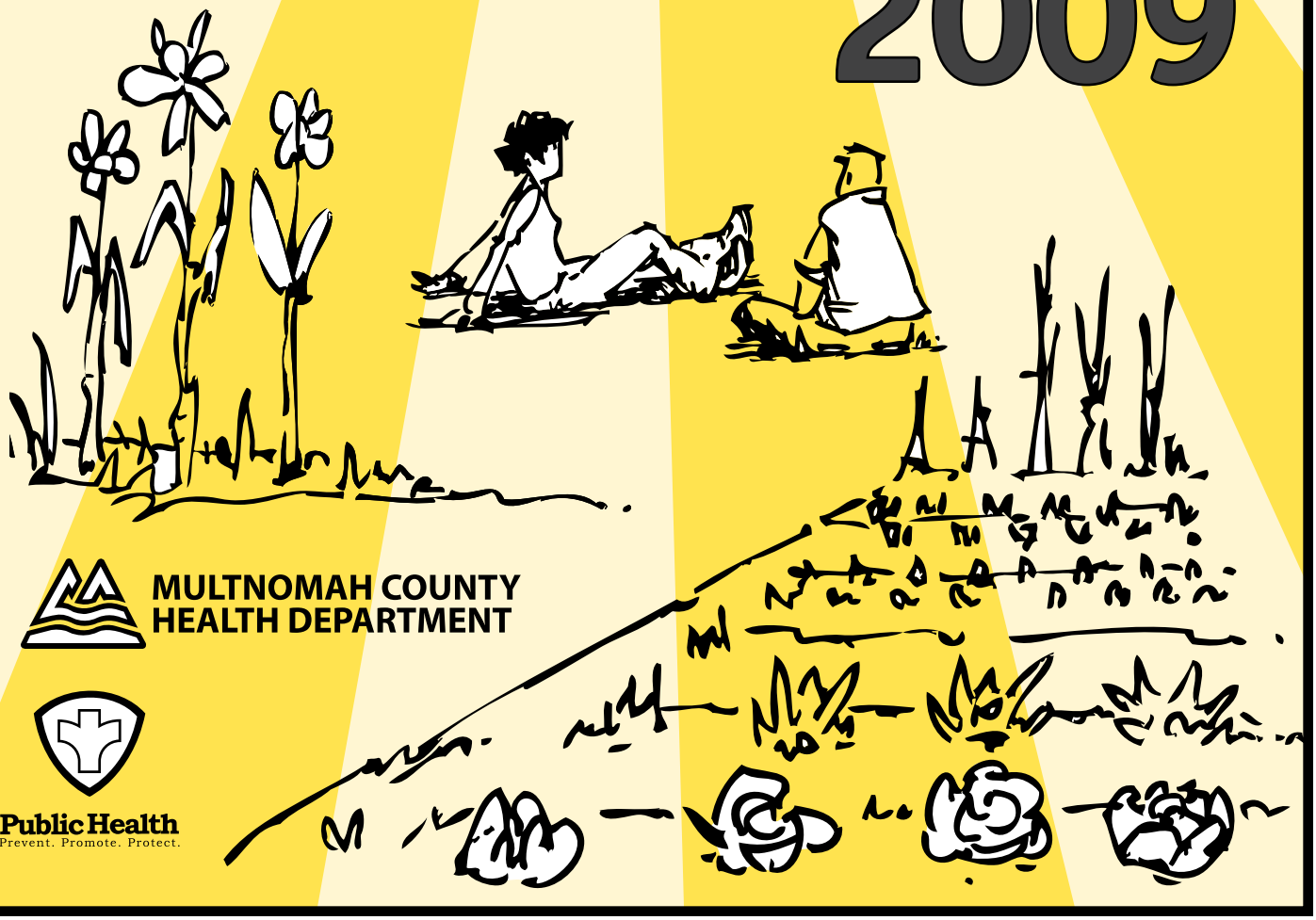
MULTNOMAH COUNTY HEALTH EQUITY INITIATIVE 2009



MULTNOMAH COUNTY
HEALTH DEPARTMENT

Public Health
Prevent. Promote. Protect.

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Produced by the Multnomah County Health Equity Initiative

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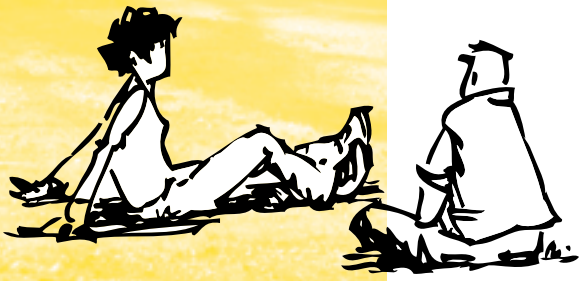


FOREWORD

This report describes the initial work of the Multnomah County Health Equity Initiative (HEI). It begins with a description of the goals of the initiative and provides an overview of the disparities in health outcomes for people in Multnomah County that result from social inequity.

Then the report explains how social determinants of health, to a large extent, directly influence health outcomes and create the context in which community members can choose health and coping behaviors.

The report describes how during this initial year we talked with individuals and groups in communities throughout Multnomah County to raise awareness of health equity issues, discuss experiences and foster solutions to inequity and health disparities.

During March, April, and May 2008, HEI launched screenings of the documentary series entitled *Unnatural Causes: Is Inequality Making Us Sick?* with Multnomah County residents and county employees. The purpose of these screenings was to increase awareness of the underlying or root causes of health inequities; stimulate discussion about the problems and causes of health inequities in Multnomah County; and generate potential solutions.

This report also provides an overview of the key informant interviews conducted with Multnomah County Health Department staff, county staff from other departments, and local community partners and advocates. Significant research on policy approaches to addressing health inequities has been undertaken to identify appropriate policy responses.

After data from the initial community dialogues and policy research was combined, a series of community report-back events was conducted in September and October, at the same locations where *Unnatural Causes* was screened. At these dialogues, community members were asked to prioritize the combined list of policy priorities. The results of that prioritization process were used to develop HEI policy recommendations.

Based on our findings, this report ends with a set of organizational policy recommendations to the Board of County Commissioners to further advance equity for the health of all county residents. Each recommendation has been informed by the initial community dialogues, policy research, and community feedback from the report-backs.

Finally, the report ends with clearly outlined next steps for HEI in the areas of: policy, partnership-building, and community engagement.

INTRODUCTION

"During my administration, Multnomah County will work to eliminate disparities based on race and ethnicity that exist in our community, and we will challenge other community institutions to work with us to make this happen."

In April 2007, Multnomah County Chair Ted Wheeler stated, **"During my administration, Multnomah County will work to eliminate disparities based on race and ethnicity that exist in our community, and we will challenge other community institutions to work with us to make this happen."** In June of 2007, Chair Wheeler and the Multnomah County Health Department funded the Health Equity Initiative, a countywide effort focusing on health inequities. The mission of HEI is to eliminate racial and ethnic health disparities.

The Initiative supports the County's commitment to improving the health of all Multnomah County residents by considering the ways that societal conditions in which we live, learn, work and play affect health.

