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Investing in Health to Achieve Equity: Integrating a Health in All Policies (HiAP) Framework to Advance the Promise Zones Agenda

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Abstract

Nearly 50 years after former President Lyndon B. Johnson launched his War on Poverty, President Obama unveiled his anti-poverty Promise Zones Initiative aimed at alleviating poverty and income inequality in the United States¹. Promise Zones aim to revitalize high poverty communities across the nation, working with local leaders to create jobs, increase private investment, improve educational opportunities, and reduce violent crime.² Historically, place-based policies have received substantial political bipartisan support.³ However, such policies have largely featured targeted, individual-level housing, education and employment strategies. These individual strategies often neglect underlying structural barriers to opportunity which perpetuates multi-generational poverty and adverse health outcomes among women, racial and ethnic minorities.⁴ Given the growing Latino⁵ demographic shift in the U.S.⁶ and the Administration's acknowledgement of health as an important economic driver⁷, it is vital that policymakers evaluate and address the structural sources of poverty, emphasizing the imbalance in societal resources as social drivers of health and inequality. Promise Zone-designated areas present an opportunity to leverage the initiative's systemic and cooperative multi-sector partnerships to integrate a Health in All Policies (HiAP) approach⁸ and

mitigate poverty among vulnerable populations. It is therefore imperative that Congress amend legislation to include a HiAP framework in place-based initiatives; and develop viable upstream interventions to promote equitable health outcomes for a diversifying U.S. population.

The Promise Zones Initiative

In his 2013 State of the Union Address, President Obama introduced the Promise Zones initiative: a federal anti-poverty place-based strategy to address the persistent poverty and income inequality in the United States.⁹ The goal of the initiative is to cultivate the social and economic conditions necessary to revitalize 20 of the nation's high-poverty urban, rural and tribal communities.¹⁰ Promise Zone designated communities would coordinate existing community-based programs by integrating and aligning resources across several federal agencies and through partnerships and investments in communities with concentrated poverty across the United States.^{11 12} Among the core Promise Zone community-based programs are *Choice Neighborhoods* under the Department of Housing and Urban Development; *Promise Neighborhoods* under the Department of Education; the *Byrne Justice Innovation Initiative* under the Department of Justice as well as the *Strong Economies Together Initiative* under the Department of Agriculture.¹³ While Promise Zone designated communities do not receive direct

federal funding, each would maintain their designation for 10 years under which they are eligible to receive various proposed tax credits¹⁴ intended to promote job growth and investment.¹⁵ In addition, local community leaders would receive coordinated assistance from federal agencies and priority access to federal funding opportunities and resources to support job creation, leverage private investment, increase economic activity, expand educational opportunities and reduce violent crime.¹⁶

A Brief History of U.S. Anti-Poverty Initiatives

For decades, the United States has been introduced to several anti-poverty initiatives and policies ranging in scale and approach. However, most were developed and implemented to address and mitigate poverty and income inequality throughout the nation. The emergence of place-based policies, also known as *ZIP code-targeted policies*, date back to the 1930s with the Roosevelt Administration. President Roosevelt introduced the *Tennessee Valley Authority*, a revitalization effort targeting areas of the country hit hardest by the Great Depression.¹⁷ Over the years place-based policies have been credited for progress and have received substantial bipartisan support. Subsequent presidents have since launched, adopted or modeled place-based policies similar to those of previous administrations. For example, the Kennedy Administration's

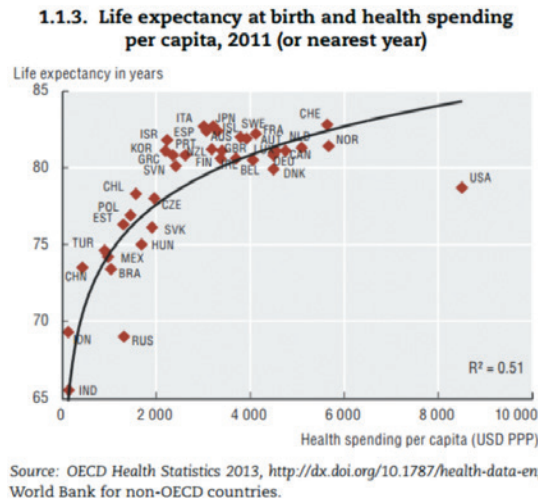
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1963 *Appalachian Regional Commission* was presented as a capacity-building and job creation program aimed at improving infrastructure to reduce isolation among the regional Appalachian community. The program was later expanded and pushed through Congress by the Johnson Administration in 1965.¹⁸ In the 1980's, President Reagan's *Enterprise Zone* program offered job-creation incentives to resource-limited businesses in urban neighborhoods. While the measure did not go through Congress, the program was picked up and launched by the George H.W. Bush Administration¹⁹. President Obama's *Promise Zone Initiative* also builds from previous place-based initiatives including the Clinton Administration's *Empowerment Zone* in the 1990's, which distributed tax credits to economically distressed urban neighborhoods. The *Promise Zone Initiative* also builds from President Obama's *Neighborhood Revitalization Initiative* introduced in 2009 during first term, which adopts a comprehensive federal multi-agency and programmatic approach to address social and economic issues in distressed communities.²⁰

