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COLORADO  
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*A Health Equity Foundation*

# Health Equity Learning Series

*Opportunity, Community, and Health Equity*

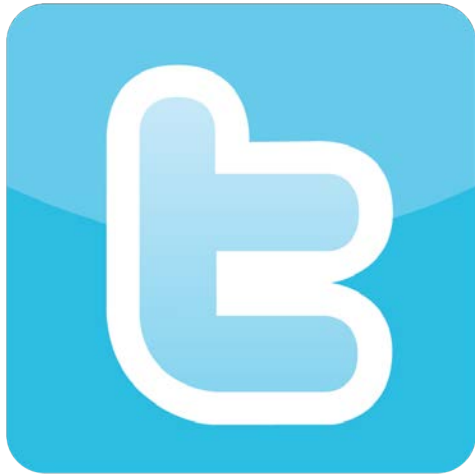
*Dedicated to Achieving Health Equity for All Coloradans*

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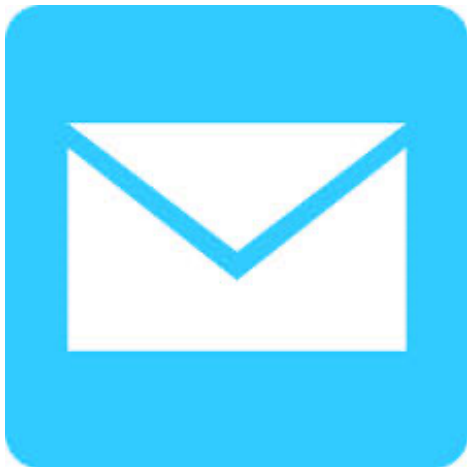
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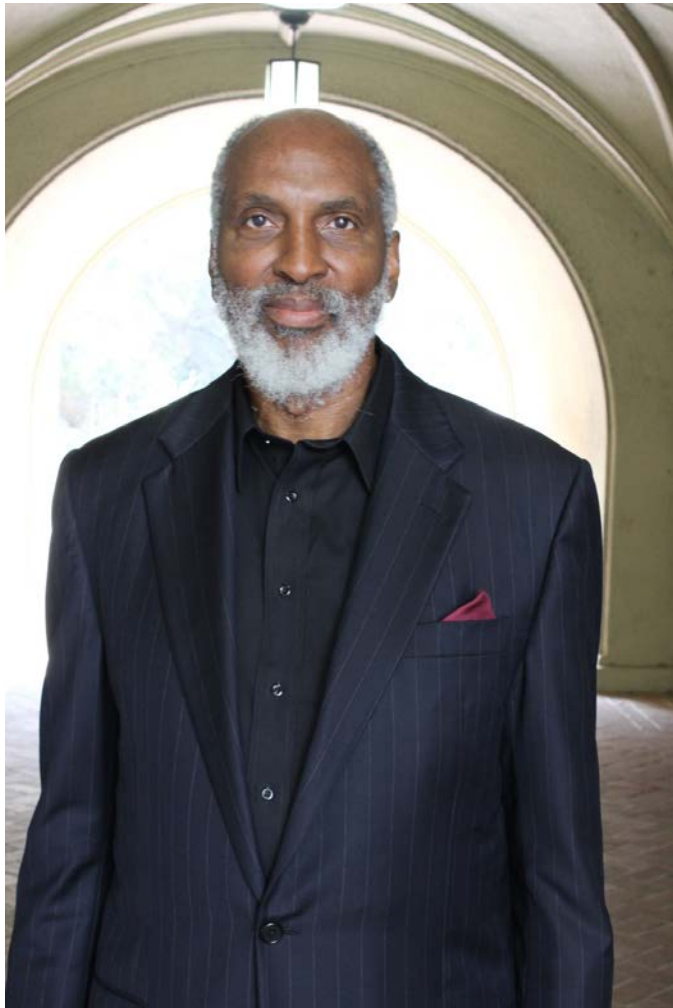


## Email

- [healthequity@coloradotrust.org](mailto:healthequity@coloradotrust.org)

# HEALTH EQUITY LEARNING SERIES

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Professor of African American  
Studies and Ethnic Studies

University of California, Berkeley



# Opportunity, Community, and Health Equity

## The Colorado Trust

**PRESENTER:**  
john a. powell

**DATE:**  
September 17, 2015



→ We all live in systems/structures.

→ These structures are not neutral.

→ They enhance or retard life outcomes.

→ We live in Structures and structures live in us.

# Structural Racialization

Structural Racism



Structural Racialization

- Race is a process

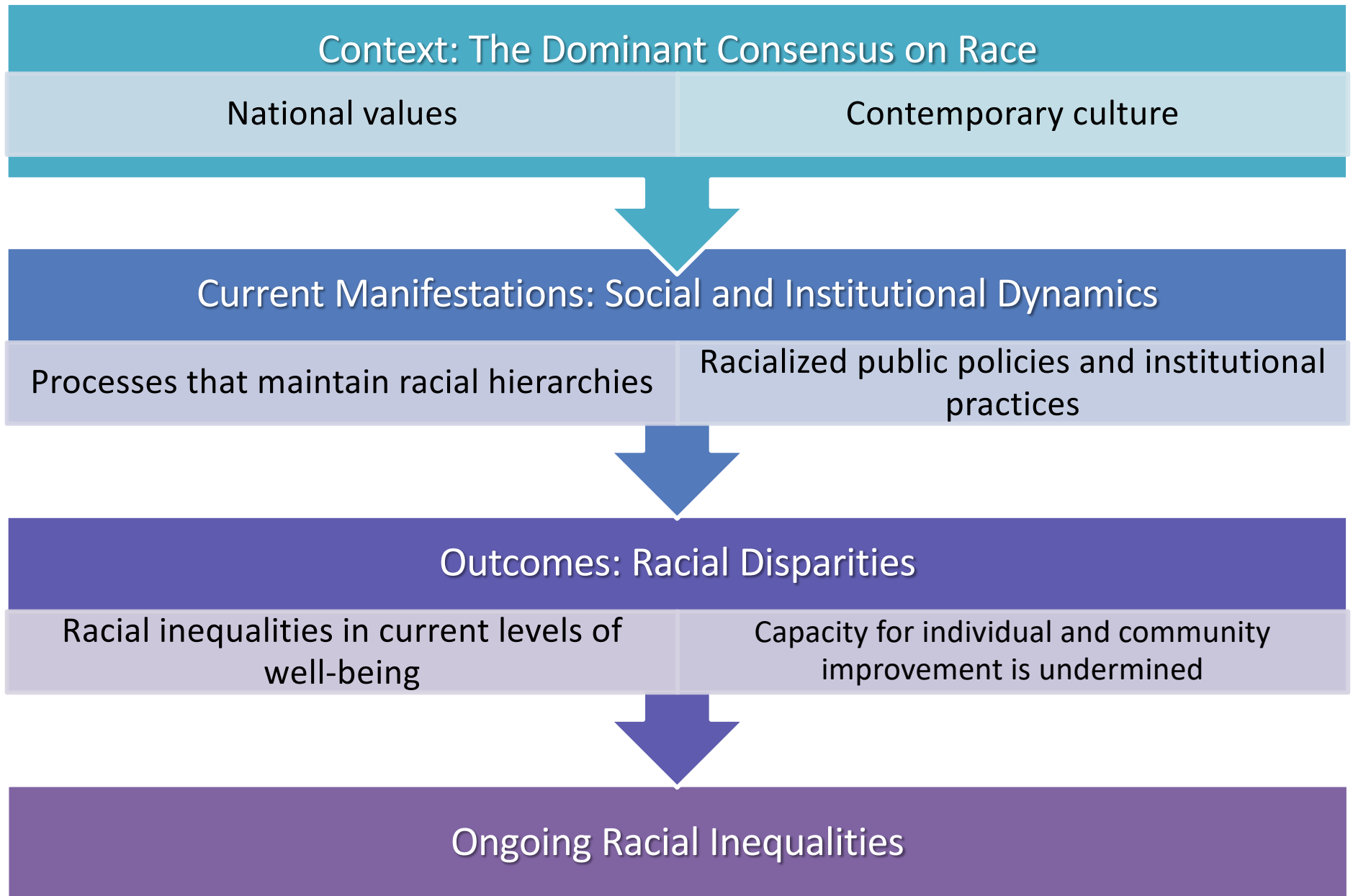
Structural racialization leads to marginalization (race, gender, ability, etc.) and blocked access to opportunity

# Structural Racialization

- How race works today
  - There are still practices, cultural norms and institutional arrangements that help create and maintain (disparate) racialized outcomes
- Structural racialization addresses inter-institutional arrangements and interactions
  - It refers to the ways in which the joint operation of institutions **produce** racialized outcomes
    - In this analysis, **outcomes** matter more than intent

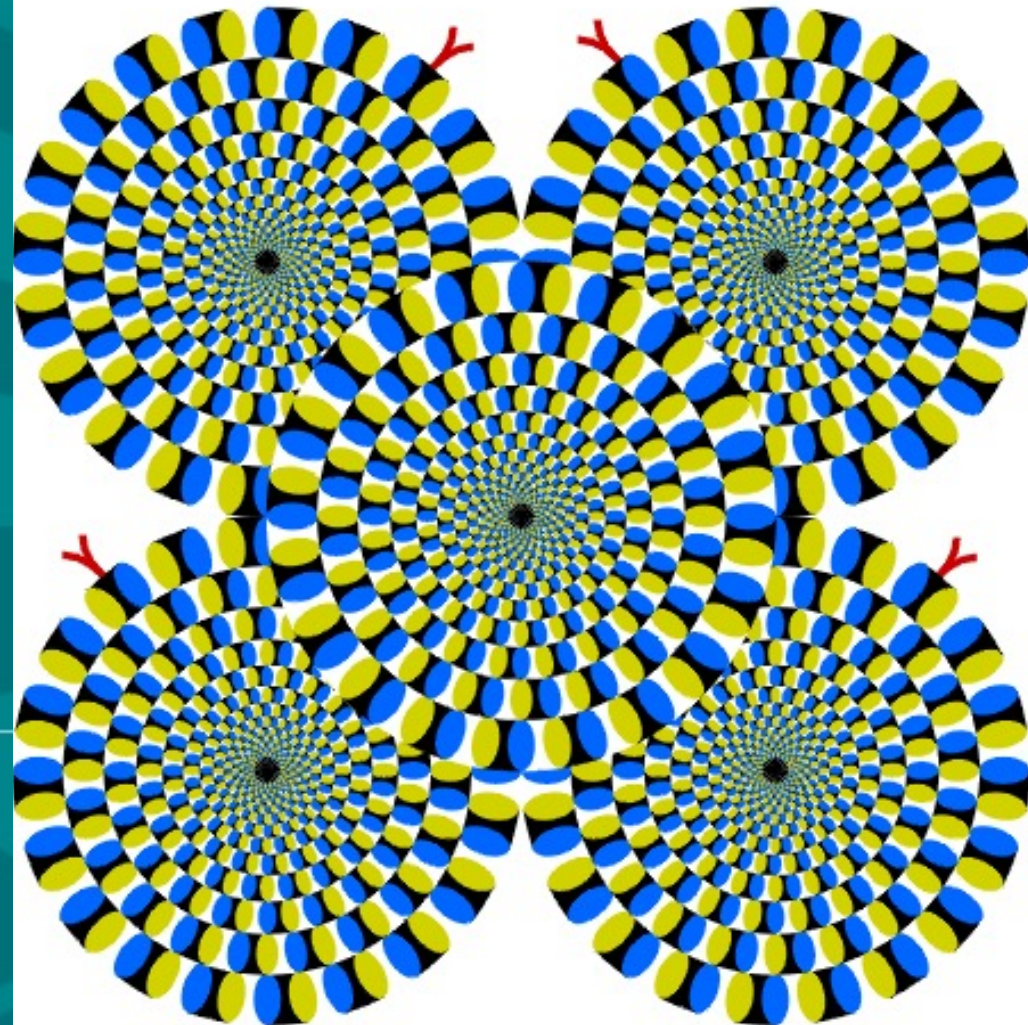


# Structural Racialization



...to an understanding of *processes* and *relationships*

- Understanding the relationships among these multiple dimensions, and how these complex **intra-**actions change processes
- Relationships are neither static nor discrete