To date, HEI has used various strategies intended to achieve three goals:

1. Create a common understanding of the root causes of racial and ethnic health disparities and their possible solutions, with a focus on justice and equity.
2. Raise the visibility of current disparity elimination efforts of community-based organizations and county departments.
3. Explore and advance policy solutions to address health inequities.

While the tactics have included media outreach, presentations to groups and conferences, and conversations with community and county partners, the following three primary strategies have been implemented and are discussed in this report:

1. Engaging community members in discussions of the social determinants of health and generating potential solutions to inequities in Multnomah County.
2. Preparing a review of health equity related policies, and supplementing that review through consultations with local and national experts in public health and health equity.
3. Involving community members in reviewing and prioritizing a list of policy options that was developed from their feedback at the report-backs and HEI policy research findings.

HEALTH INEQUITIES

Health disparities are differences between population groups in the presence of disease, health outcomes, or access to care.[1] Disparities include both acceptable and unacceptable differences. **Health inequities** are health disparities that result from a variety of social factors such as income inequality, economic forces, educational quality, environmental conditions, individual health behavior choices, and access to health care. Health inequities are unfair and avoidable.[2]

Multnomah County Health Department has evaluated and reported on the community's health, including racial and ethnic health disparities. The 2008 Report Card on Racial and Ethnic Health Disparities describes 17 health indicators examined for African American, Hispanic, Native American, and Asian Multnomah County residents.[3] Six of the 28 health disparities that existed in the 1991-95 period had been eliminated by 2001-05. An additional 14 disparities had been reduced.

However, several disparities were identified that require intervention. For example, the rate of new cases of gonorrhea infections among African American residents was 6.5 times the rate of White non-Hispanics in the county. The Native American HIV disease mortality rate was more than three times higher than the rate for White non-Hispanics.

Another area of concern is the rate of births to teenage mothers in communities of color. In the 2001-05 period among Hispanics the percent of live births to teen mothers was more than six times higher than for White non-Hispanic teens. For African American residents the teen birth rate was more than 2.5 times the rate for White non-Hispanics. The 2008 data showed that the homicide death rate was more than six times higher among African Americans as compared with White non-Hispanics in Multnomah County.

Statewide data show disparities in chronic diseases and their related risk factors. In Oregon, African Americans are significantly more likely than Whites to die from heart disease, stroke, diabetes and cancer. The diabetes rate for African Americans is 13 percent versus six percent for Whites. African American Oregonians have a 42 percent rate of incidence for high blood pressure versus 25 percent for White Oregonians. And compared with Whites, African Americans are more likely to smoke, be overweight, and be obese in Oregon.

It is known nationally that health disparities exist in access to health care, quality of care, chronic diseases, and numerous causes of death. Reliable data for a comprehensive set of health indicators is not currently reportable by race and ethnicity at the county level.

The data highlight disparate health outcomes that result from societal inequities. Examples of health inequities include health disparities arising from unequal opportunities for a healthy life because of racial and ethnic bias or discrimination stemming from national origin or sexual orientation. It is widely recognized that eliminating health inequities of all types must be a priority in order to achieve optimal health, not only for disadvantaged groups, but also for the community as a whole.

HEALTH EQUITY FRAMEWORK

"Based on my experience, this society and culture makes us sick. In school, they teach our kids to be independent. When they come home, we teach them to depend on each other. They say we don't want to listen to you. We have to work hard to keep food on the table, so we have no time to watch them. We blame it on the society, the structure. That is why we become sick."

The term "social determinants of health"[4] grew out of research to identify the specific reasons why members of different socio-economic groups experience varying degrees of health and illness, even in social structures where access to health care is guaranteed.[5] The social determinants of health include:

• **Income and social status (income inequality and social class)** • **Social support networks (social exclusion and social isolation)** • **Education** • **Employment and working conditions (unemployment)**	• **Physical environments (food, transportation)** • **Social environments** • **Community norms** • **Healthy child development** • **Health services** • **Gender and culture**

Health experts now know that our health is determined by how much access we have to the benefits of society and how many burdens we bear. Equity refers to the fair distribution of social and economic benefits and burdens. Social benefits and burdens are hidden health factors that are often determined by social policies – how, where, and with whom we invest our collective resources – and affect our quality of life.

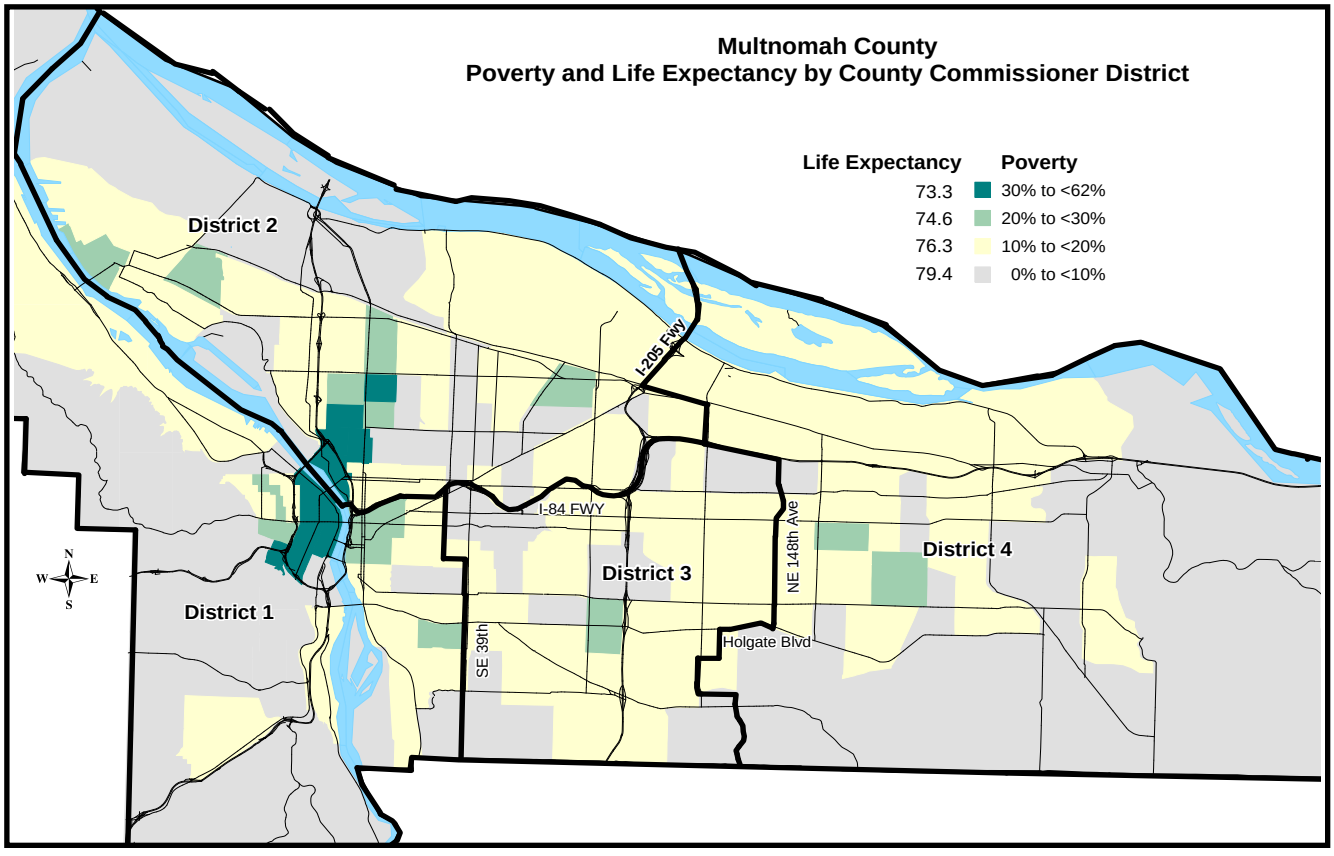
Virtually all major diseases are primarily determined by a network of interacting exposures that increase or decrease the risk for disease. These conditions are a result of social, economic, and political forces.

