

"Universal programs are often based on non-universal standards," he said. "For example, our social security system was created for able-bodied white males working outside the home for full-time pay."

## » Examining Structures as Threats to Opportunity

*"We all live in structures and structures live in all of us—and, for the most part, structures are not neutral."* ~ john a. powell

According to powell, structures can either enhance our health outcomes or impede them. We're mostly blind to structures—and this is where

**Health care is only a small part of what really affects our health. The choices we make, our behavior, has a large impact on our health. But the places where we live, work and play—our social conditions—affect the choices we make.**

~ *New Mexico Health Equity Working Group (quoted by Gonzales)*

the problem lies: We're blind to how opportunity is unequally distributed within a structure.

Although we have made strides in removing overt racism from our structures, certain groups continue to be marginalized. It's what powell calls "structural racialization." He asserts that practices, cultural norms and institutional arrangements help create and maintain disparate racialized outcomes.

Gonzales agrees we must focus on the broad policy and systems environment to create health equity. "Health disparities are often avoidable, as they result from economic and social conditions as well as policy decisions," she said.

Powell demonstrated how structures influenced hundreds of African American and Latino students in California. He shared a story about a class-action lawsuit in which these students came together after being denied admission to schools like Berkeley—despite achieving 4.0 grade-point averages and high SAT scores.

"Turns out, the average Berkeley freshman has a 4.3 GPA. How do you get above a 4.0? You take AP classes—classes that weren't available to minority students who attended school in disadvantaged neighborhoods," powell explained.

"[The minority students] did everything they could do. But the structure of their worlds was such that they couldn't achieve what students outside of their structures could."

## ABOUT STRUCTURES

Structures are, according to the online Business Dictionary,<sup>11</sup> “the framework of identifiable elements (components, entities, factors, members, steps, etc.) which give form and stability and resist stresses and strains. Structures have defined boundaries within which 1) each element is physically or functionally connected to the other elements, and 2) the elements themselves and their interrelationships are taken to be either fixed or changing only occasionally or slowly.”

According to Powell, structures are present in or involve the following:

- Social and racial inequities are geographically inscribed.
- The government plays a central role in the arrangement of space and opportunities.
- These arrangements are not neutral, natural or colorblind.
- There is a polarization between the rich and the poor that is directly related to the areas in which they live.
- A series of mutually reinforcing federal policies across multiple domains have contributed to the disparities we see today.

Structures also impede health in rural areas. As a result, rural populations experience higher levels of poverty when compared to urban areas. People in rural areas:

- Have reduced access to health services.
- Are less likely to have employer-provided health insurance.
- Must travel greater distances, often in poor conditions, for basic needs such as obtaining food.<sup>9</sup>

Even locales deemed “great places to live” are impacted by structures. According to Doran Schrantz, executive director of ISAIH, a faith-based community organizing coalition, Minnesota was ranked second in the U.S. for living conditions. Yet it’s only great if you’re not a person of color: Health outcomes for children of color in Minnesota are among the worst in the nation—worse than the oft-described “unhealthy” state of Mississippi.<sup>10</sup>

“It’s not that we don’t have the resources,” Schrantz said, asserting that these racialized outcomes were the result of structures.

### » To Advance Health, Difficult Conversations are Necessary

Structural racialization leads to marginalization and blocked access to opportunity. But it’s not something most people want to talk about.

According to Powell, most of us aren’t very skilled at talking about race. We prefer to avoid the topic. He’s concerned that if we continue to avoid the subject, we won’t move forward.

Schrantz calls the issues she most frequently works on as “topics you can’t bring up at the dinner table,” including religion and politics.

Her work also involves the use of terms that have negative connotations.

“We have to reclaim the words politics and power,” she said, explaining that both terms are now largely seen as abusive in nature. She argues that power is what gives a person or community the ability to enact change. As for politics? “It’s where voice and public expression happen. It’s the highest form of public freedom.”

Yet people from marginalized communities often feel they lack the power necessary to create change. And community marginalization can take many forms, including simply having small numbers of residents.

Susan Wilger is the director of programs for the National Center for Frontier Communities.

“Your voice is so small when you’re rural, you just don’t have the economic power to make changes,” Wilger said.

So how can people without a voice move their communities forward? By working in collaboration with those who are able to create opportunities and build the capacity to act.

## » Giving People Opportunity and Power

*“Everyone is entitled to a healthy life.”*

~ Denise Gonzales

Giving vulnerable populations a voice involves the setting of a universal goal, which Powell refers to as “targeted universalism.” We need to set a universal goal and create targeted strategies to reach it.

Such “targeted strategies” usually lie within the vulnerable population itself. “We have to look to communities for the answers to their own problems,” Gonzales said. She shared an example of a community that found solutions for improving health outcomes for its members.

“We recently worked with a Zuni tribe who was experiencing food insecurity. The stories we heard involved how their tribe always depended on agriculture. But recent generations had lost touch with their ancestors’ stories about the importance of corn in their community. So we helped them reestablish agriculture within their community by planting a school garden,” she said. This small garden attracted the community at large.

### POWELL ON BEING “OTHERED”

Americans live in a democracy. In theory, everyone has the power to bring about change. Yet many people, especially minorities, live in structures that do not promote belonging.

“Othering” is a set of common processes that engender marginality and persistent inequality across any of the full range of human differences. Powell asserts that, through our structures and social contexts, minorities in the U.S. are constantly being sent the message that they don’t belong.