# Opportunity Matters: Space, Place, and Life Outcomes

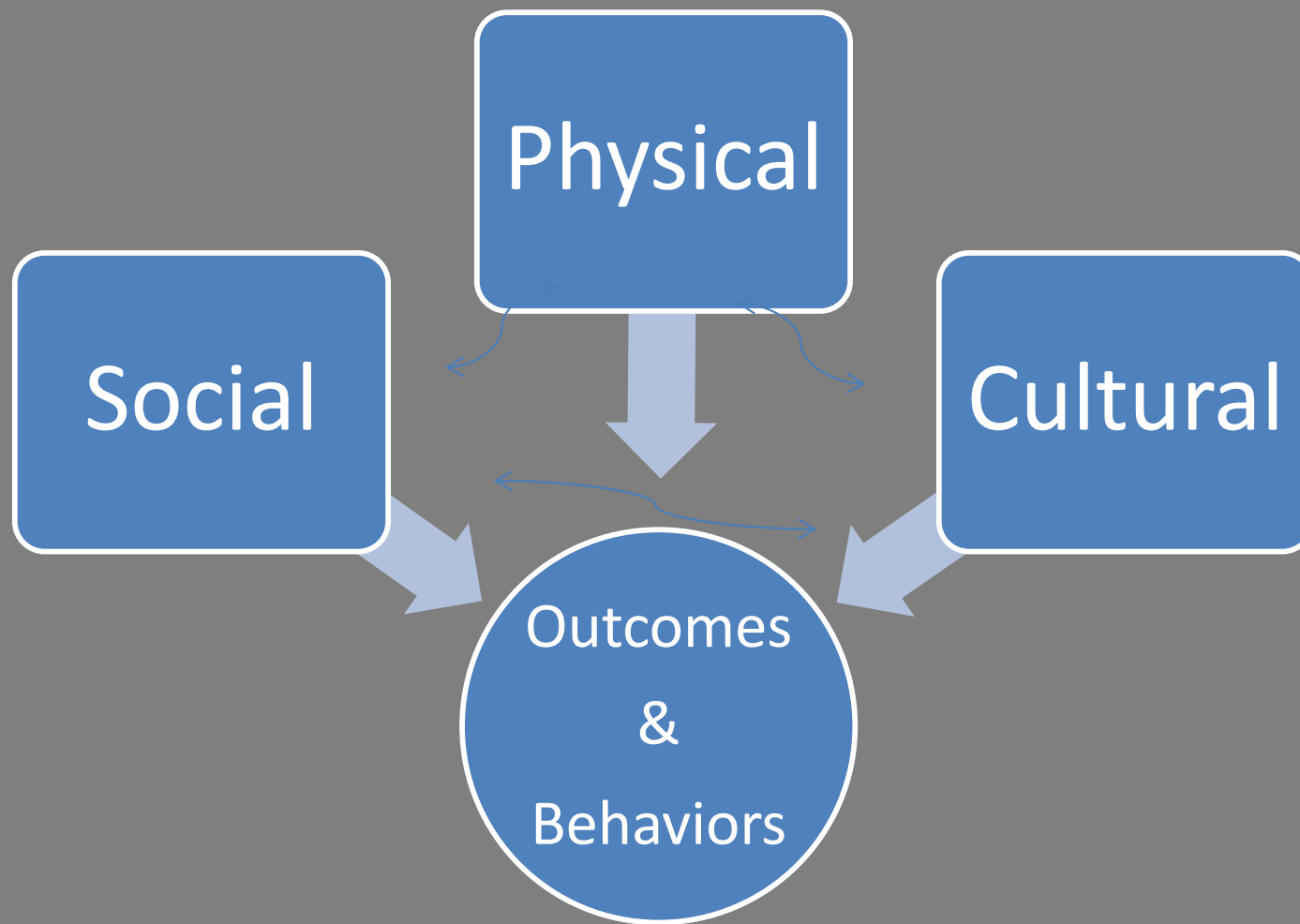
“Opportunity” is a situation or condition that places individuals in a position to be more likely to succeed or excel.

Opportunity structures are critical to opening pathways to success:

- High-quality education
- Healthy and safe environment
- Stable housing
- Sustainable employment
- Political empowerment
- Outlets for wealth-building
- Positive social networks



# Systems Thinking: We are all situated within “opportunity structures”



*These structures interact in ways that produce racialized outcomes for different groups, but also in ways that influence identity*

# Place, Race and Opportunity Structures: Neighborhoods & Access to Opportunity

- Five decades of research indicate that your environment has a profound impact on your access to opportunity and likelihood of success
- High poverty areas with poor employment, underperforming schools, distressed housing and public health/safety risks depress life outcomes
  - A system of disadvantage
  - Many manifestations
    - Urban, rural, suburban
- People of color are far more likely to live in opportunity deprived neighborhoods and communities



# Opportunity pathways vary...

- ▶ How can we be sensitive to inter- and intra-group differences?
- ▶ How do the ladders or pathways of opportunities differ for different people?
- ▶ Every institution has built in assumptions, i.e. “stairways” are a pathway – but not for people in wheelchairs, baby strollers.



# The Highly Uneven Geography of Opportunity...

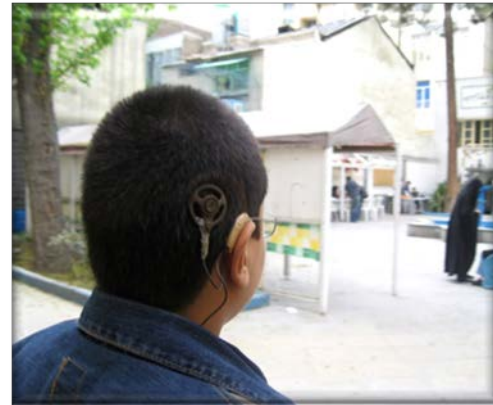


...Some people ride the  
“Up” escalator to reach  
opportunity

...Others have to run up  
the “Down” escalator to  
get there

# People are “differentially situated”

Not only are people situated differently with regard to institutions, people are situated differently with regard to infrastructure

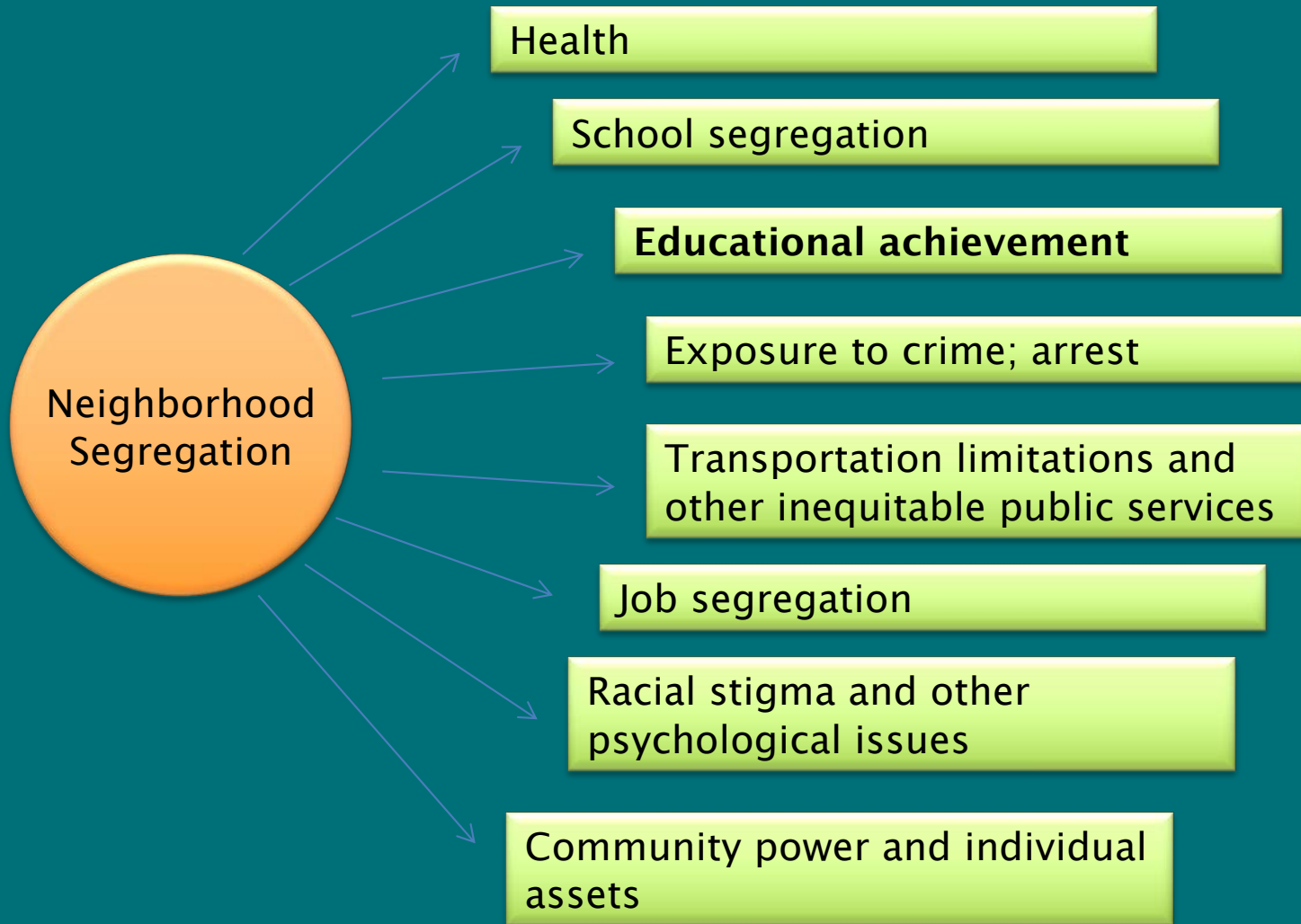


People are impacted by the relationships between institutions and systems...

...but people also impact these relationships and can change the structure of the system.



# Spatial, racial, and opportunity segregation impact a number of life opportunities



# The Arrangement of Structures



- How we arrange structures matters
  - The order of the structures
  - The timing of the interaction between them
  - The relationships that exist between them
  - We must be aware of how structures are arranged in order to fully understand social phenomena

# Today,

Institutions and structures continue to support, not dismantle, the status quo. This is why we continue to see racially inequitable outcomes even if there is good intent behind policies, or an absence of racist actors. (i.e. structural racialization)



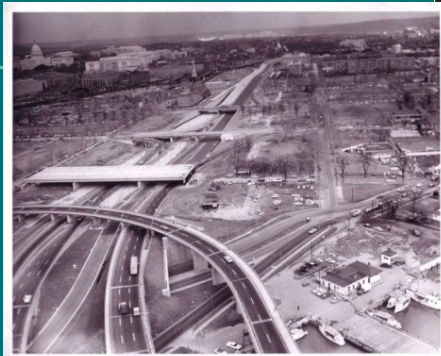
*"With these credit-default swaps, I never know whose legs I'm supposed to break."*

# Spatial Racism and Inequality

- The government plays a central role in the arrangement of space and opportunities
- These arrangements are not “neutral” or “natural” or “colorblind”
- Social and racial inequities are geographically inscribed
- There is a polarization between the rich and the poor that is directly related to the areas in which they live

# Historic Government Role

- A series of mutually reinforcing federal policies across multiple domains have contributed to the disparities we see
  - School Desegregation
  - Homeownership/Suburbanization
  - Urban Renewal
  - Public Housing
  - Transportation



# Place & Neighborhoods: Significant Impact on Child Development and Health - *Neighborhoods as Systems of Disadvantage*



# How Segregation Can Affect Health

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1. Segregation determines SES by affecting quality of education and employment opportunities.
2. Segregation can create pathogenic neighborhood and housing conditions.
3. Conditions linked to segregation can constrain the practice of health behaviors and encourage unhealthy ones.
4. Segregation can adversely affect access to medical care and to high-quality care.