In 2007, the United States spent more than two trillion dollars on health care.[6] According to former Surgeon General David Satcher, more than 90 percent of our country's health care spending focuses

on treating diseases and their complications - many of which are preventable.[7] The result is a nation sicker across all races and classes than our industrialized counterparts and numerous developing nations.[8]

For example, income is a significant factor in determining health status. In areas with a higher percent of the population living in poverty, life expectancy is up to six years shorter than in areas with the lowest percent of poverty. The influence on health is more than just between the areas of high poverty and areas of low poverty. People who live in areas with a moderate percent of the population living in poverty can expect to live longer than those in poorer areas, but not as long as those in more affluent neighborhoods.

The map below demonstrates a relationship between poverty and life expectancy in Multnomah County. Based on the 2000 U.S. Census, poverty is concentrated downtown, inner Northeast Portland, and along NE Martin Luther King Jr. Boulevard. This map can be replicated using other social determinants of health to illustrate their impact on the health outcomes of the community, where reliable data exists.

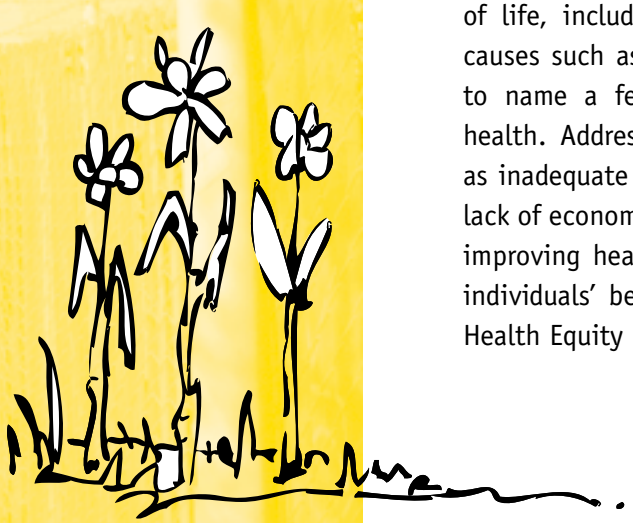


HEALTH EQUITY FRAMEWORK

Social factors leading to health inequities can be changed. HEI is an important step toward eliminating health inequities and assuring a healthy community for all Multnomah County residents because it seeks to improve policies related to the social factors that influence health outcomes.

If we attribute the main source of racial and ethnic health disparities not to poor decision making by individuals or genetics, but to the cumulative result of inhumane past policies and current inequitable social structures and policies, what does this mean for the solutions? Solutions require policy makers to look at policies and investments that create a more equitable society.

Though health care and services are important, solutions to racial, ethnic, and income inequities should be focused further upstream on the policies affecting the social determinants of health. In developing strategies to address health disparities, it is important to recognize that at its heart, promoting equity is not simply providing more services. It is also about how those services are developed, prioritized and delivered. What is needed to fundamentally address health disparities is a broad-based, coordinated effort among many partners acting to address root causes. The root causes of health disparities are broadly based in inequities in many aspects of life, including social and economic policies. Addressing root causes such as racism, classism, homophobia, and powerlessness, to name a few, is moving 'upstream' along the continuum of health. Addressing risk factors caused by such root causes such as inadequate transportation, poor educational opportunities, and lack of economic resources can be considered more 'midstream,' and improving health care access, service delivery, and strengthening individuals' behaviors and knowledge as more 'downstream.' (See Health Equity Framework, p. 10).

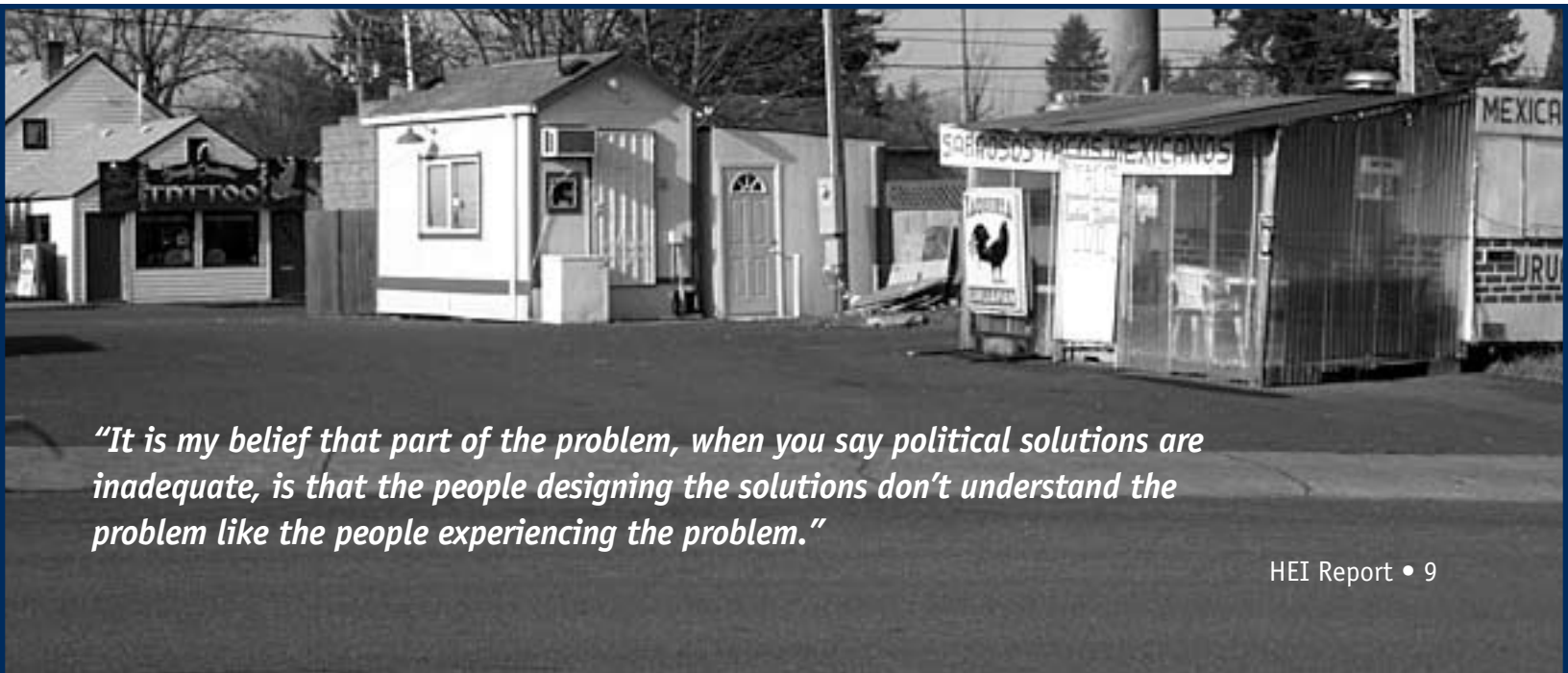


HEALTH EQUITY FRAMEWORK

Solutions should emphasize consideration of the social determinants of health, including a wider range of economic, social, environmental, and political forces that can either promote or compromise the health of populations, especially of the historically disadvantaged, including people of color, women, the disabled, sexual minorities and the poor. A commitment to social and economic equity must lie at the heart of efforts to eliminate disparities.