This othering is what is making many people sick. Our structures need to be changed so we send this message to everyone: You belong.

“Belonging is the greatest gift society can give us,” said Powell.

### KEY QUESTIONS IN CREATING THE CAPACITY TO ACT

1. Are we forging pathways for people to act with agency and power around their own interests and agenda?
2. Who has the power to decide?
3. How are we shifting the arrangements of power to change the “distribution of money, power and resources”?

~ Doran Schrantz

“It was remarkable. They took our modest grant and leveraged it to get additional grants, which led to the development of a soccer field,” said Gonzales. The community’s health has improved, thanks to a reduction in food insecurity and the addition of a space for people to exercise.

## » Helping People Tell Their Stories

*“People learn by telling their stories. It’s not until we own our stories as individuals and members of a community that we’re able to make meaning of the events and conditions that impact our lives.”*

~ Doran Schrantz

As a community organizer, Schrantz helps people own and share their stories. This training allows them to be effective when telling stories to people in power, which she asserts is how change can happen.

Two years before Minnesota’s new governor was elected, ISIAH’s leadership asked its constituents how they wanted to interact with the new governor. A nonpartisan organization, the group held strategy meetings to determine their agenda and story. The group decided to tackle the health disparities that exist for children of color in Minnesota, leveraging its power to bring the issue of improving health outcomes to the attention of the new governor.

“The question became, if you’re not giving money or working on a campaign, how do you have an accountable relationship with elected officials?”

said Schrantz. “Our goal became, whoever is elected [governor], we wanted a meeting with their entire transition team. We wanted a place at the table when the new governor chose his agenda.”

The two-year campaign was filled with meetings and leadership development. It involved ISALAH’s entire community coming together—writing thousands of postcards, practicing their storytelling and conducting public demonstrations.

It paid off. Once the new governor was in place, ISALAH was granted their wish for an immediate meeting. The organization assembled 2,000 people, who surrounded the new governor and his team. The governor and his staff listened to stories of racial inequality, not just from the faith-based community but also from teachers, unions, school principals and more.

“The funniest thing happened two days after the meeting,” Schrantz said. “We got a call from the governor. He actually asked us to help vet his candidates for commissioner positions. We helped choose four of his top administrators, including the person in charge of the Department of Health.

“It’s a shocking example of what can happen when you build enough power.”

In her role with the National Center for Frontier Communities, Wilger went through a similar process to establish a voice for the people who live in four impoverished rural counties in New Mexico, where food insecurity tops the list of pressing health issues.

“We could only do so much on the county level. Our voice was just too small,” she explained. “So we asked ourselves, what if we collaborated as a region?” They approached Con Alma, which gave

them a grant to help develop a structure for their collaborative that could allow them to leverage and diversify funding, increase member capacity and build local support.

By using their resources effectively, the coalition created a sustainable campaign and secured nearly \$100,000 in funding in 12 months. They engaged stakeholders at all levels, from food pantry coordinators and recipients to elected officials. They worked with population health advocates to examine policy issues that impacted food security in their region. And they changed the system to be equitable—revising the formula for food distribution, upping nutrition standards for food donations and increasing distribution frequency.

## » The Road to Health Equity

The 2015 Health Equity Learning Series demonstrated the need for radical change in order to achieve health equity. We know that by focusing on changing the policies and bias inherent in the structures that we live in, we can improve the health status of marginalized communities. Setting a universal goal of improving health for everyone—and then distributing resources equitably, rather than evenly—will help us reach this goal.

We also learned that collaboration is essential to success. We need to understand the strengths brought to a table, and those inherent within the communities we serve. As we use our resources to empower people who are negatively impacted by our existing structures, we can help them find solutions that work, and change these structures over time for the betterment of all.

## 2013-2015 HEALTH EQUITY LEARNING SERIES EVENTS

Presentation recordings, slides and additional reading materials are available online at [www.coloradotrust.org](http://www.coloradotrust.org) to continue the health equity discussion.

» Endnotes

- 1 Denise Gonzales, Susan Wilger. "Health Equity in Rural Communities" (presentation for The Colorado Trust Health Equity Learning Series, Denver, Colorado, July 23, 2015).
- 2 Ibid.
- 3 powell does not capitalize his name.
- 4 Arialdi M. Miniño, Sherry L. Murphy. Death in the United States. 2010, National Center for Health Statistics Data Brief July 2012 (99), accessed November 2015.
- 5 john a. powell, "Opportunity, Community and Health Equity" (presentation for The Colorado Trust Health Equity Learning Series, Denver, Colorado, Sept. 17, 2015).
- 6 Ibid.
- 7 Ibid.
- 8 National Equity Atlas (Poverty Link) at <http://nationalequityatlas.org>, quoted in Gonzales, "Health Equity in Rural Communities."
- 9 Rural Assistance Center at [www.raconline.org](http://www.raconline.org) and National Center for Frontier Communities, Silver City, New Mexico at [www.frontierus.org](http://www.frontierus.org), quoted in Gonzales, "Health Equity in Rural Communities."
- 10 Doran Schrantz, "Health Equity and Community Engagement" (presentation for The Colorado Trust Health Equity Learning Series, Denver, Colorado, Feb. 5, 2015).
- 11 <http://www.businessdictionary.com/definition/structure.html>



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