# Segregation and Neighborhood Quality

- ↓ Municipal services (transportation, police, fire, garbage)
- ↓ Purchasing power of income (poorer quality, higher prices)
- ↓ Access to Medical Care (primary care, hospitals, pharmacies)
- ↑ Personal and property crime
- ↑ Environmental toxins
- ↑ Abandoned buildings, commercial and industrial facilities



# Racial Disparities in Health

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- Blacks have higher death rates than Whites for 12 of the 15 leading causes of death.
- Blacks and American Indians have higher age-specific death rates than Whites from birth through the retirement years.
- Minorities get sick sooner, have more severe illness and die sooner than Whites
- Latinos have higher death rates than whites for diabetes, hypertension, liver cirrhosis & homicide

# Inequality also affects our health

Structural racialization → inequality → different health outcomes

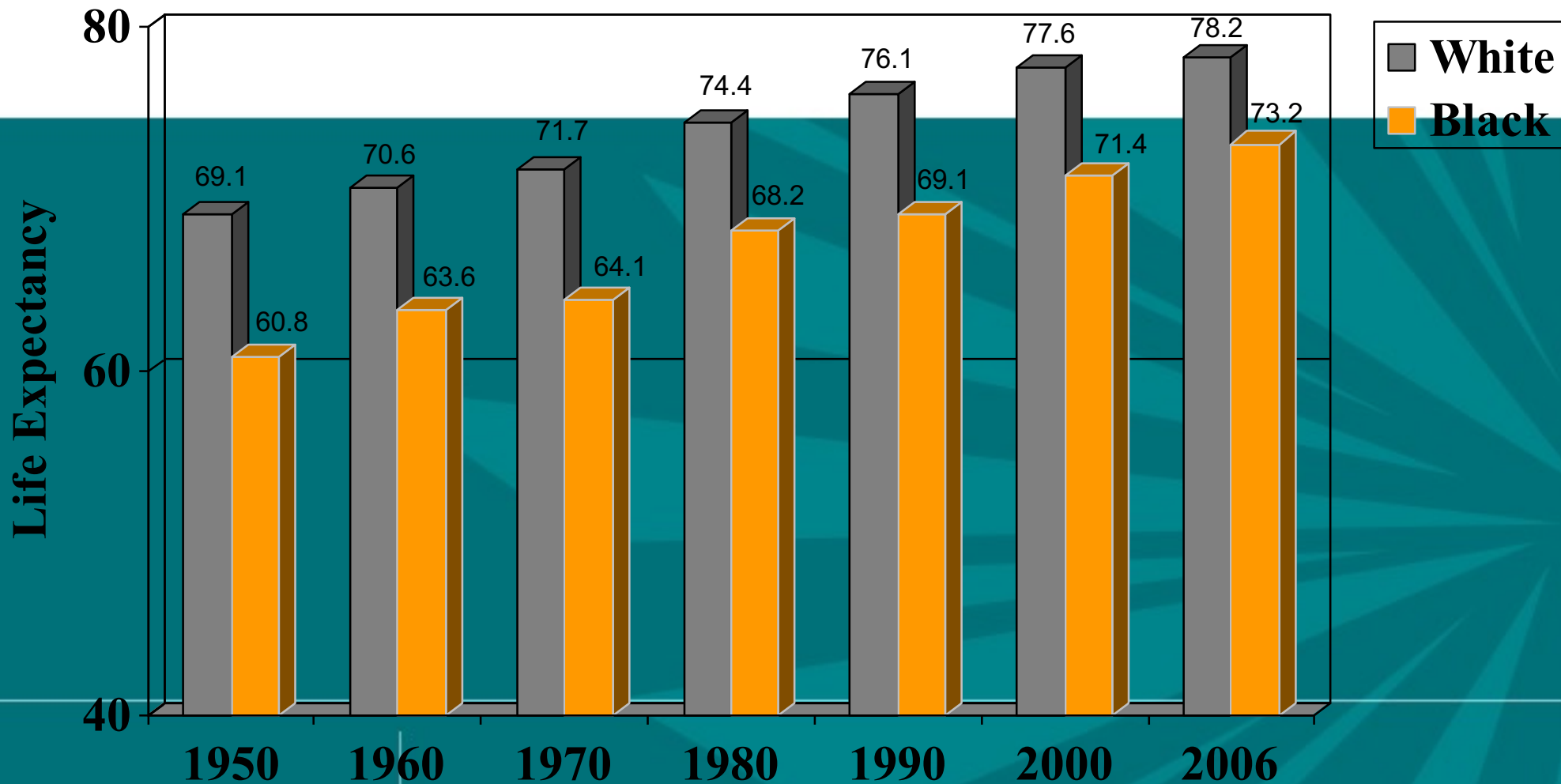
## Example :

- College educated Black women more likely to have premature babies than white women without high school diploma
  - Due to stress caused by racialization

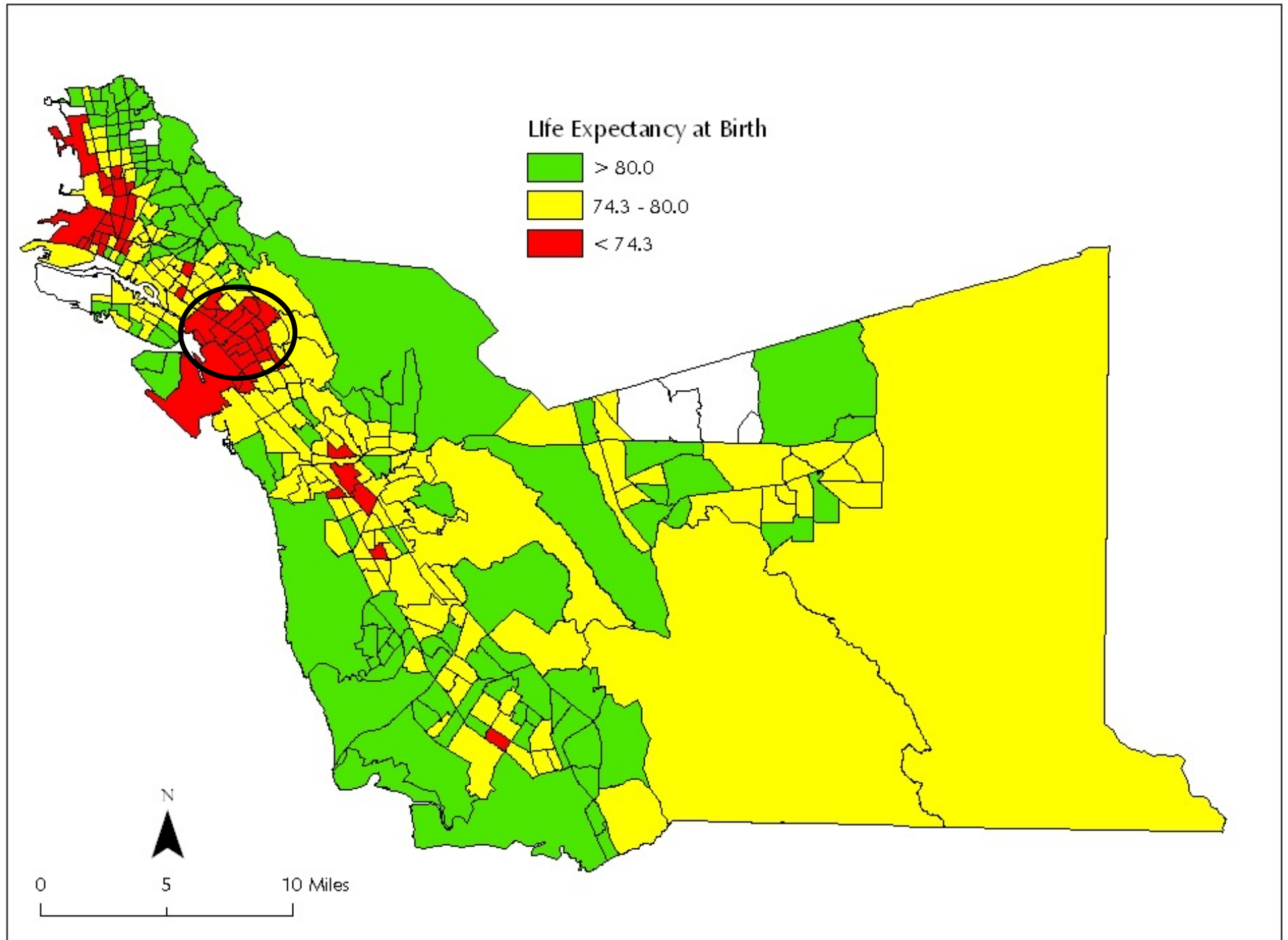
## Example:

- Twins who grow up in different environments of opportunities have dramatically different health outcomes
  - Recommended: “Unnatural Causes...Is Inequality Making Us Sick?” on PBS