Policy solutions should target root causes of racial and ethnic disparities and be developed with members of the communities most impacted by inequities.[9] A first step to address racial and economic injustices is for the government and community to recognize and dismantle intentional and de facto policies and practices that maintain privilege among historically advantaged groups, such as Whites, males, and the wealthy. With training and self-reflection, decision makers can avoid reinforcing institutional racism, sexism and class privilege through policies.

In communities across the nation, tools are being created to guide policy development by examining who is burdened and who benefits from policy, and in this way, truly assess and remediate the effects that policies have on the most burdened in our society.[10] These tools, when used with integrity and not as pro forma checklists, can be considered an "equity lens" for examining social and economic policies. As an "equity lens" is applied more consistently across multiple sectors, public policy will be enriched by the consideration of its impact on the most vulnerable. This approach, when applied to social determinants of health, such as education, transportation, housing, community safety and other policy arenas, will lead to long-term improvements in communities historically burdened by poorer health. HEI will use this framework to assess current efforts and advance policies and organizational development strategies.



"It is my belief that part of the problem, when you say political solutions are inadequate, is that the people designing the solutions don't understand the problem like the people experiencing the problem."

HEALTH EQUITY FRAMEWORK

UPSTREAM: Addressing racism, classism, and powerlessness
(Social and institutional privilege)

MIDSTREAM: Addressing risk factors caused by racism, classism, and powerlessness
(Neighborhood and community conditions)

DOWNSTREAM: Improving access and quality of service delivery system

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UPSTREAM: Addressing Racism, Classism, and Powerlessness
(Root Causes of Social Determinants of Health)

Examples of policies and actions to strengthen upstream policy may include:

- Chair ensures culturally responsive workforce
- Chair advocates/personally lobbies for policies such as immigration reform
- Board of County Commissioners supports undoing institutional racism through training
- Board of County Commissioners creates career pipeline for racial and ethnic minorities in public service for Multnomah County
- Board of County Commissioners evaluates current County policies and practices for discrimination and institutional racism
- Board of County Commissioners pursues community-informed policy by supporting/allocating resources for community-based policy and advocacy leadership development
- Board of County Commissioners mandates diverse representation on policy advisory committees
- Board of County Commissioners enacts or advocates for economic development, workforce development and equitable education policies

MIDSTREAM: Addressing Risk Factors Caused by Racism, Classism, and Powerlessness
(Social Determinants of Health)

Examples of policies and actions to improve the social determinants of health:

- Board of County Commissioners enacts or advocates for place-based strategies focused on social determinants of health equity in neighborhoods where people of color and low-income individuals live to:

1. Promote economic security and wealth development
2. Foster affordable low-income housing and home ownership
3. Ensure access to healthy, affordable food
4. Create and maintain safe, accessible opportunities for physical activity
5. Prioritize educational attainment and equitable school environments
6. Limit marketing of products and services that promote unhealthy choices

DOWNSTREAM: Improving Access and Quality in Service Delivery System

Examples of policies and actions to strengthen and improve individual behaviors and care:

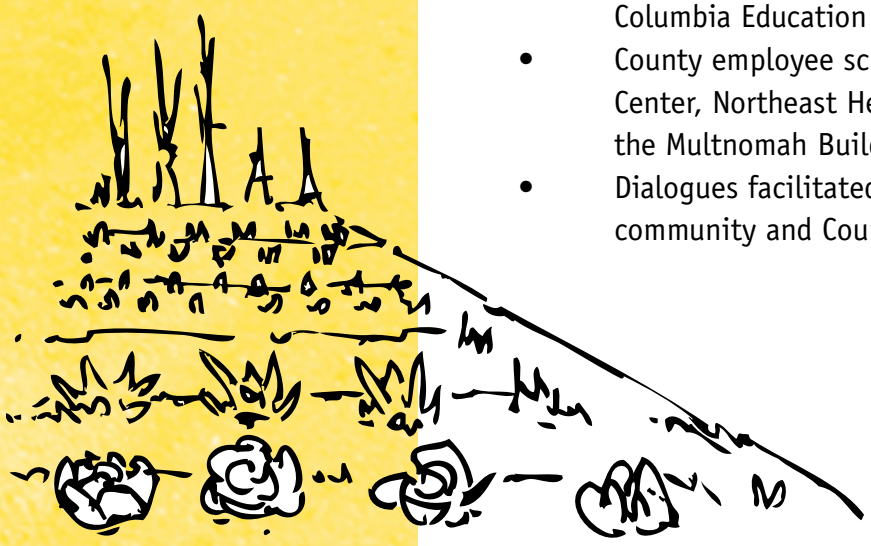
- Board of County Commissioners advocates for increased access to health and human services for all as a human right
- Board of County Commissioners allocates resources targeted at addressing racial and ethnic disparities in Health & Human Services
- Multnomah County provides culturally competent services
- Multnomah County ensures equity in quality of all services

DISCUSSING SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY

In order to raise awareness of the root causes of health inequities, HEI screened a seven-episode documentary series on social determinants of health for Multnomah County residents and county employees at ten sites throughout the county. The series, *Unnatural Causes: Is Inequality Making Us Sick?*,[11] was produced by California Newsreel and aired on national TV. The goals of the screenings were to (1) increase awareness of the underlying or root causes of health inequities; (2) generate discussion about the problems and causes of health inequities in Multnomah County; and (3) identify potential solutions to health inequities in Multnomah County.

The screening events consisted of:

- Fifty-seven screenings throughout Multnomah County between March 2 and May 17, 2008 (29 screenings for community members and 28 screenings for county employees).
- Participation by more than 500 viewers.
- Approximately one third of the participants were people of color.
- Community screenings at Gresham Library, Central Library, Midland Library, Northwest Library, Portland Community College Cascade Campus, and New Columbia Education Center.
- County employee screenings at East County Health Center, Northeast Health Center, McCoy Building, and the Multnomah Building.
- Dialogues facilitated by trained volunteers from the community and County departments.



DISCUSSING SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY

Health priority surveys were completed by 327 viewers. The survey listed 30 factors that affect health and asked respondents to indicate their priorities based on their level of concern (low, medium or high) for each factor. While the survey is not scientific, it does provide insight into the level of concern for selected health-related issues.