Health as an Economic Driver

Although the link between socioeconomic position^{21 22} and health has long been established,^{23 24 25 26} the domain of health has often played a supporting role in anti-poverty policies and initiatives. Based on a recent Organization for Economic Cooperation and Development (OECD) report, in 2011 health care spending accounted for 17.4% of gross domestic product (GDP) in the United States- the highest among all OECD countries.²⁷ Despite spending the most on health care, compared to other nations, the United States performed poorly on most health measures including infant mortality, obesity and chronic disease.²⁸ In addition, the United States has made lower gains in life expectancy (Figure 1), ranking 26th 29 among less

Figure 1



industrialized nations and 34th among comparable high-income nations.³⁰

While population health is influenced by the nation's economy, it is the health of individuals and communities that has a substantial impact on the federal budget, fiscal policies and economic health of the United States.³¹ There are numerous and often inequitable means by which poverty damages health throughout the lifespan. Poverty creates barriers to opportunity and participation that stem directly from inadequate financial resources, which limit access to safe and healthy environments, employment and educational opportunities, and quality housing and health care options.^{32 33} As income and wealth inequalities continue to rise in the United States, it is projected that health inequalities in mortality and preventable health outcomes will also increase.³⁴ Health disparities translate into substantial preventable downstream health care and societal costs. A study commissioned by the Joint Center for Political and Economic Studies, conducted by researchers from Johns Hopkins University and the University of Maryland examined the financial burden of health

disparities. The study found that between 2003 and 2006, the combined health care and societal costs of health inequities and premature deaths in the United States were \$1.24 trillion dollars.^{35 36}

Social Determinants of Health: Key Drivers of Health Inequities

In recent years the acknowledgement of health disparities^{37 38}, health inequities^{39 40} and social determinants of health have emerged as priority areas of research and policies, garnering a considerable amount of social and political interest in the United States.^{41 42 43 44 45 46} Social determinants of health are defined as the "conditions" that influence the health risks and outcomes of individuals and communities among which include: concentrated poverty; residential segregation; racism and discrimination; public safety; access to quality housing, health care services, education and job opportunities and exposure to environmental toxins.⁴⁷ Despite leading the world in health spending, only 15-20% of all health outcomes can be attributed to clinical care.⁴⁸ Consequently social determinants of health have a far greater influence on an individual's health

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outcomes than their ability to access a medical provider.⁴⁹ Additionally, the US Department of Health and Human Services (HHS) integrated social determinants of health as one of the main topic areas under their national Healthy People 2020 goals and objectives, aimed at achieving health equity and improving overall population health over a decade.^{50 51} Utilizing a “place-based” organizing framework, Healthy People 2020 outlines the underlying factors that make up the social determinants of health.⁵² The World Health Organization’s (WHO) Commission on social determinants of health created a model (Figure 2) that describes relationships among individual and structural variables driving social determinants of health and health inequities. It provides a conceptual framework for understanding the socioeconomic and political context; structural determinants and socioeconomic position; intermediary determinants and the impact on health equity and well-being measured as health outcomes.^{53 54 55}

Place Matters: The Impact of Place on Health

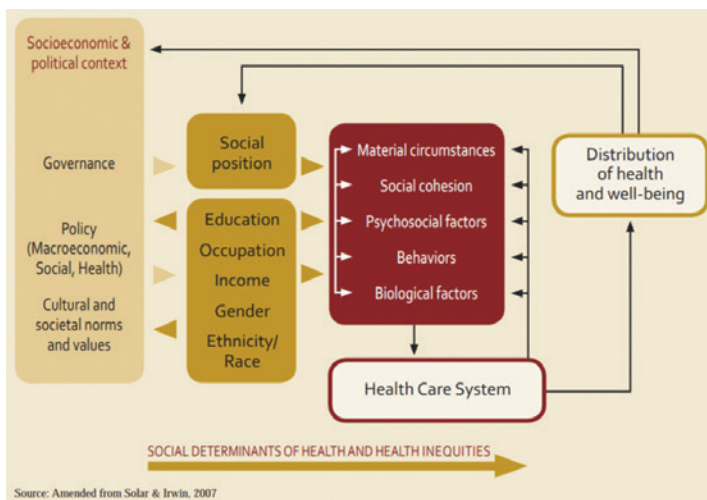
Social determinants of health are found within various environments and settings including schools, workplaces and communities and have collectively been referred to as, “place”.⁵⁶ Central to the social determinants of health is understanding how individuals and communities experience *place* and the impact that *place* has on health. Therefore, *place* matters with respect to health outcomes because Social Determinants of Health shape *place* for individuals and communities.⁵⁷ Many health inequities can be linked to a variety of Social Determinants of Health.⁵⁸ For example, not only are individual and neighborhood poverty associated with poor health outcomes,^{59 60 61} but studies have indicated that people living in neighborhoods with high rates of poverty can have life expectancies up to fourteen years shorter than those who live in neighborhoods with less poverty.⁶²