# Life Expectancy Lags, 1950-2006

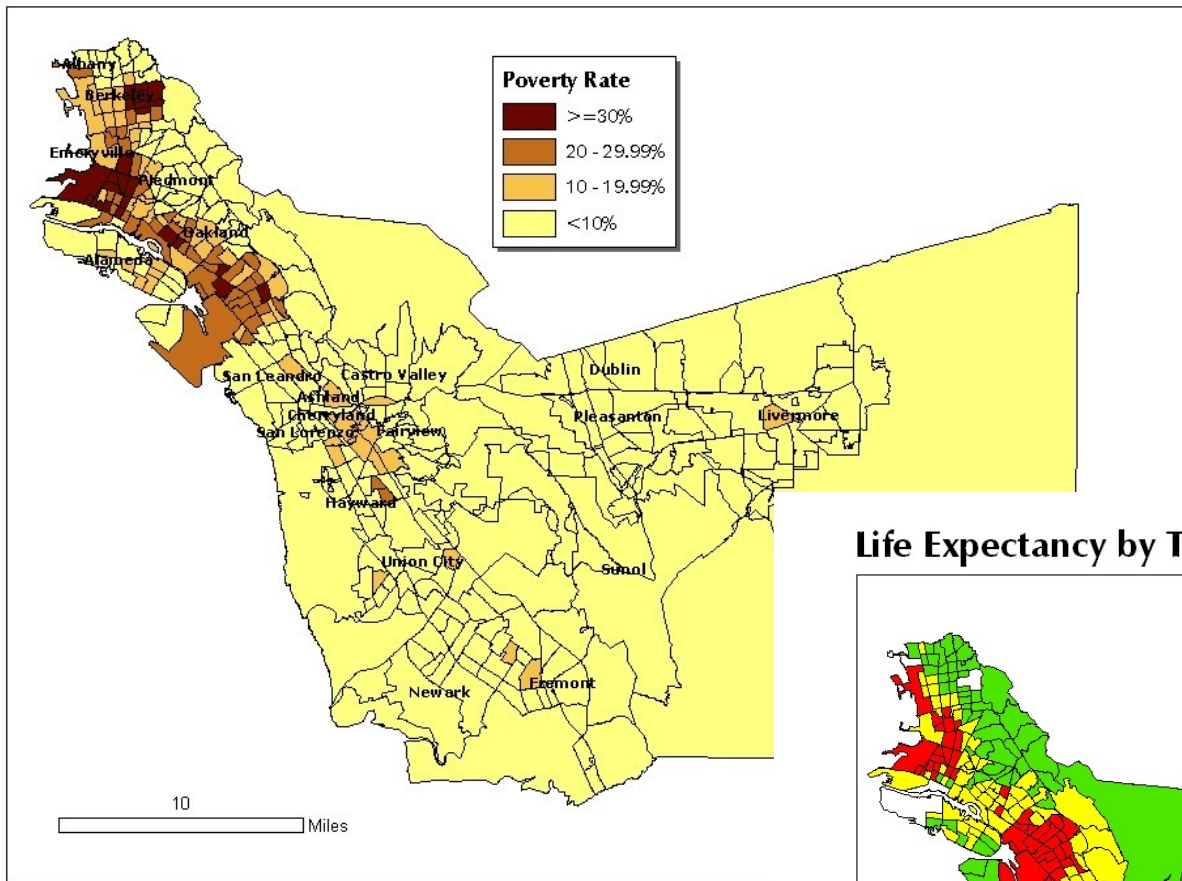


# Life Expectancy by Tract



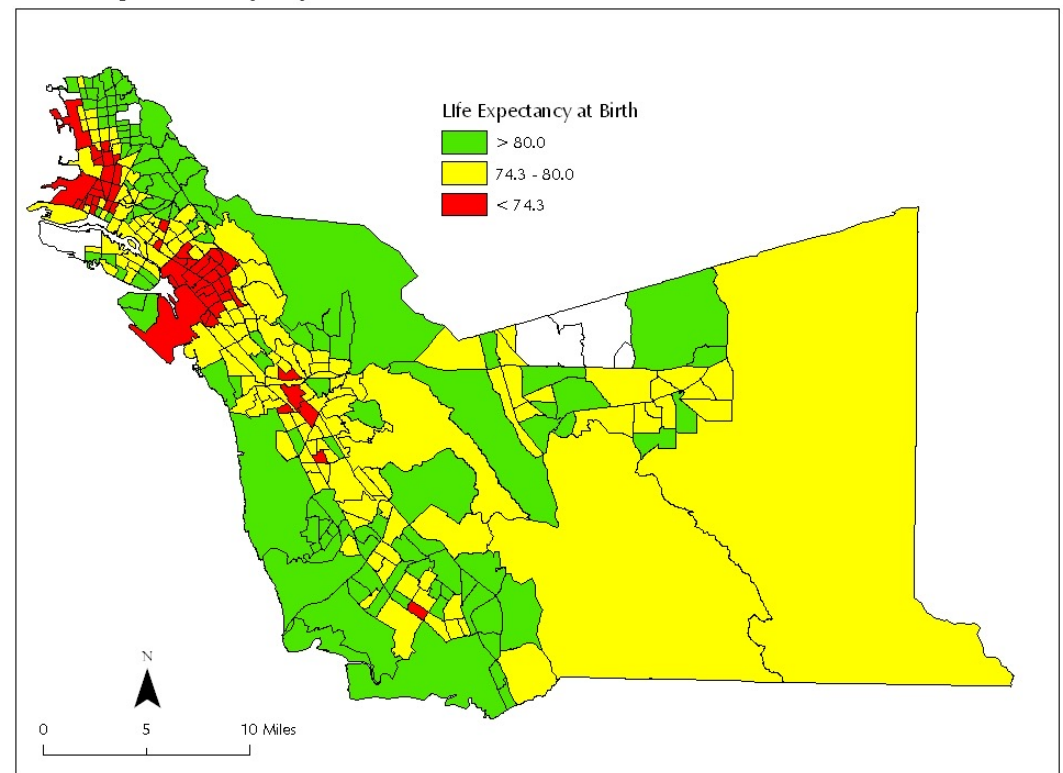
Source: CAPE, with data from vital statistics 1999-2001.

# Alameda County Poverty



Every additional \$12,500 in household income buys one year of life expectancy

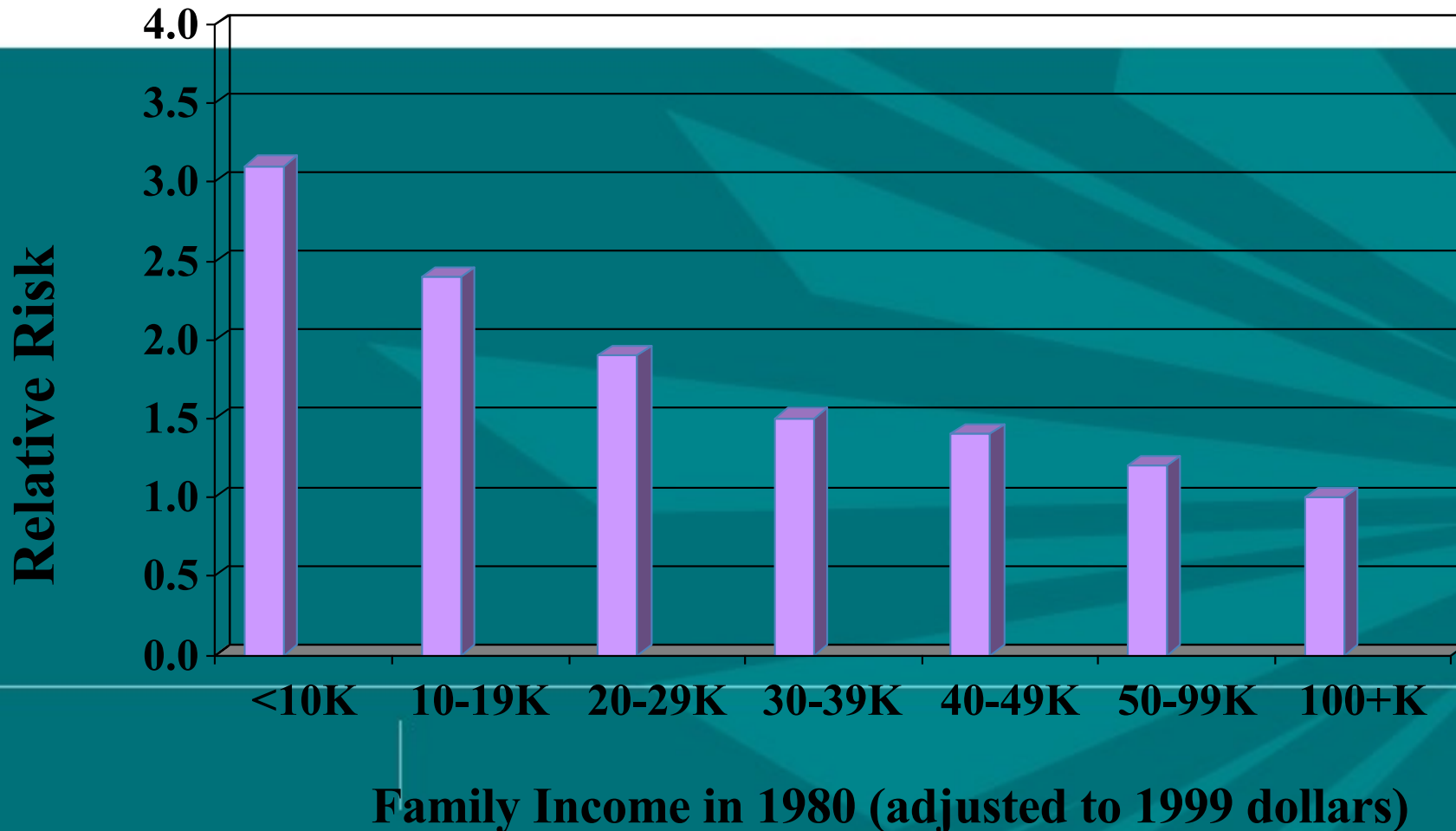
# Life Expectancy by Tract



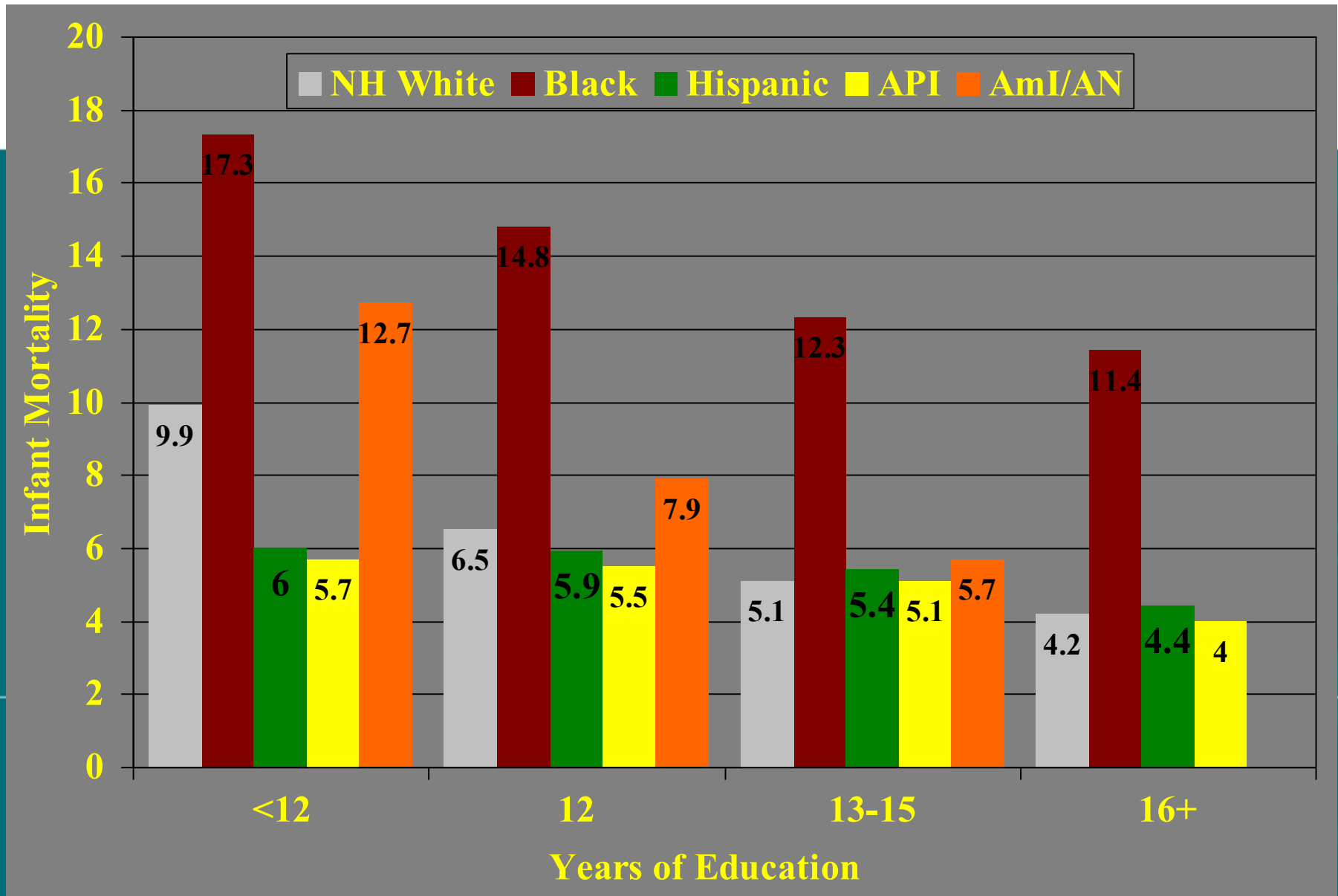
Source: CAPE, with data from vital statistics 1999-2001.

For every 10% increase in neighborhood poverty there is a 3 year decline in life expectancy.