The surveys provided demographic details about the participants at this phase of the project. For example, both the community dialogues and county employee dialogues included a diverse cross-section of participants. In general, there were more participants younger than age 35 at community dialogues than at county employee dialogues. County employee respondents were more likely to report being White and to report higher incomes.

"I think that the kinds of things that can be done to relieve stress – home ownership among African Americans, the zoning for not so many fast food places, being able to walk outside – those are doable. Do those kinds of things that can be solved from a leadership perspective."

After each screening, viewers were asked to discuss the following questions:

(1) What did you see?, or What caught your attention?

(2) What were the problems/causes?

(3) How do these problems affect our community?

(4) How can we work together to solve these problems?

For a full description of the methodology, findings, and limitations of the community engagement process, see **Appendix A**.

DIALOGUE THEMES

"We saw that there was health inequality, and I found two main things cause it. First are social factors that can be controlled. The second is the power to control them... We make choices, but within limits we are given. Society determines what you eat, where you live, and what kind of education we can pursue. The problem is that policy needs to change. The people who make policy need to make changes."

It was clear from the initial viewings that community members see health inequities as a complex problem and hold an expectation that government can improve health inequities through policy. Community members believed that policy could be used to change the social and environmental contexts that limit their life choices.

"We saw that there was health inequality, and I found two main things cause it. First are social factors that can be controlled. The second is the power to control them... We make choices, but within limits we are given. Society determines what you eat, where you live, and what kind of education we can pursue. The problem is that policy needs to change. The people who make policy need to make changes."

– Participant at Gresham Library, 3/2/08

Similarly, county employees see the complexity of the conditions leading to health inequities and also feel that, as government employees, it is their responsibility to be part of the solution.

SOCIAL DETERMINANTS OF HEALTH

Participants associated social factors with health inequities, including access to healthy foods; lack of affordable, healthy housing; alternative transportation; hopelessness and lack of power; challenges for immigrants, including language barriers and balancing the pressure to assimilate with maintaining their own cultural identity; and government responsibility.

"Based on my experience, this society and culture makes us sick. In school, they teach our kids to be independent. When they come home, we teach them to depend on each other. They

say we don't want to listen to you. We have to work hard to keep food on the table, so we have no time to watch them. We blame it on the society, the structure. That is why we become sick."

– Participant at Midland Library, 3/24/08

In addition to these challenges, some community viewers saw feelings of hopelessness and powerlessness in their communities.

"I see a general sense of despair in my community. People don't know what or how they can make an impact."

– Participant at Northwest Library, 4/2/08

HEALTH CARE

Although most experts estimate that only 10-15 percent of health inequities are due to lack of access to health care,12 most viewers of the documentaries expressed a belief that everyone was entitled to health care and favored universal health care. Many also expressed a need for culturally competent health care, including mental health care.

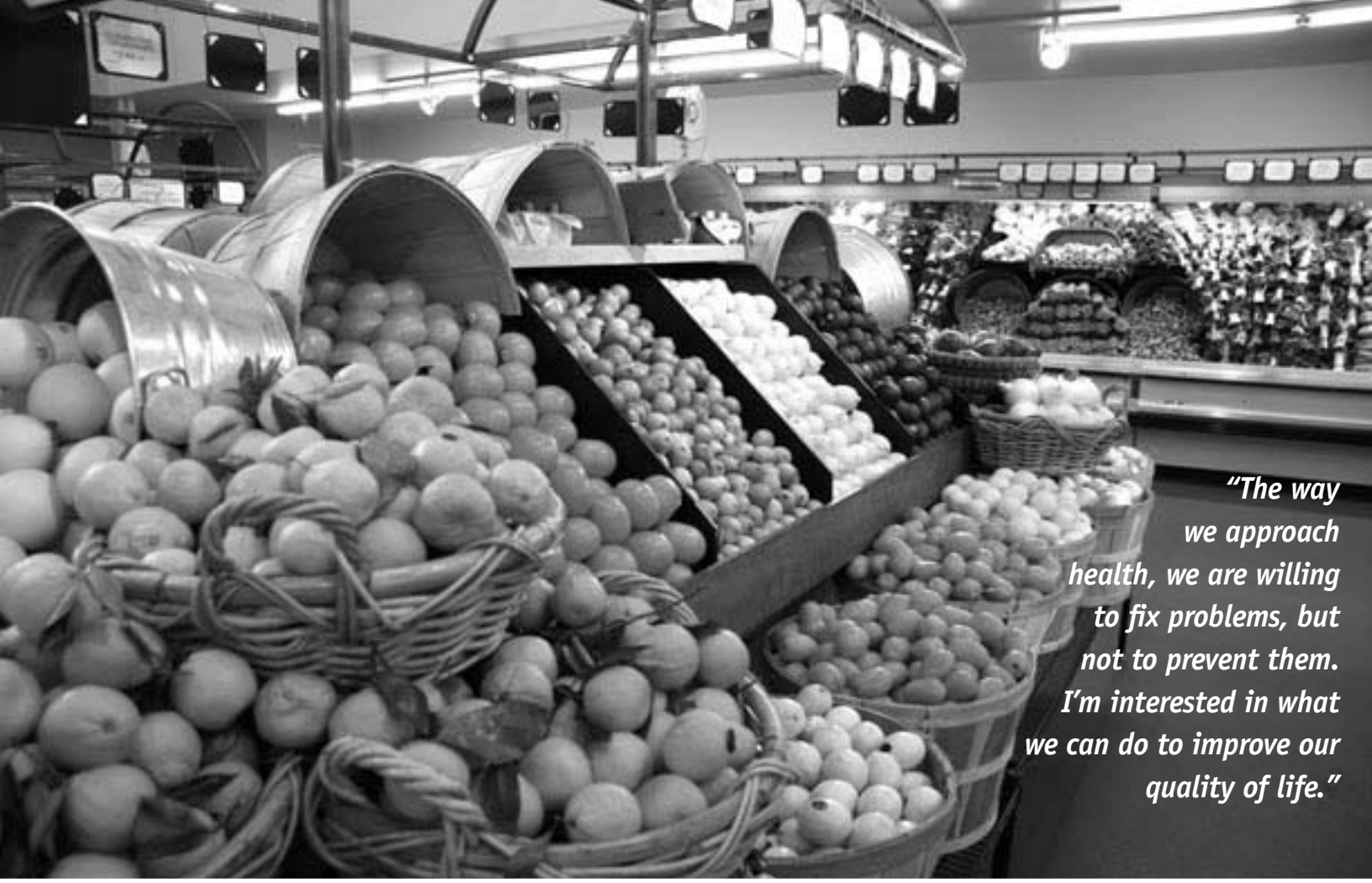
Dissatisfaction with health care spending stemmed from a belief that the State spends too much money on emergency room visits and too little on health promotion and prevention.

"The way we approach health, we are willing to fix problems, but not to prevent them. I'm interested in what we can do to improve our quality of life."

– Participant at Gresham Library, 3/30/08

PUBLIC POLICY

Participants in the community dialogues believe that government at the local, state, and national levels should take leading roles in addressing health inequities. They asked for better coordination of services and more voice in government decisions.