How Neighborhoods and Race Help Determine Place

The Healthy People 2020 goals acknowledge that the majority of life-course and multi-generational health inequities are shaped by specific social determinants of health; namely socioeconomic position and discrimination.⁶³ Socioeconomic position and discrimination emerge from societal economic conditions, social norms and attitudes that create and maintain structural sources of poverty and barriers to opportunity.^{64 65} Poor, segregated communities are often subject to disinvestment and institutional neglect, which contributes to increased exposure to poor quality housing, environmental toxins, and crime.⁶⁶ Differences in social determinants of health, such as individual, neighborhood poverty and low socioeconomic position, exist along racial and ethnic lines. Racial and ethnic minorities are more likely to live in places with very high rates of poverty⁶⁷ and experience significantly worse health outcomes and disparities in mortality rates (CDC) in every state and community.⁶⁸ In addition, despite adjusting for income and education levels racial and ethnic minorities are more likely to live in places with high concentrations of poverty than their white counterparts.⁶⁹

Figure 2

World Health Organization’s Commission on Social Determinants of Health Conceptual Framework



Health Inequities Arise from Inequitable Conditions

While sources of poverty can be complex and multi-dimensional, they are primarily systemic and structural in nature. Issues of poverty are often socially constructed and ignored by society. Class, race, and gender stereotypes often perpetuate false beliefs where the individual is blamed for their own poverty.⁷⁰ However, these societal beliefs fail to recognize that unequal baselines exist at birth and impede an individual’s upward mobility throughout their lifespan.⁷¹ While the identification and

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acknowledgment of social determinants of health; as conditions that shape place and drive health outcomes is key, it is also important to address the larger systems of power and societal policies that create and perpetuate conditions fostering adverse health outcomes and health inequities. It is therefore essential that the federal government critically examine past and existing policies with a health lens and work towards ameliorating the structural inequities of past discriminatory policies to improve health outcomes and consequently mitigate poverty. The imbalance in societal resources rooted in upstream social determinants of health perpetuate inequitable conditions such as racial residential segregation and multi-generational poverty.^{72 73} It is these inequities that inhibit individuals and communities from accessing the resources necessary to lead healthy and productive lives.⁷⁴

Challenges and Subsequent Changes to Previous Anti-Poverty Initiatives

Policies that effectively address the social determinants of health driving health inequities may be complex to develop and implement. Such policies may require identifying and addressing the root source of a specific social determinant of health, which may differ substantially or may be linked to multiple sources, and in turn require an alternate policy approach than initially anticipated.⁷⁵ Additionally, effective policies may require understanding and engaging with multiple sectors in ways that support and consider their respective goals, priorities and capacities.^{76 77} For decades, the United States has undergone various anti-poverty initiatives and policies. Many of the previous targeted, individual-level place-based strategies/policies have encountered various challenges, demonstrated nominal results and/or have fallen short of their intended

goals.⁷⁸ One of the biggest criticisms place-based policies have faced is their lack of evidence-based outcomes.⁷⁹ It is difficult to assess whether beneficial outcomes within a targeted zip code can be attributed to a particular place-based strategy or instead to other outside factors.⁸⁰ Evaluating place-based programs is complex in part due to their unique and targeted approaches. Previous evaluations and assessments of place-based initiatives and programs have provided mixed or inconclusive results and any benefits have been anecdotal at best.⁸¹ A 2006 Government Accountability Office report assessing the impact of the Empowerment Zone (EZ) program indicated it was difficult to conduct and concluded that “although improvements in poverty, unemployment, and economic growth had occurred [*in EZs*],” analysts “could not tie these changes definitively to the EZ designation.”⁸² Without proper tracking and evaluation of these outcomes, it is difficult to determine exactly what attributable benefits, to whom, and to what extent are distributed among individuals, households and communities located within a targeted zip-code area. In addition, it is important to consider the potentially detrimental effects of place-based policies on surrounding areas. It is difficult to anticipate how place-based strategies, specifically those that propose tax credit extensions may potentially drain resources (i.e. investment, jobs, people) and further exacerbate the levels of poverty from surrounding areas located just outside the zip-code targeted neighborhood of interest.⁸³