# Relative Risk of Premature Death by Family Income (U.S.)



# Infant Mortality by Mother's Education, 1995



**Video:**  
**Race & Infant Mortality**







Social  
Determinants  
of Health

Physical hazards

Violence and  
disorder

Concentrated  
poverty

School quality

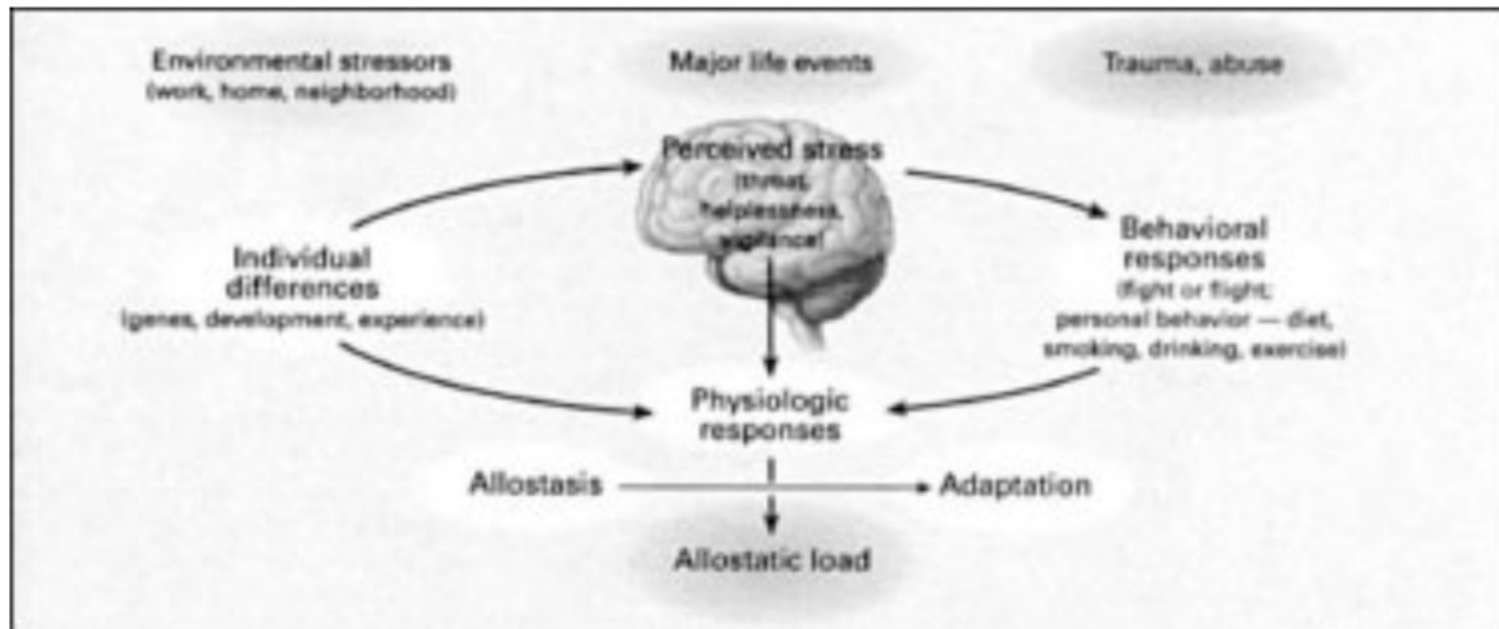
Housing quality

Racialized  
Segregation

Neighborhood  
blight

Exposure to  
toxins

Air and water  
quality



**Figure 1. The Stress Response and Development of Allostatic Load**

# atic Load

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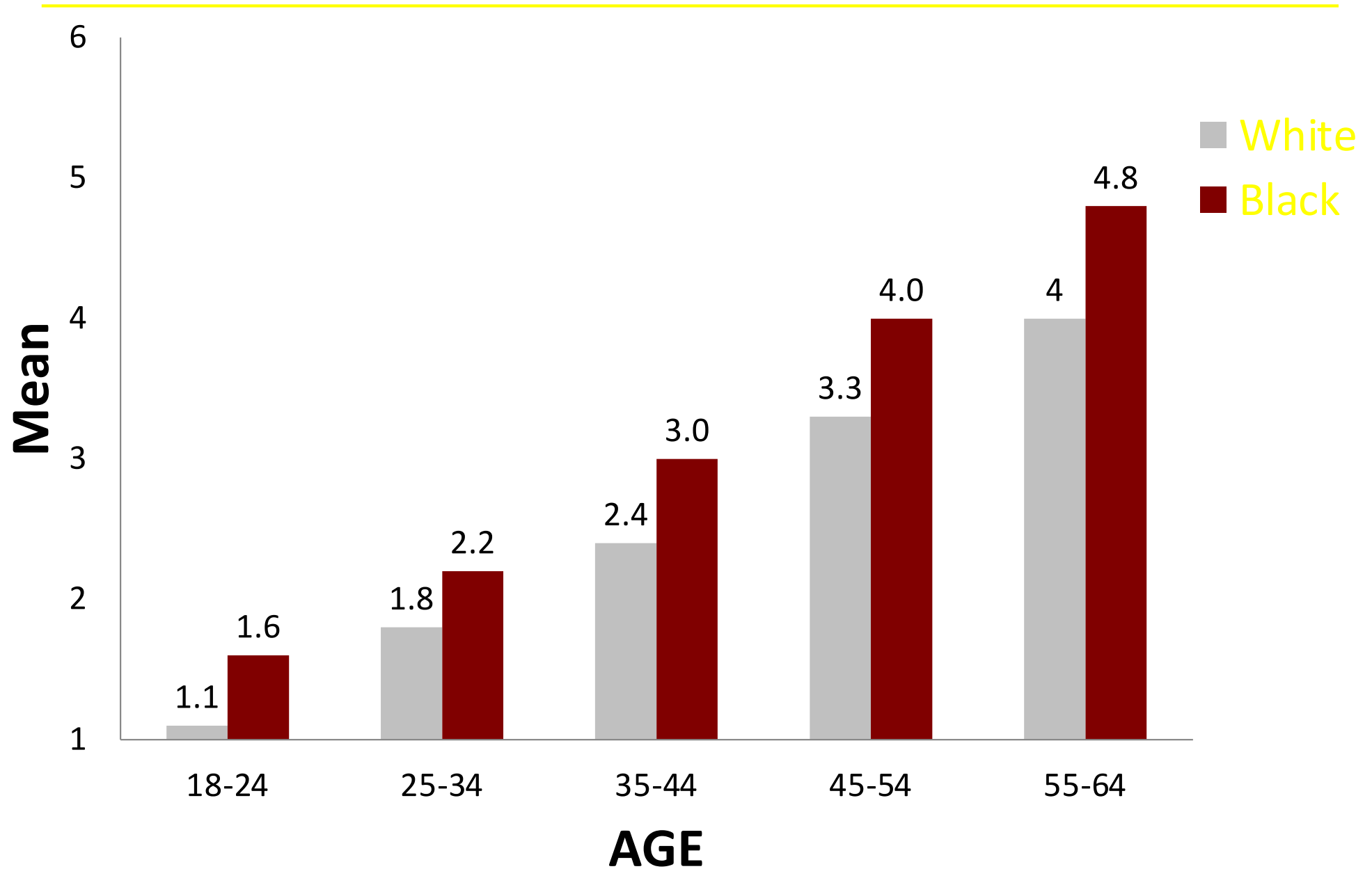
## 10 biomarkers

## High-risk thresholds \*

1. Systolic blood pressure 127 mm HG
2. Diastolic blood pressure 80 mm HG
3. Body Mass Index 30.9
4. Glycated hemoglobin 5.4%
5. Albumin 4.2 g/dL
6. Creatinine clearance 66 mg/dL
7. Triglycerides 168 mg/dL
8. C-reactive protein 0.41 mg/dL
9. Homocysteine 9  $\mu$ mol/L
10. Total cholesterol 225

\* = < 25<sup>th</sup> percentile for creatinine clearance; >75<sup>th</sup> percentile for others

# Mean Score on Allostatic Load by Age

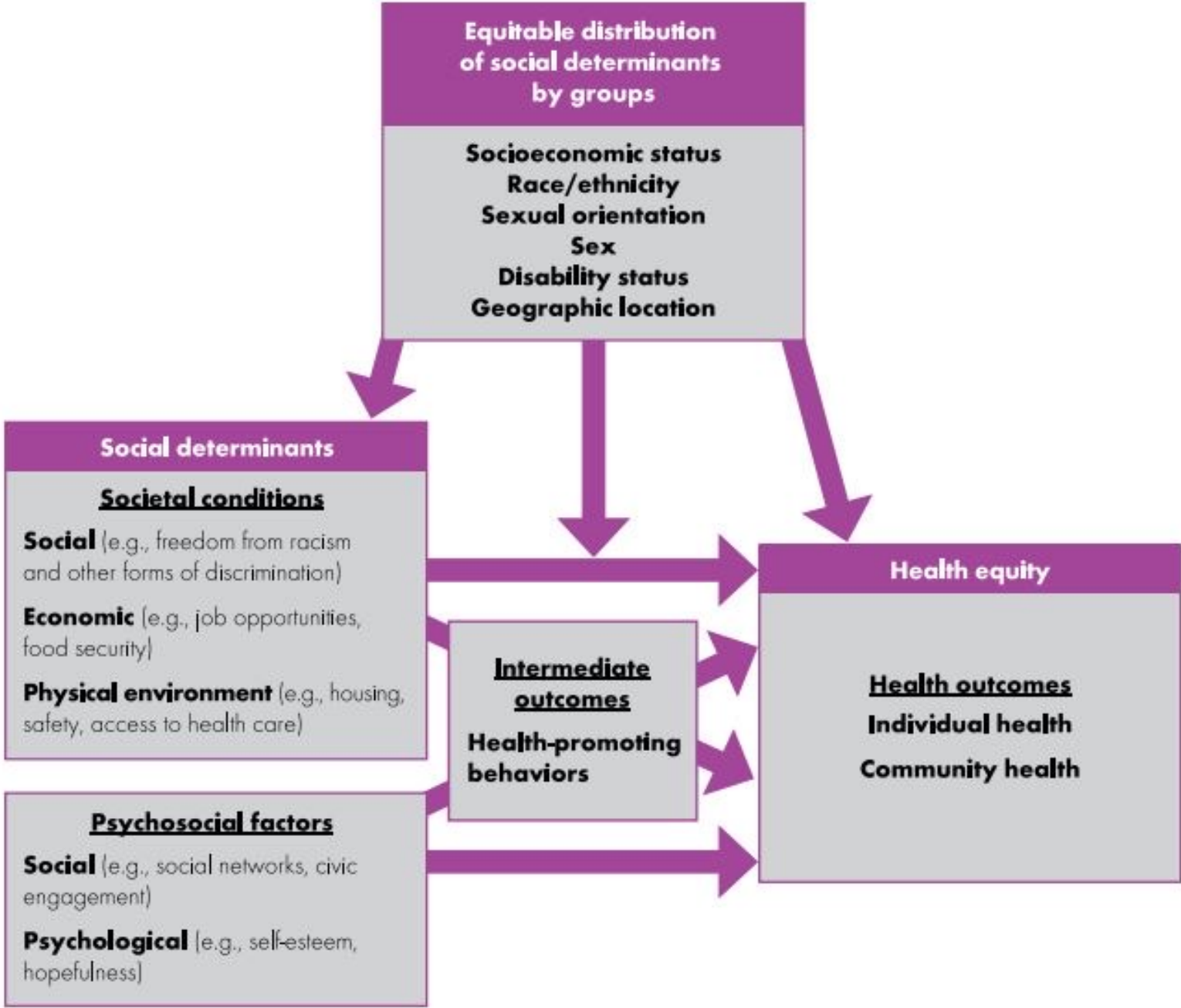


# Community, Opportunity, Poverty & other Social Determinants of Health

- A person's health is significantly influenced by social determinants or the socioeconomic and environmental conditions in which they live
- Social & environmental determinants of health can include:
  - resource limitations, social norms, exposure to crime, violence and social disorder, persistent or concentrated poverty, school quality, transportation barriers and segregation, the built environment, quality of housing, exposure to toxins, air and water quality, and physical hazards.



**Figure 1.1: Pathways from Social Determinants to Health**



Social determinants of health broadly include both societal conditions and psychosocial factors, such as opportunities for employment, access to health care, hopefulness, and freedom from racism.