"The way we approach health, we are willing to fix problems, but not to prevent them. I'm interested in what we can do to improve our quality of life."

DIALOGUE THEMES

DISCUSSIONS OF THE SOCIAL DETERMINANTS OF HEALTH

"It is my belief that part of the problem, when you say political solutions are inadequate, is that the people designing the solutions don't understand the problem like the people experiencing the problem."

– Participant at Central Library, 3/31/08

Frequently mentioned causes of health inequities that emerged from the dialogues included racism and discrimination, gentrification, capitalism and consumerism, social isolation, and income and wealth distribution. Some community viewers believe that the problems of racism, poverty, and access to health care can only be resolved when there is sufficient national will for the government to step up to the challenge. There is a will within our local community to address social ills.

"It speaks to whether we have the national will to solve issues of racism, access to health care and poverty. These are things that we can individually take action on, but we are doing it all in the context of a nation that lacks the will to take action. This is a national problem, and it isn't a matter of growing a garden or getting along with your neighbor. Until we build a community where we all work together, we will not make progress, even if there is education."

– Participant at Gresham Library, 3/30/08

Community and county employee viewers noted challenges with government services. Both groups noted a problem with coordination of information about county services. In addition, several county employees saw the money spent on U.S. dominance and war as contributing to health inequities by diverting money away from health care and the development of healthy communities.

"I think that the kinds of things that can be done to relieve stress – home ownership among African Americans, the zoning for not so many fast food places, being able to walk outside – those are doable. Do those kinds of things that can be solved from a leadership perspective."

– Participant at Midland Library, 3/10/08

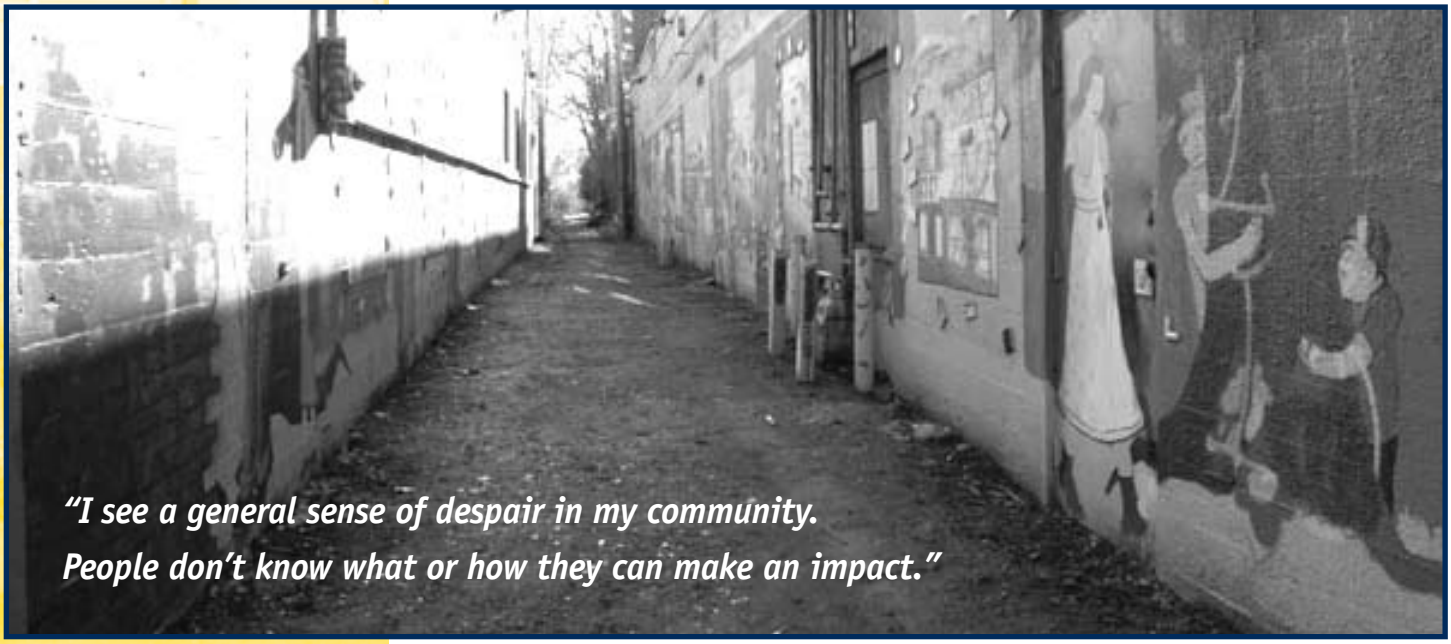
POLICY RESEARCH

Community members and Multnomah County staff who viewed the *Unnatural Causes* series had the opportunity to propose policy solutions to health inequities. Proposals tended to fall into three areas:

1) Policy level recommendations
2) Ideas for practice improvements
3) Proposals for individual actions

Considerable overlap existed between policy and practice recommendations and practice and individual recommendations, but they were categorized on the basis of subjective judgment for ease of presentation. Specific policy options are reported in the fourth section of this report; full lists of policy options are provided in **Appendix B** where they are also organized by community priority and government jurisdiction.

Concurrent with the community input process, the Health Equity Initiative researched policies that can reduce health and social inequities in Multnomah County by conducting interviews and reviewing relevant literature.



In addition to conversations with staff from the Health Department and other Multnomah County departments, ideas were collected from:

- Reports containing local statistics on health and social inequities
- Literature on national efforts to reduce health and social inequities
- Local County program and evaluation reports
- Local community partners, advocates and government entities
- National policy experts

Interviews were conducted with:

- Multnomah County Health Department staff
- Multnomah County staff from various departments
- Local community partners and advocates
- National experts in health equity policy from the Centers for Disease Control and Prevention (CDC) and the National Association of County and City Health Officials (NACCHO)
- Local public health department experts in Ingham (Lansing, MI area), Alameda (Oakland, CA area) and King (Seattle, WA area) counties, and Louisville Metro Public Health and Wellness (KY) and Boston Public Health Commission (MA)
- Harvard School of Public Health
- PolicyLink, a national research and action institute advancing economic and social equity

In reviewing literature, researchers collected more than 100 reports or scientific publications identifying hundreds of possible interventions that promote health equity.

Research identified policies that could be implemented quickly (2-3 years) as well as those that will take longer to put into effect. Some of the policies can be implemented solely by Multnomah County. Some of the policies will need the County to partner with local governments and community advocates. Other policies will require advocacy and partnership with the State.

See a full list of policy examples in **Appendix B**. These policy options are part of a comprehensive list of policy options that includes contributions from the community.

RE-ENGAGING COMMUNITY

AND COMMUNITY-INFORMED PRIORITIES

HEI returned to the sites where *Unnatural Causes* initially was screened to find out what the community valued in this emerging list of priorities. Attendees prioritized a list of policy recommendations compiled from community recommendations at the initial screenings and policy research findings. The combined list of proposals consists of 140 recommendations, organized into seven theme areas consistent with the social determinants of health. The re-engagement events were called "report-backs."

