

6 Understanding How Health Happens

Your Zip Code is More Important Than Your Genetic Code

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I. Introduction

The Evergreen Jogging Track in Boyle Heights is a heavily frequented place for walkers, joggers, and moms pushing baby strollers. Working class Boyle Heights is not a place of many fancy health clubs or golf courses; it is a densely populated urban neighborhood sandwiched between multiple notorious LA freeways. The Evergreen Jogging Track is a place where all walks of East LA life come together to take advantage of vehicle-free exercise and the verdant ambiance. It is, in essence, an outdoor public health club. Over the years so many people used the path for their daily exercise over the years that neighborhood activists forced the city to install decorative streetlamps and a high-tech rubberized track surface so that residents could safely exercise without tripping over broken concrete and tree roots.

Throughout the United States there are “immigrant gateways”—communities that present new immigrants with their first taste of what America has to offer. Boyle Heights is one of those gateway communities. In the middle part of the last century in Los Angeles, Boyle Heights welcomed Jews, Latinos, Russians, African-Americans, Chinese, Portuguese, Armenians, Serbs, Croatians, and Japanese among others. When these groups acquired some money they often moved out of Boyle Heights to other parts of LA, making way for a new wave of immigrants. Boyle Heights today remains a working class, mostly Latino neighborhood east of downtown Los Angeles adjacent to the Los Angeles River.

An aerial view of Boyle Heights reveals multiple freeways, the 101, the I-5, the I-10, and a tight grid of city streets lined with the homes of the neighborhood’s 90,000-plus residents. The sea of rooftops and concrete is only sporadically punctuated by green. Despite its dense population, Boyle Heights is park poor. According to the Los Angeles Department of City Planning, Boyle Heights has approximately 0.9 acres of park space per 1,000 residents, while the average in the City of Los Angeles is 8.9 acres per 1,000 residents—*almost 10 times as much!* There is a clear connection between easy access to parks and a person’s health. People

living near parks have greater opportunities to be physically active and lead active lifestyles that reduce stress and obesity, and even lower the risks of heart disease and diabetes. High-quality parks spur economic development by attracting homebuyers and boosting property values by as much as 15%. Exposure to the outdoors improves analytical thinking, making students better problem-solvers in math and science. Well-maintained parks promote community engagement and civic pride—many a community leader is born through efforts to improve local parks. There is less crime in residential areas close to parks. The list could go on, but the point is clear: parks result in stronger and safer communities.

Visible on the aerial map of Boyle Heights is Evergreen Cemetery, a big splotch of brownish-green. It is the biggest “greenspace” in Boyle Heights. Evergreen’s tombstones mark the lives of Chinese laborers, black politicians, white land barons, Latino community leaders, and various successive waves of diverse immigrants. Yes, the Evergreen Jogging Track is built around a cemetery. It is hard not to see the cruel irony—residents striving to beat the odds and live long and healthy lives, running circles around tombstones coldly marking the shortened life expectancies of Boyle Heights residents.

Boyle Heights is also home to Hollenbeck Park, a beautiful century-old park. In 1960 it was violently transected by the I-5 freeway, with concrete freeway pylons plunked right down in the park’s beautiful duck lagoon.



Figure 6.1 Aerial Map of Boyle Heights

Despite the noise and pollution, children and families determined to run free defy the signs that read “No soccer”. They have no other choice. In Boyle Heights, there is literally nowhere else to play, except perhaps among the dead.

In 2010 the California Endowment initiated Building Healthy Communities (BHC), a ten-year, \$1 billion health improvement initiative in Boyle Heights and thirteen other similarly situated neighborhoods throughout California where young children and families are struggling to find basic health opportunities like parks, grocery stores, and bike lanes. BHC is designed to remedy some of the glaring ironies found in Boyle Heights and throughout the state that create health disparities and ultimately rob low-income Californians of years of life.