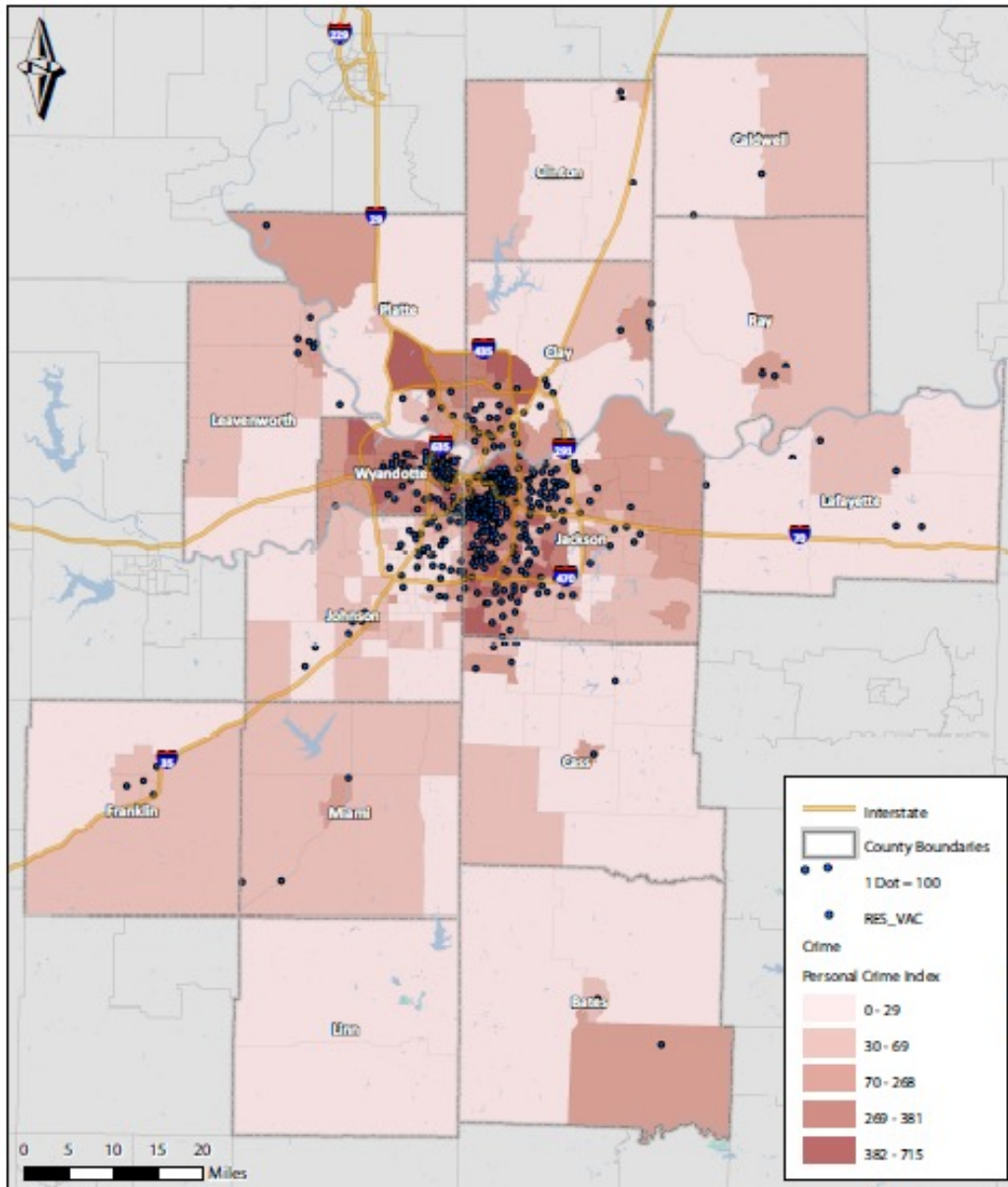
These determinants can affect individual and community health directly, through an independent influence or an interaction with other determinants, or indirectly, through their influence on health-promoting behaviors by, for example, determining whether a person has access to healthy food or a safe environment in which to exercise.

Figure adapted from Blue Cross and Blue Shield of Minnesota Foundation, [http://www.bcbsmnfoundation.org/objects/Tier\\_4/mbc2\\_determinants\\_charts.pdf](http://www.bcbsmnfoundation.org/objects/Tier_4/mbc2_determinants_charts.pdf) and Anderson et al, 2003.<sup>38,39</sup>

## Map 2: Vacant Homes vs. Violent Crime



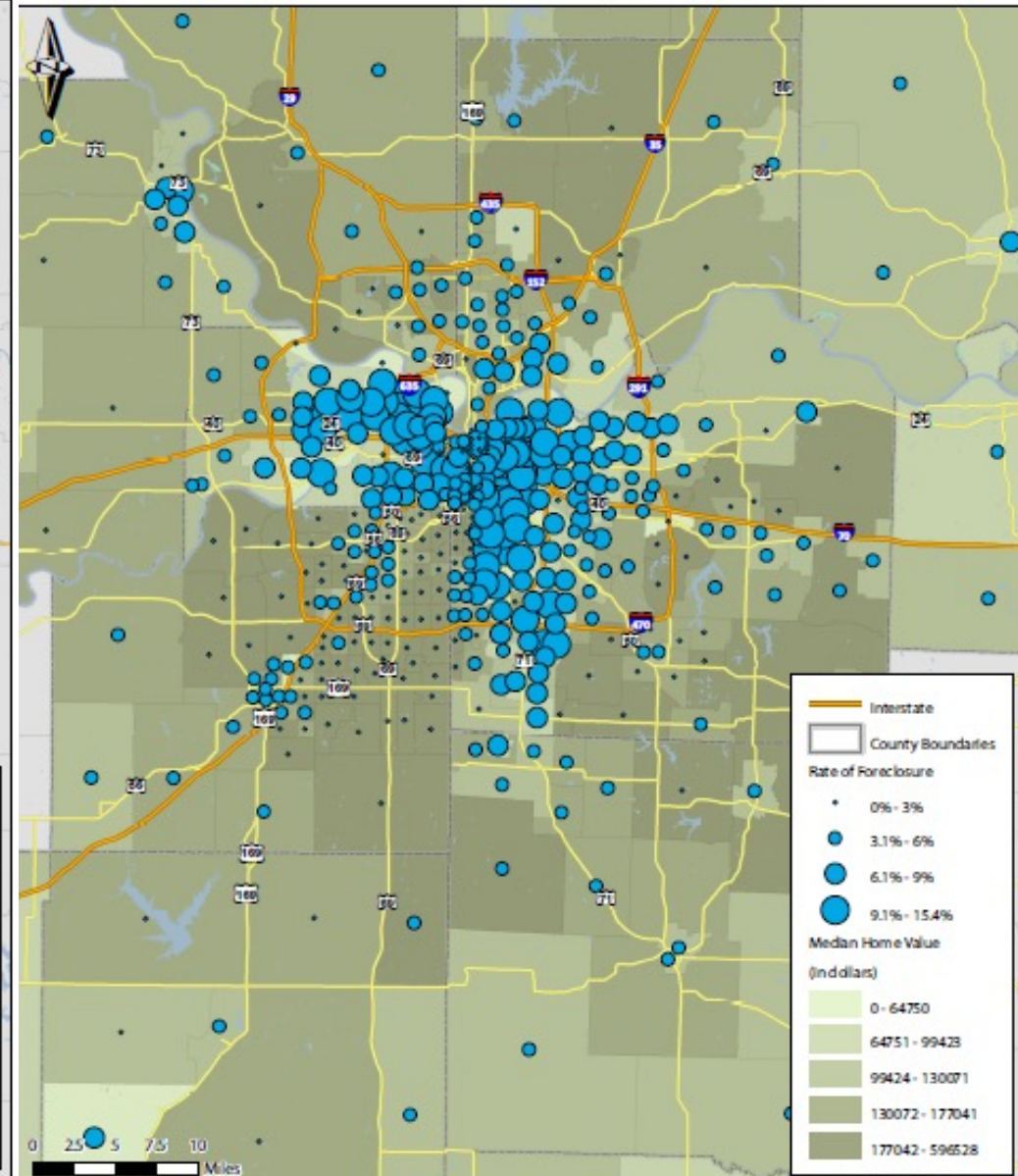
Sources: Residential Vacancy (HUD User, Sept. 2010), Crime (Tetrad PCensus, 2010)



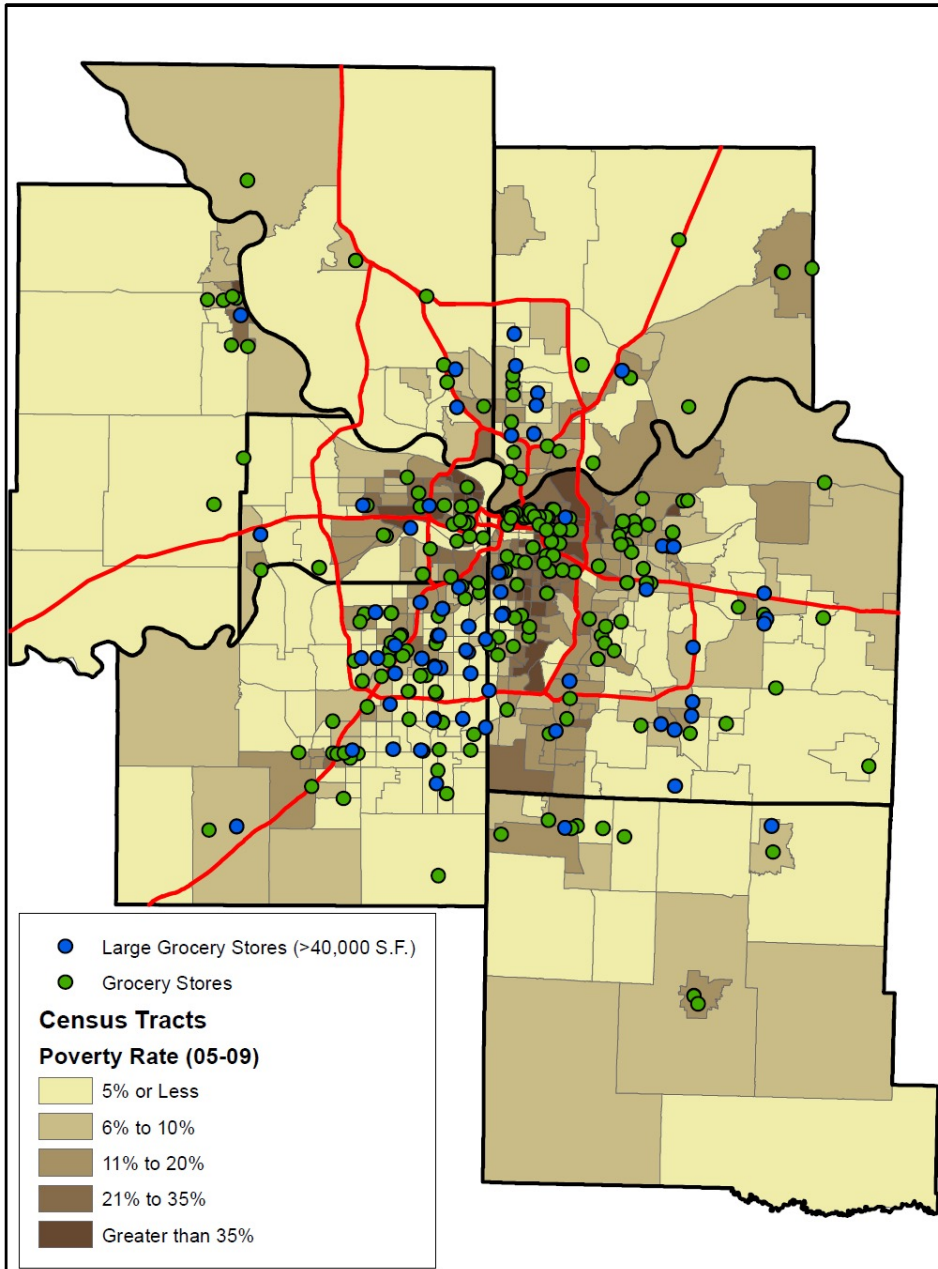
## Map 1.5: Foreclosure Rates vs. Property Values