One hundred twenty-six people attended a report-back, 59 percent were community members and 41 percent were county employees. Fifty-two percent had attended a screening of *Unnatural Causes,* though more had seen the documentary on their own. Almost two thirds of participants (62 percent) completed an evaluation, which provided the demographic data summarized below:

- More participants lived in Commissioner District 2 than in any other.
- The average age range of community participants was between 45-54 years.
- Of community participants, there were more African `Americans (42 percent) than any other racial or ethnic group. Whites accounted for 34 percent of community participants.
- Most community participants earned less than $25,000. The second largest income group of community participants was more than $80,000.

HEI asked participants to engage in brief discussions about the policies in each theme area to identify:

- What solutions were missing?
- Which policies would make the most difference to vulnerable communities?
- Which solutions people would be most interested in working on, advocating for, or supporting?
- Which recommendations are unclear?
- Which solutions are possible, practical, and realistic?

POLICY PRIORITIES & RECOMMENDATIONS

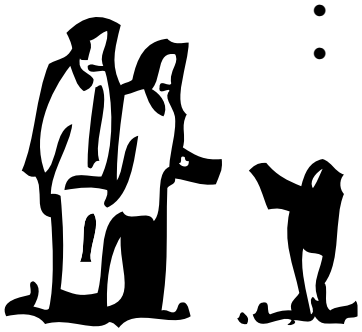
Report-back participants identified their priorities for action to help inform the policy priorities of HEI and the County. Those action priorities are listed below in the same categories as they appeared at the report-backs.

I. INCOME AND SOCIAL STATUS

- Revise government policies that cause working poor to lose all of their welfare or disability benefits if they take a job to supplement their benefits; increase poverty thresholds to increase eligibility for services.
- Require corporations, such as those who benefited from the development of Northwest Portland's Pearl District, to give back to the community in some way.
- Promote current efforts to establish a County staff that mirrors the communities it serves by hiring, retaining and promoting a diverse workforce, such as health care providers, librarians, and service contractors. Improve County's current efforts to train, mentor, and promote persons of color to management careers.
- Partner with corporations to remove financial barriers to higher education in public service fields employed by Multnomah County, i.e., library science, public health, social work, criminal justice.
- Tax pornography to leverage dollars for women's health.

II. ACCESS TO MEDICAL CARE

- Universal health care including mental health care and prevention. Support efforts to ensure access to healthcare for all Oregonians, such as the work of the Oregon Health Fund Board with particular attention paid to the recommendations of the Health Equities Committee.
- Require affordable or free access to mental health services. Enhance the mental health system.
- Require health insurance to cover alternative health care.
- Expand (childhood) early intervention programs. Increase screening of children for developmental delays and disabilities; provide early intervention for children to avoid more serious and expensive long-term health problems.



- Require health insurance to cover costs of health promotion and prevention activities.
- Support the collaboration of provider systems (e.g., Kaiser, Legacy, Multnomah County) to establish an urgent care system to divert patients from more expensive emergency department care.
- Engage health systems and educational institutions to create minority scholarships for health career education for graduates of public schools.
- Require businesses with more than 20 employees to pay towards health care coverage.

III. QUALITY PUBLIC EDUCATION

- Assure equitable access to courses in civics, nutrition, physical education, health education and personal finances. Schools and job training programs should teach basic life skills, such as buying a house, financial literacy, civic engagement and advocacy that would foster a sense of community.
- Improve nutrition and physical activities in day cares and schools. For example, help implement relevant recommendations in A Healthy Active Oregon: A Statewide Physical Activity and Nutrition Plan 2007-2012, such as expanding the Farm to School program and requiring daily physical education.
- Continuation and expansion of education programs to provide youth with resources, skills, and connections to succeed, such as SUN Community Schools and Connected by 25.

IV. QUALITY AFFORDABLE HOUSING

- Support programs that encourage minority ownership. Encourage home ownership through Community Land Trusts and low down payment, low interest loans for minority homeownership programs.

- Promote a "heat security" policy that would guarantee heat for low-income people by convening a forum of local energy producers, distributors and policy makers.
- Increase the number of homeless shelters for women and children.
- Add exercise rooms to new public housing.
- Assure the availability of healthy publicly funded housing including setting standards for indoor air quality and promoting "breathe easy homes" constructed with special features to improve indoor air quality and reduce air pollutants. Direct emergency department savings to develop more "breathe easy" public housing.

V. DISCRIMINATION

- Convene community dialogues to understand and confront racism.
- Provide and expand low-interest loans to minority-owned businesses.
- Promote the adoption by other local governments of an equity review process to consider equity in policy decisions related to community development, education, employment, transportation, etc.
- Provide Undoing Institutional Racism course for Multnomah County managers.

VI. HEALTHY CHILD DEVELOPMENT

- Advocate for full and adequate funding for early childhood programs such as Head Start. The CDC recommends comprehensive, center-based, early childhood development programs for low-income children based on strong evidence that such programs improve cognitive development.
- Examine the current distribution of County services, such as preventive services for children, checkups, etc., and consider expanding those services by geographic area of need.

VII. ACCESS TO AFFORDABLE, HEALTHY FOOD

- Ban the marketing/sale of junk foods in school.
- Expand Multnomah County's connection with community food programs such as community gardens, gleaners and harvest share programs, and learning gardens through such community partners as Oregon Food Bank and Growing Gardens. Create an organized effort to help neighborhoods plant gardens.

"It speaks to whether we have the national will to solve issues of racism, access to health care and poverty. These are things that we can individually take action on, but we are doing it all in the context of a nation that lacks the will to take action. This is a national problem, and it isn't a matter of growing a garden or getting along with your neighbor. Until we build a community where we all work together, we will not make progress, even if there is education."

Promote school gardens and garden-based learning for children. Create a county-sponsored "Friends of Gardens" program to establish gardens within neighborhoods.

- Increase taxes on unhealthy products. Tax tobacco, alcohol, non-nutritional beverages, and junk food to fund policies and programs to decrease health inequities and subsidize healthy foods in local markets.
- Promote connections among small, local farms and low-income neighborhoods by (1) convening a policy forum with local farmers, residents and policy makers to identify policy and remove barriers to connecting local farmers with low-income people and reduce the cost of doing business for small, local farms, and (2) establishing land use agreements for food co-ops and farmers markets in low-income neighborhoods. Expand farmers' markets to eastern areas of Portland and Multnomah County. Expand the use of food stamps and WIC vouchers at farmers' markets.

VIII. EMPLOYMENT AND WORKING CONDITIONS

- Require employers to provide "livable" wages.
- Mandate paid sick days and paid vacations, and incentives for healthy behaviors. Provide incentives, such as TriMet passes monetary incentives or a reduction in work hours to people who practice healthy behaviors like walking or biking to work.
- Promote current efforts to develop an equitable process for promoting and contracting with minority, women, and emerging small businesses, which may include a streamlined certification process.
- Protect workers from the consequences of company relocation. Require companies that relocate out of

the area to finance retraining programs for workers in industries that are growing (e.g., health care, engineering, technology, media, etc.) or severance pay for layoffs.