Focusing Upstream: A Health in All Policies (HiAP) Framework

Building on a long public health tradition of inter-sectoral collaboration, Health in all Policies (HiAP) is a collaborative approach to improve population health. HiAP

systematically takes into account the health implications of decisions, seeks collaborations, incorporates health considerations and facilitates actions in and across multiple sectors and policy areas.⁸⁴ Originating from the 1978 World Health Organization's Declaration of Alma-Ata Primary Health Care Strategy,⁸⁵ HiAP is based on the principle that health is fundamental for a society's economic vitality and that health outcomes depend primarily on Social Determinants of Health, which consequently are primarily shaped by a variety of non-health priorities.⁸⁶ HiAP is specifically linked to a government policy agenda, coordinated by formal government structures and driven by people within those structures.⁸⁷ Over the past 37 years, HiAP has developed as a mechanism to address and promote action on the Social Determinants of Health. HiAP aims to ensure that all policies generated from sectors where health is and has not typically been a primary policy consideration, have positive or minimally neutral impacts on population health, well-being and health equity.⁸⁸ There is no “right” way of establishing or implementing a HiAP approach, which may take on different variations based on initiative needs. This would depend on the structure and availability of resources by jurisdiction and/or the level of collaborative action taken among the various sectors, organizations and agencies.

Building on Promise Zones: A Pathway Toward Economic and Health Equity

One of the key features of President Obama's Promise Zones Initiative lies in its commitment to build from the strengths and capacity of previous successful approaches.⁸⁹ HiAP is an innovative approach that can enhance the Promise Zones agenda. Over the last decade, HiAP has been adopted in sixteen countries with varying governance structures and priority settings across

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the world at the national, state and local levels.⁹⁰ In the United States, HiAP is currently being implemented in a variety of ways through the Surgeon General's National Prevention Strategy in states, cities and counties across the nation.⁹¹ In addition, the US Department of Health and Human Services has identified the application of HiAP as an emerging strategy to address Social Determinants of Health and advance their Healthy People 2020 goals and objectives towards achieving health equity and improving overall population health.⁹²

HiAP is complementary to the current goals of the Promise Zones initiative in several ways. Both the Promise Zones initiative and HiAP utilize a multi-sector collaborative approach. The ten year Promise Zone designations align with HiAP's long-term strategy, which acknowledges that collaborative efforts require a great deal of relationship building and an adequate amount of time to develop.⁹³ The HiAP framework is flexible in that it can be tailored to the unique needs and partner structures in each Promise Zone designated area. As the Promise Zones Initiative continues to refine its strategy based on the latest evidence and best practices available, the HiAP framework is designed to anticipate constantly changing political and organizational environments, windows of opportunity and adapt to the realities of short-term or insecure funding streams. In addition, the HiAP framework would provide meaningful opportunities to address the evaluation challenges identified in previous anti-poverty place-based initiatives and leverage existing resources such as provisions and mandates under the Affordable Care Act that may enhance the goals of the initiative.⁹⁴ The cost of investing in approaches that identify and address the root Social Determinants of Health associated with con-

centrated poverty is minimal compared to the health inequalities and downstream health costs that accompany it. Findings from a study estimating the economic burden of health disparities in the United States from 2003-2006 reported that eliminating health inequities for minorities would have reduced indirect costs associated with illness and premature death by more than \$1 trillion dollars.⁹⁵

Conclusion

President Johnson was cognizant that his commitment to eliminate poverty would not be achieved during his Presidency. To ensure that future presidents and legislators would continue this effort out of political and self-interest, Johnson sought to persuade Congress and the American people that the elimination of poverty was a moral imperative. President Johnson made the War on Poverty a centerpiece of his political agenda.⁹⁶ In his 1964 State of the Union Address, President Johnson declared an unconditional war on poverty stating, "...*It will not be a short or easy struggle, no single weapon or strategy will suffice but we shall not rest until the war is won.*"⁹⁷ With the foresight that success would require trial and error, Johnson pledged his commitment that even if some of his early initiatives failed, he would continue to test innovative ideas. Given the recent changes in the political landscape, and the upcoming round of Promise Zone designations, we are presented with a two year window of opportunity to foster political will and try an innovative approach. Integrating a HiAP framework into the Promise Zones agenda presents a key opportunity to enhance the existing goals of the initiative while piloting an emerging framework to address the upstream sources of concentrated poverty and health inequities and improve the overall economic health of the United States.

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