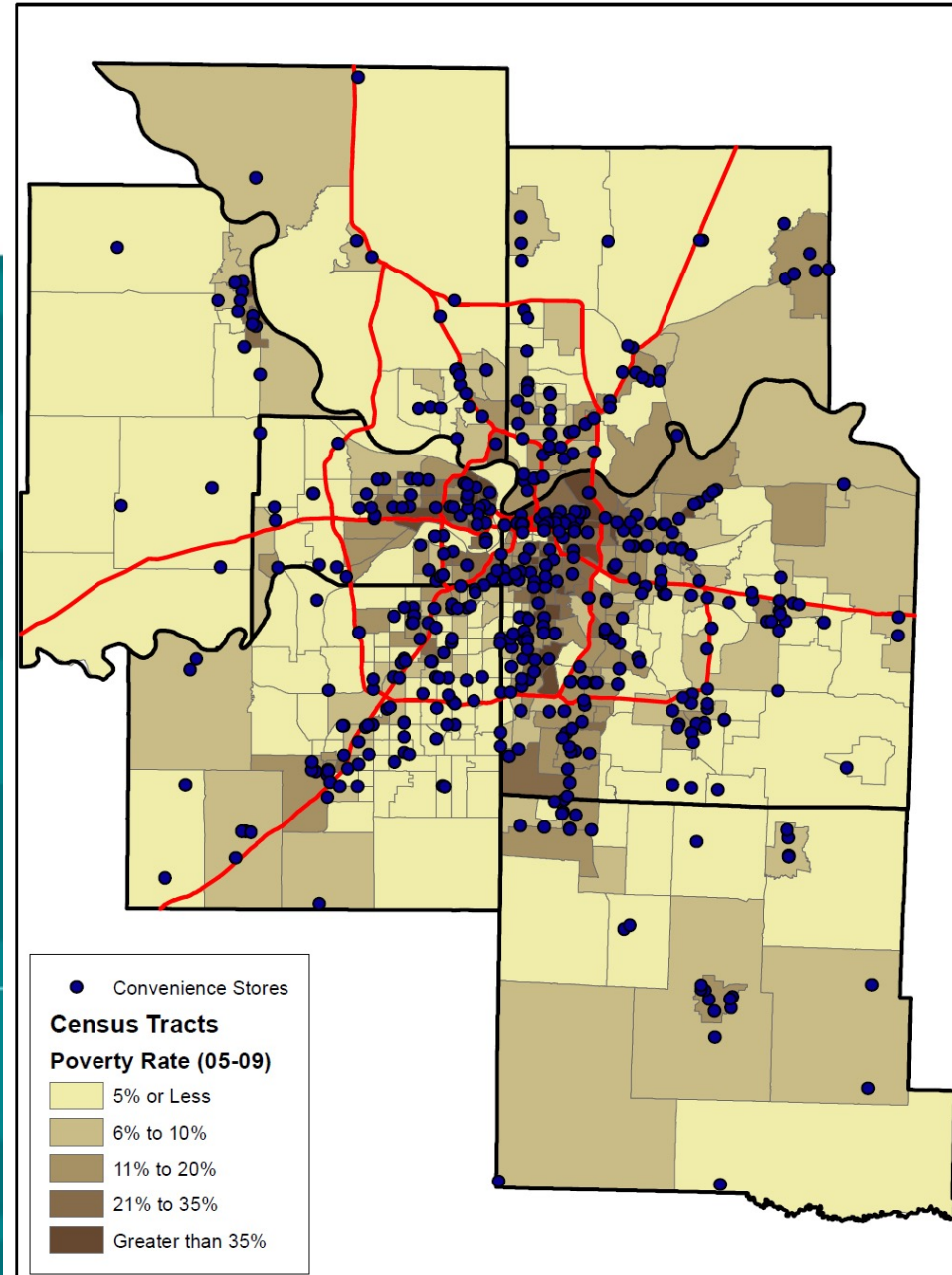
Sources: Foreclosures (HUD User, Jul 07-Dec 08), Median Home Values (ESRI Business Analyst, 2010)



Poverty Rate by Census Tract and Area Grocery Stores



Poverty Rate by Census Tract and Area Convenience Stores





# Kansas City's Geography of Health Equity

Figure 8.2 Kansas City Health Zones

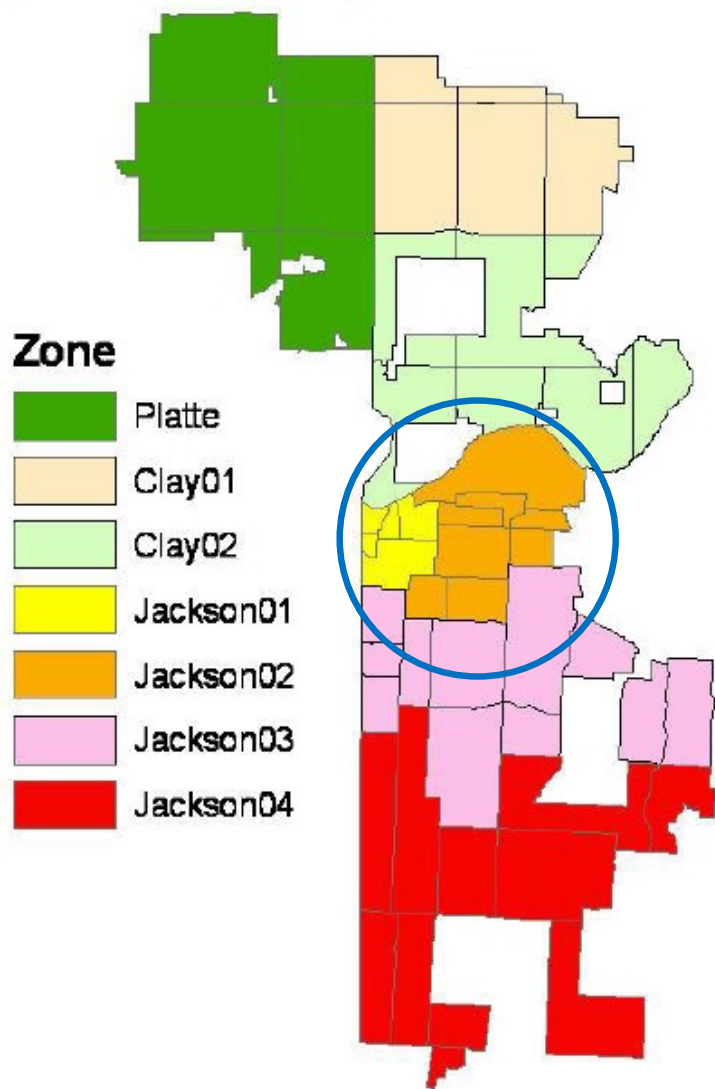


Table 8-8 Comparison of select health indicators for Kansas City Health Zones

	Citywide	Platte	Clay01	Clay02	Jackson01	Jackson02	Jackson03	Jackson04
<b>Race</b>								
White	60.7%	89.3%	93.5%	89.6%	44.0%	34.6%	48.7%	64.1%
Non-white	39.3%	10.7%	6.5%	10.4%	56.0%	65.4%	51.3%	35.9%
<b>Population</b>								
Infant mortality rate per 1,000 live births	8.2	1.6	3.8	1.7	16.8	8.5	14.8	8.4
Percent of babies with low birthweight	8.4	6.4	5.2	7.9	13.5	8.4	9.8	8.6
Percent of mothers with no 1 <sup>st</sup> trimester prenatal care	18.1	11.7	6.5	13.0	22.8	26.5	20.2	18.7
Birth rate to teenagers per 1,000 live births	12.5	6.7	3.6	8.5	14.8	21.5	13.4	11.0
Percent of women smoking during pregnancy	12.0	11.8	4.8	14.4	11.5	14.0	13.6	10.1
Number childhood lead poisoning screening tests [2009 data]	10,569	439	520	1,105	681	3,664	2,432	1,712
Percent of elevated blood lead levels [2009 data]	1.5	0.0	0.0	0.2	1.5	2.6	1.5	0.6
<b>Mortality Indicators (rates per 10,000) (Year 2008)</b>								
Premature deaths (% prior to 65 y)	34.2	28.7	30.8	27.7	44.4	44.3	35.5	25.8
Persons <20 years	2.6	0.3	2.8	1.3	3.1	2.1	3.6	2.3
Heart disease	18.3	15.9	17.4	15.5	15.7	19.6	17.5	21.1
All cancers	19.8	13.6	19.7	17.7	19.5	19.1	21.0	22.7
Lung cancer	6.5	3.5	7.0	6.1	5.0	6.9	6.3	6.9
Diabetes	2.5	1.4	0.9	2.4	3.1	2.2	3.2	2.5
Stroke	5.0	6.7	6.6	3.4	5.7	4.8	4.4	6.0
Homicide	2.5	0.9	0.0	0.5	2.5	5.1	3.3	1.6

Source: Table and Map produced by the Kansas City Health Department, 2010 Community Health Assessment

# Understanding ER Use

- The health and healthcare system is a complex system— poverty, neighborhood & environmental conditions, and the public health delivery system are all implicated in health disparities.
- To ground the complexity of the system, we are using emergency room visits as an indicator of a larger systemic issue.
  - i.e. we know the health care system is broken because people are relying on the ER for things that are not emergencies....The ER *is* their primary source of care.

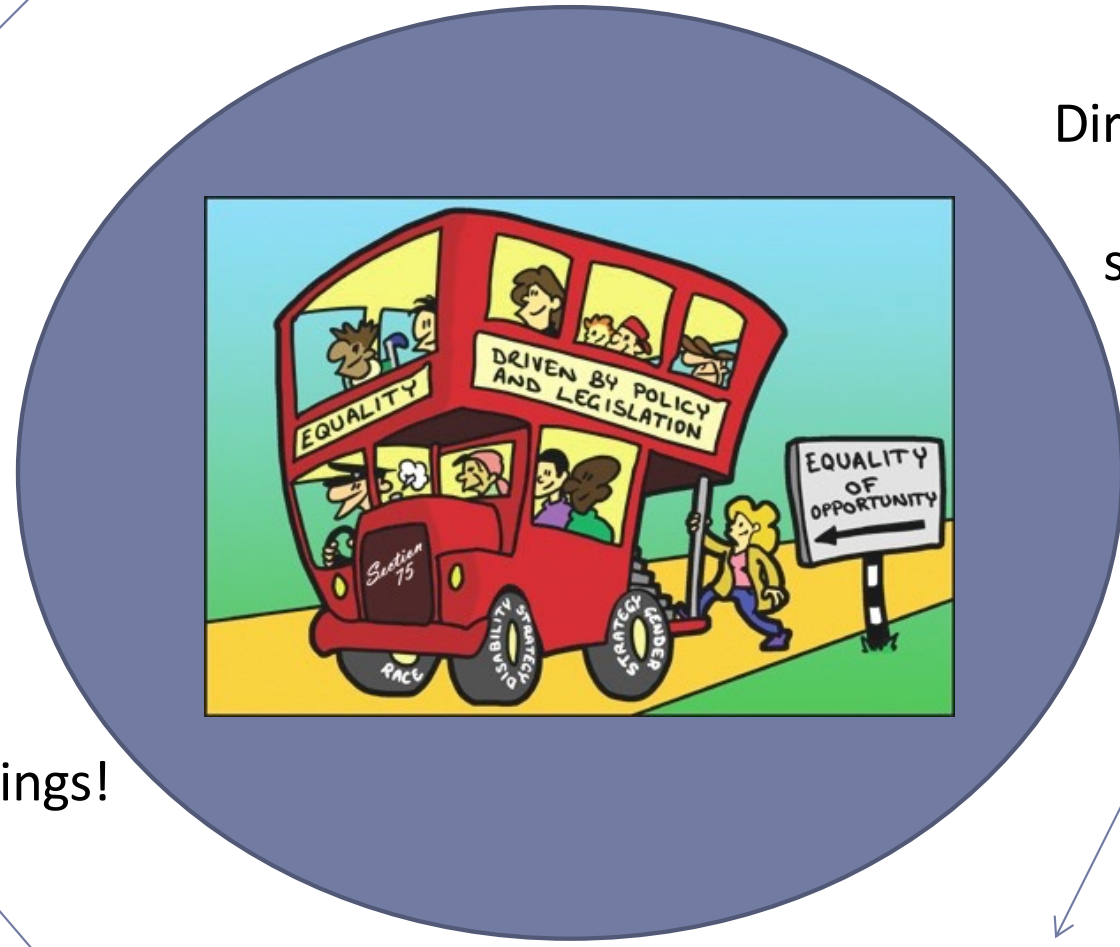


# Make Healthcare Work for ALL Patients

Identify patients and barriers to healthcare

Re-invest savings in primary/preventative care services and other community health needs

Direct concentrated wrap-around services to those patients with doctors, nurses & social workers



Capture Savings!

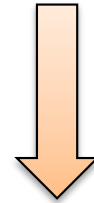
Lower emergency room and hospital readmission rates

How do we ensure equitable T/U access  
to health and opportunity for *all*  
people?