II. From Health Disparities To Health Inequity

Just five miles to the west of Boyle Heights, down Cesar Chavez Avenue as it becomes Sunset Boulevard, is the community of Beverly Hills. If you live in Beverly Hills, you make more than twelve times the per capita income of residents who live in Boyle Heights. You also live six years longer (Health Atlas 2013). Recent studies show that the longevity gap between those with low and high income has been increasing dramatically in the US (Brookings 2016). Childhood obesity rates are also 2.5 times higher in Boyle Heights than in Beverly Hills. Boyle Heights is certainly not alone; many low income neighborhoods across the United States are plagued by profound health disparities. Beginning in 2008, a series of authoritative reports appeared in the scientific literature that summarized the astounding lack of progress in reducing health disparities in the U.S. According to the CDC, during the past decade, documented disparities have persisted for approximately 80% of the *Healthy People 2010* objectives and have increased for an additional 13% of the objectives (Myers, Yoon, and Kaufmann 2013). In its November 2015 report, *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*, HHS notes that “[M]any leading health indicators, such as those from the Healthy People 2010 Final Review and the Agency for Healthcare Research and Quality (AHRQ) National Healthcare Disparities Report, have shown little reduction in racial and ethnic health disparities over the past decade” (U.S. Department of Health and Human Services 2015).

For many years the NIH promulgated a particularly unhelpful definition of health disparities that offered no insight regarding the social roots of health disparities: “Differences in the incidence, prevalence, mortality and burden of diseases and other adverse health conditions *that exist* among specific population groups in the United States” [emphasis added]. However, after the series of embarrassing reports documenting the lack of substantial progress in reducing U.S. health disparities, national public health leaders finally began to discard the somewhat simplistic notion of

health disparities in favor of the concept of health inequity. Health inequities are disparities in health that are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity. In their national reports on health disparities, HHS is now comfortable stating that: “Individuals, families and communities that have systematically experienced social and economic disadvantage face greater obstacles to optimal health. Characteristics such as race or ethnicity, religion, SES, gender, age, mental health, disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to exclusion or discrimination are known to influence health status” (U.S. Department of Health and Human Services 2015). The concept of health inequity acknowledges that life circumstances are not equal in the U.S. and that those unequal circumstances include neighborhood environments that are harsh, dangerous, and unhealthy, particularly if you are poor, black, Native American, or an immigrant.

A. Why Place?

A recent study of life expectancy in California demonstrated a twenty-five-year life expectancy gap between California neighborhoods (Woolf et al. in press). In the community with the lowest life expectancy in California residents can expect to live to about the age of 65, equivalent to the overall United States life expectancy in 1940. People in that California neighborhood are experiencing living conditions—in terms of both material and opportunity deprivation—that are about seventy-five years behind those of the average American, or about the equivalent of the country of Yemen. Residents of the California community at the top of the list can expect to live to almost 90 years old, longer than any country in the world. Two and a half decades of life separate the top of the list from the bottom in California. Why? Because our country was built on profound and pathological racial and class exploitation.

B. The Enduring Legacy of American Apartheid

Eight thousand. That is the number of children in Flint, Michigan that pediatrician Dr. Hanna-Attisha believes have been lead poisoned after the Michigan Governor’s appointed Emergency Manager switched drinking water sources for the City of Flint (Goodnough 2016). Lead is an irreversible neurotoxin to children, impairing their IQ and behavior.

Historically, redlining practices consigned African Americans to Flint’s north end where today many homes sit abandoned, essentially worthless, in the shadow of enormous and defunct auto plants. Over the past several decades Flint’s population plummeted by half after auto plants shut down, rapid disinvestment set in, and massive white flight reshaped the city’s demographics. African Americans now make up 57% of Flint’s

population, and 40% of Flint's residents live below the poverty line. Marginalized, devalued, and ignored, the basic human needs of Flint's mostly black and poor residents were barely even an afterthought when Flint's Emergency Manager decided to switch the city's drinking water to the notoriously murky Flint River.

As in Michigan and elsewhere in the United States, our neighborhoods in California did not evolve naturally. The practice of geographically separating people into different neighborhoods according to race, income, religion, and ethnicity is a longstanding practice in the United States. For the majority of the twentieth century these segregation practices were sanctioned by local, state, and federal governments (McKibben 2011; Self 2003). This practice is so embedded in our culture that we have numerous colloquial terms for undesirable neighborhoods: ghetto, barrio, slum, reservation, trailer park, and of course, "wrong side of the tracks". When speaking about desirable neighborhoods we speak of upscale, well-to-do, affluent, exclusive, or posh. We do not hesitate to use these terms in everyday conversation, almost as if this is just a natural phenomenon, but the reality is that we have been actively shaping and reshaping neighborhoods through policy (redlining, racially-restrictive covenants, steering, zoning, subprime lending) for over one hundred years in California (Self 2003).