IX. PUBLIC TRANSPORTATION

- Promote alternative modes of transportation such as walking, biking, and public transportation. Develop more walking and biking trails. Establish bike boulevards separated from traffic. Establish more off-street or low-use street bike paths and sidewalks throughout county neighborhoods. Establish, in partnership with City of Portland, a community bike-lending program, with plentiful low-cost rentals.
- Partner with community enhancement CBOs like City Repair to change the underlying physical structure of neighborhoods to enhance community connections.
- Build small communities with access to shopping and services within walking distance. Expand car-free neighborhoods on a regular basis to enhance the opportunity for neighbors to connect with each other. Promote telecommuting, fewer workdays, or longer workdays.

Additionally, three themes emerged: (1) there is no single "magic bullet" policy or short list of policies that will eliminate the inequities that result in health disparities, solutions need to come from the coordinated effort of policy makers, bureaucrats and community members, (2) local efforts at eliminating inequities should be driven by local data on existing health disparities, and (3) local governments should look at their own policies that perpetuate inequities.

HEALTH EQUITY INITIATIVE

RECOMMENDATIONS

HEI's policy priorities integrate community input and priorities, best practice research in health equity policy, and an analysis of current momentum in health equity areas. Priorities focus on addressing mid and upstream causes of racial and ethnic health disparities. The team is currently developing a transparent health equity policy development process and an evidence-based list of key policy improvements to tackle. The following list highlights a few of HEI's current areas of focus:

Improving living and working conditions, and strengthening community:

- Improve access to health care and social services (building capacity for health policy advocacy in partnership with communities of color, health providers, and interested community organizations)
- Connect transportation, land use and environmental practice to health equity in practice (collaborating with the Coalition for a Livable Future on building a health equity policy agenda across public and private sectors)

Strengthening healthy and sound macro-policies:

- Improve racial and cultural competence of County management (Undoing Institutionalized Racism program and Equity and Justice trainings)
- Integrate equity review into County practice (developing and implementing an equity review tool)

We recognize that while extensive local work is currently occurring -- both inside and outside County government -- to address health and social inequities, collaborative efforts are needed and no single additional policy or program will effectively eliminate these inequities. Indeed, there is currently no set of identified "Best Practices" nationally to eliminate health and social inequities.

Through this Initiative's work, it has become evident that all levels of government need to pay close attention to the impact that their

policy decisions -- whether it is the location of a new housing development or a tax -- might have on reducing or exacerbating health and social inequities. To promote equity in our community, we recommend that Multnomah County leadership weave an equity perspective into the fabric of policy and funding decisions by adopting two initial policies:

1. Adopt an equity policy package to ensure that promoting equity is part of Multnomah County government's decision making. Specific actions include:

Equity Inventory

Mandate a countywide equity inventory to identify actions across county departments to address equity issues, understanding that not all equity actions will be directly related to health.

Equity, Social Justice, and Undoing Institutional Racism Training

Require Multnomah County managers to participate in training for undoing institutional racism. This training will build on existing diversity and interpersonal communication trainings currently being offered, and will add skills and tools for identifying and dismantling policies that maintain inequity.

Equity Impact Review Tool

Mandate development and utilization of a tool and process for Multnomah County managers and policy makers to ensure promoting equity is part of policy development and practice improvement. Develop policy to require use of the tool in specific situations, and encourage its use in general. Seattle and King County Washington have developed tools that could serve as models for Multnomah County. These tools provide simple, step-by-step processes for departments to use as an equity lens in reviewing policies, programs, or projects, revealing who benefits and who carries the burden, and how inadvertent inequities can be ameliorated.

2. Adopt a policy that requires each county department to identify two strategic activities to promote equity between FY 2010 and 2014, and annually evaluate progress. These new Multnomah County department activities -- whether policy or practice changes -- could build on or expand current work within the departments and should ideally involve collaboration with community partners.

HEALTH EQUITY INITIATIVE

NEXT STEPS

HEI will continue to refine and advance both specific and organizational policy options. Strategies for the next phase of HEI include:

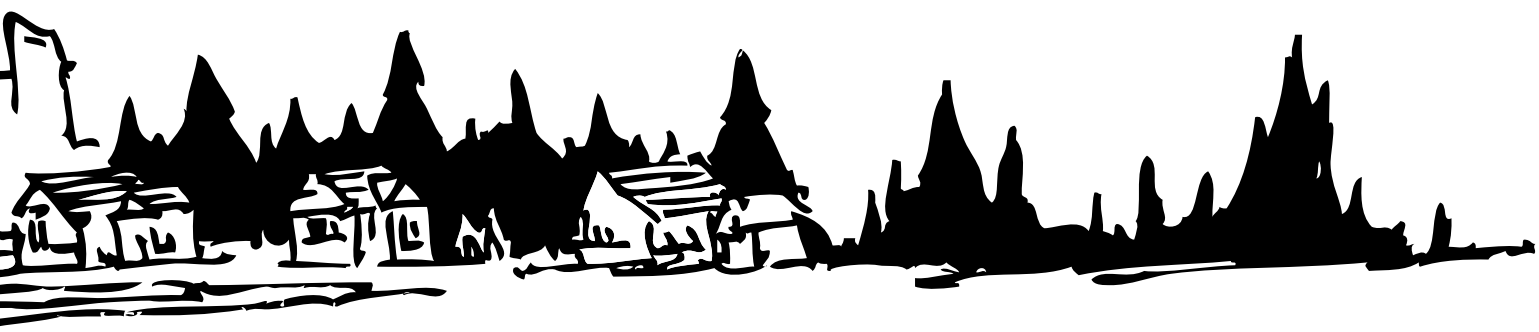
- Promoting current government and community efforts to advance equity policies.
- Coordinating HEI proposed policies with respect to the policy agendas of other community and governmental entities.
- Working in cooperation with community-based advocacy and empowerment organizations to support existing policy advocacy work.
- Identifying partners (community organizations and other local jurisdictions) who can implement policies outside the purview of Multnomah County government.
- Investing in policy advocacy training for community members and county employees who wish to become more engaged in advancing health equity in our community.
- Implementing and evaluating additional policies prioritized by community members, Multnomah County Board of Commissioners.

CONCLUSION

Since its public launch in March 2008, the Multnomah County Health Equity Initiative has been able to engage diverse citizens in conversations about equity and social justice. This is the first time Multnomah County has taken the lead and brought together a broad cross-section of our community to talk about the connections between health and equity. County residents want and expect their government to involve the citizenry in addressing societal matters that affect their lives. By doing so, Multnomah County can create effective policy that promotes health and wellbeing throughout our community.

To move forward, Multnomah County must continue its commitment to building the capacity of ordinary people to advocate for a community that is fair and just. In partnership with the community we serve, the County must pursue policies that prevent and redress societal ills. Also, Multnomah County needs to promote and use equity as a tool to assure that new programs and policies do not create short-term benefits at the expense of long-term inequities that reverberate through the community.

In addition to bringing community members together for robust conversations, an encouraging outcome of the discussions is the recognition that inequities are avoidable. With sufficient political courage and will, Multnomah County and other jurisdictions can create and implement policies that promise a greater measure of equity for all residents. The health impacts can be measured over time. This effort, along with other local, regional, and national efforts, can contribute to a society that is a fuller reflection of our ideals of equity and justice.



"The way we approach health, we are willing to fix problems, but not prevent them. I'm interested in what we can do to improve our quality of life."

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