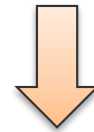
# Targeted Universalism cont.



1. Universal programs alone are not truly universal
  - Often based on a non-universal standard
    - Example – social security: able-bodied white males working outside the home full-time for pay



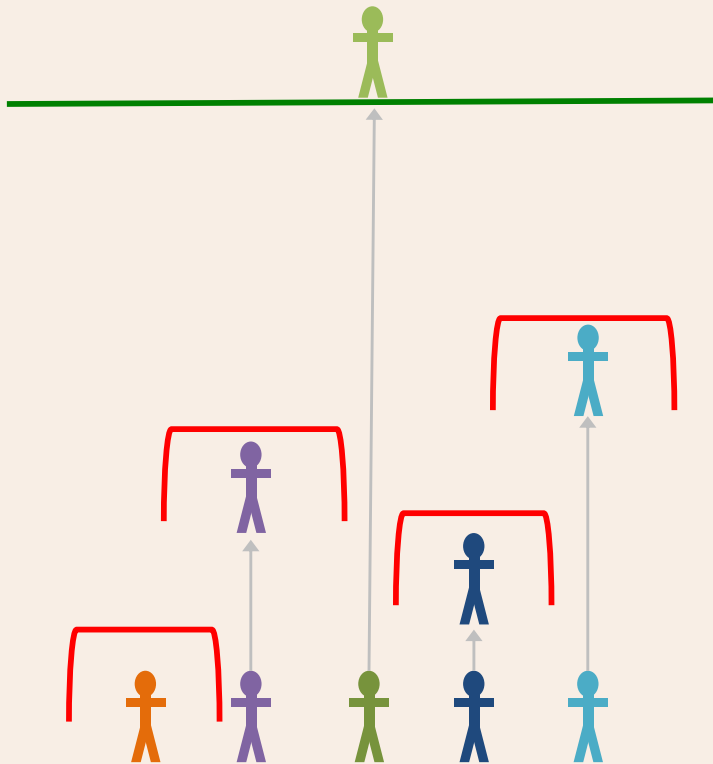
2. Targeted programs alone are not desirable because they appear to show favoritism toward a certain group, thus stigmatizing them



3. Targeted universalism recognizes racial disparities, while acknowledging their presence within a larger inequitable, institutional framework

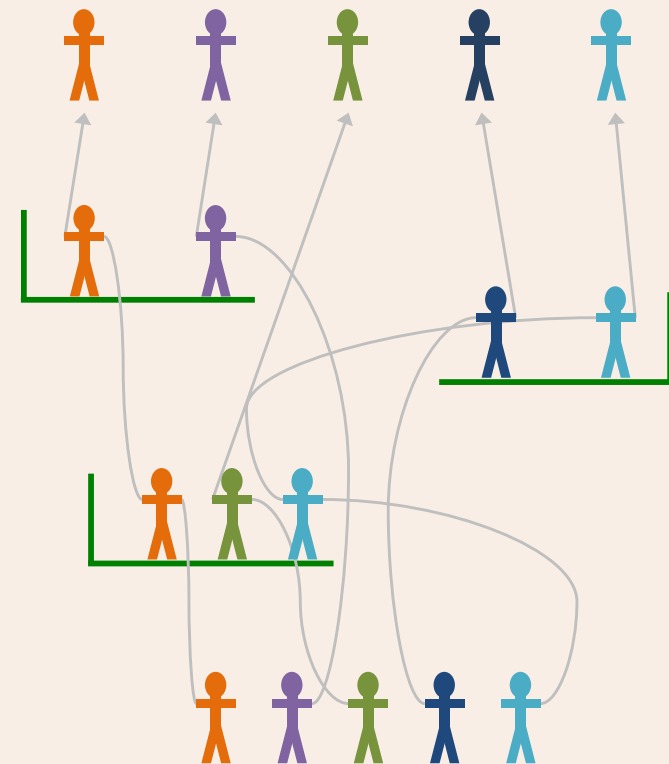
# Targeted Universalism cont.

Structural inequity produces consistently different outcomes for different communities

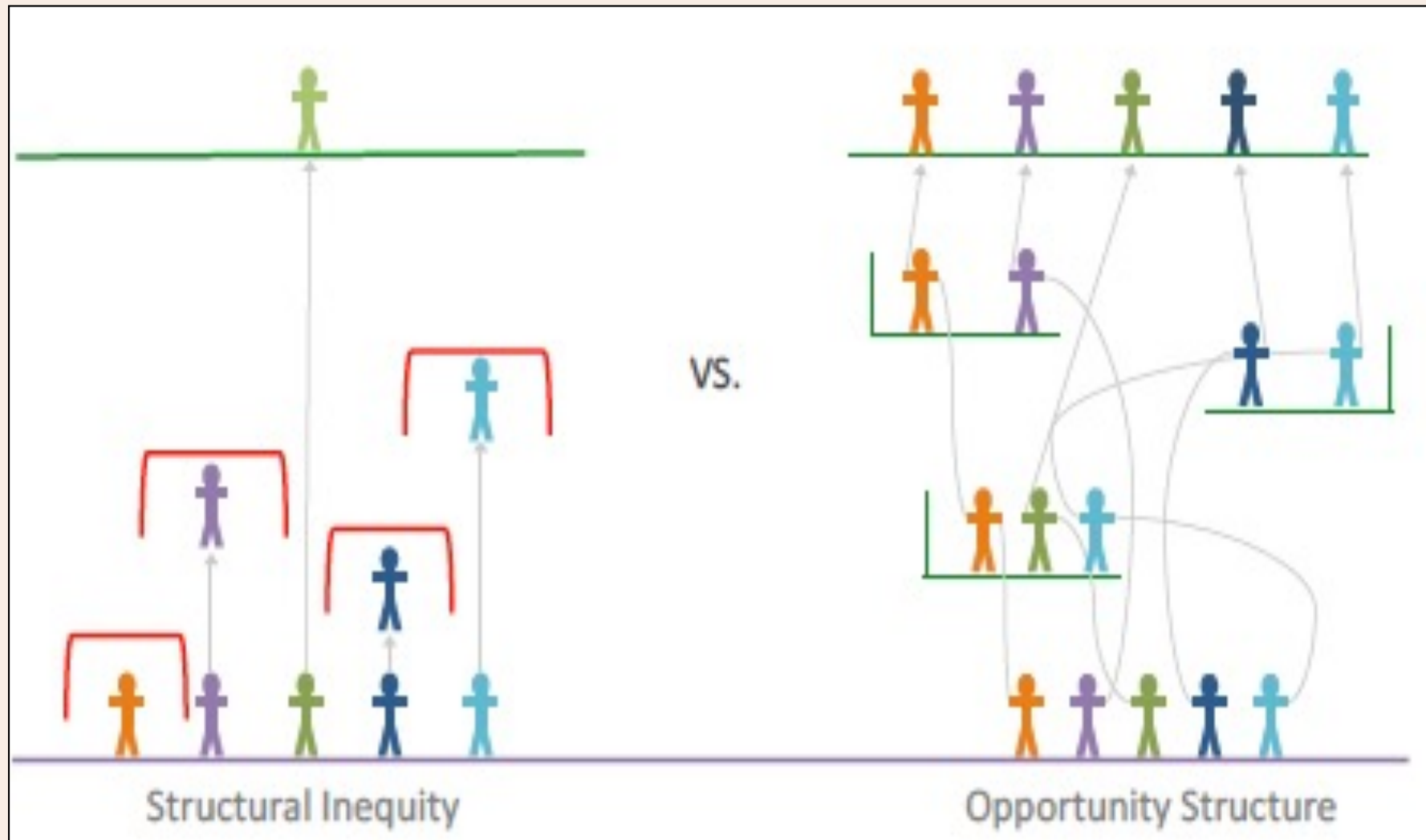


VS.

**Targeted universalism responds with universal goals and targeted solutions**



# Universal Goal with Targeted Strategy





Oh, thank goodness, a rising tide!





Oh, thank goodness, a rising tide!



# Example contd.

- But the 3 are ***not*** all in the stormy water in the ***same*** way...
- Which person would be most likely to survive the 6 hours it would take to reach them?
- If water is a “structure,” (housing, education, etc.) some groups are able to navigate the structure more successfully than other groups...



# Othering is making us sick...



**Othering is a set of common processes that engender marginality and persistent inequality across any of the full range of human differences**

- Although the axes of difference that undergird these expressions of othering vary considerably and are deeply contextual, they contain a similar set of underlying dynamics, discursive heuristics, and structurally reinforcing mechanisms
- Mechanisms of “othering” occur the mind
  - We explain not only how group-based differences become socially relevant, but how difference itself is constructed in the first place. Categorical boundaries are not natural, but emerge or are created, often deliberately, from a social context

# 6. Collective work in health must be...

## Transformative

- Create System Level Change
- Catalyze change
- Target Leverage Points
- Impact Cross-Domain, Cross-Sector, Cross-Issue

## Power-Building

- Support Alliances
- Build Coalitions
- Broaden Stakeholders
- Build Movement

## Change the Narrative

- Inspire Action
- Raise Consciousness
- Create Coherence Between Issues
- Resonate Widely

# Developing Network Partnerships in Health



## Infrastructure and Structured Alliances

- More than a coalition, but less than an organization.
- A shared platform or structure that holds together and has the capacity to support and link critical interdisciplinary and inter-sector relationships, with a particular emphasis on those that bridge across social cleavages.

## Achieve Scale to Play Big

- Tackle Big Issues/Game Changers
- Alignment: Bring together Advocates, Researchers, Organizers, and Policymakers

## Identify Strategic Partners and Expand Outward

- Identify core groups
- Grow in stages. Legitimate and communicate community ambition.
- Shared Governance: Participants contribute to and define the agenda.

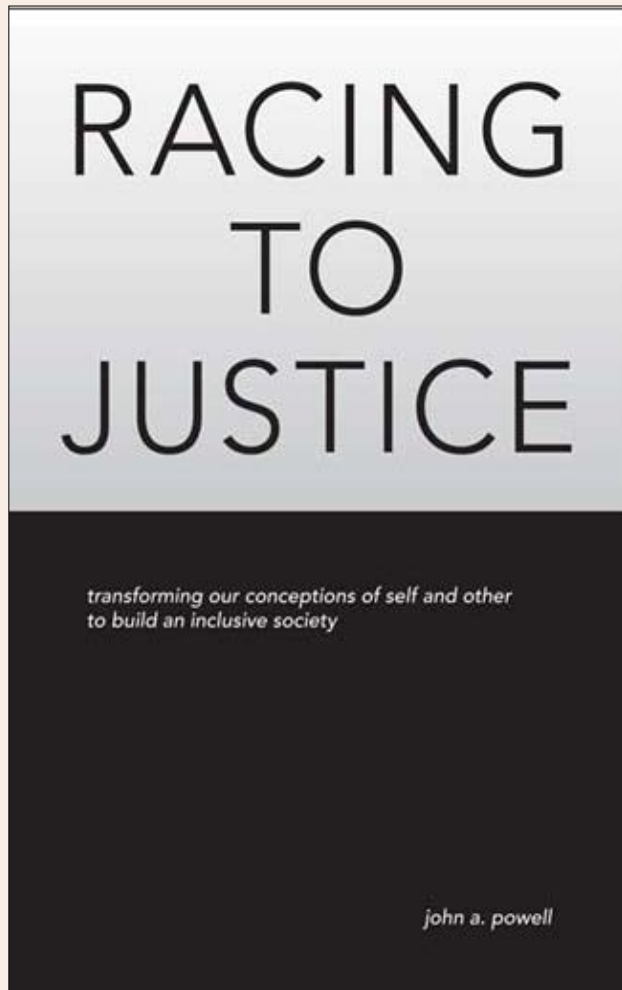
# Achieving Transformative Change



To achieve transformative change, we must create an environment in which everyone *belongs*.

*Belonging* is the greatest gift society can give us.

# Suggested Reading...



**For more information, visit:**

<http://www.iupress.indiana.edu/catalog/806639>



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