Of course, associated with neighborhood type is the quality of schools, parks, stores, transportation systems, housing, infrastructure, and even street quality and design. These neighborhood amenities and resources have been conclusively linked to health status. So why is it that we are surprised by expectancy differences of two and a half decades between neighborhoods? We have literally designed this health outcome into our land use decision making. This wide spectrum of life expectancy is patterned into the wide spectrum of neighborhood environments that we have designed and reinforced through land use policy—so much so that we can say "*when it comes to your health, your zip code is more important than your genetic code*". Or better still, "*Give me your address, and I'll tell you how long you'll live*".

Growing up on the "wrong side of the tracks" is a familiar part of the American narrative. Many great leaders, artists, athletes, and entertainers describe an origin story that is set in a ghetto fraught with hazards and risk. Their rags-to-riches stories never fail to captivate and intrigue us and make up the very essence of the American Dream. But the truth is, these stories wouldn't stand out if more of their peers and friends could actually "make it out". Economic and social mobility has declined in this country (Chetty 2014), so millions of low-income Californians are consigned to the same stark neighborhood conditions for much of their lives. While many do move, more often than not they move to communities with the same basic socio-economic status and thus similar neighborhood conditions. Low income people and people of color disproportionately

reside in communities that are systematically deprived of critical health protective resources such as parks, grocery stores, good schools, quality housing, and maybe most importantly, hope.

C. Rich People and Poor People Are Physiologically Different

Like all Californians, low-income people are in search of opportunity. They seek safe places to raise their children with good schools, clean parks, healthy food, good transportation, and decent and affordable housing. However, because many low income neighborhoods lack these basic resources, low-income Californians are often shrouded in a fog of chronic stress that results from having to navigate multiple daily hazards including crime, traffic, poor quality housing, and low quality schools. Many of us have to balance some risks against our resources. If you think of risks as juggling balls, we juggle a couple of balls every day. However, if you are on a low income, you are constantly forced to juggle multiple balls and inevitably balls get dropped. When higher income people drop balls they have resources (e.g. savings, employers, banks, home equity, healthcare) that will help them respond to the consequences of dropping a ball. When low income people drop one of their many balls, the consequences are more severe (e.g. foreclosure, eviction, homelessness, untreated illness). The constant worry that results from having to juggle so many balls produces chronic stress that actually changes our physiology. Chronic stress kills. It kills by altering our physiology to exacerbate cardiovascular injury, accelerate chronic disease, and facilitate premature aging (MacArthur Research Network). Chronic stress also changes how our brains function and limits executive function—the ability to plan, focus attention, remember instructions, and juggle multiple tasks successfully (Harvard Center). As a consequence, poor people are physically different from rich people. Residents of low-income communities are forced to contend with high levels of chronic stress due to a lack of control of the multiple stressors that confront them on a daily basis. Poverty robs people of control over their lives. That lack of control, or agency, steadily erodes health and fosters a pervasive sense of hopelessness in many low-income communities. Much of this is unnecessary and the product of inequitable American policy, or often times it is the inevitable product of the absence of appropriate policy in the face of abject need.

III. The Bay Area Regional Health Inequities Initiative

In 2002 a group of public health officials in the San Francisco Bay Area came together out of frustration that the tools of the traditional “medical model” approach to public health practice were not sufficient for the challenges facing modern public health. Chief among those challenges

was health inequity. Recognizing that health outcomes are strongly influenced by the social and environmental conditions that many low-income people in the Bay Area are forced to contend with on a daily basis, these pioneering health officials created the Bay Area Regional Health Inequities Initiative (BARHII) whose mission is to transform public health practice with the purpose of eliminating health inequities, using a broad spectrum of approaches that create healthy communities (www.barhii.org). The BARHII framework is an effort to visualize and organize public health interventions and strategies across a spectrum from downstream to upstream. In essence, the BARHII framework is an integration of the medical model and the socio-ecological model with a specific eye towards situating types of interventions along the upstream-downstream continuum.

The basic idea underlying the BARHII framework is that upstream inequity creates downstream disparity. The medical model focuses on preventing premature death by treating and managing disease and injury that is the product of risk factors and risk behaviors like smoking, poor diet, and lack of exercise. The medical model is grounded in the assumption that autonomous individuals are making independent behavioral choices from a broad array of options, some healthy and others not. The tools of the medical model are healthcare services, health education, and to a limited extent, genetic analysis and modification. The medical model costs \$3 trillion per year (\$9523 per capita) or 17.5% of the gross domestic product. Meanwhile upstream, the socio-ecological model recognizes that

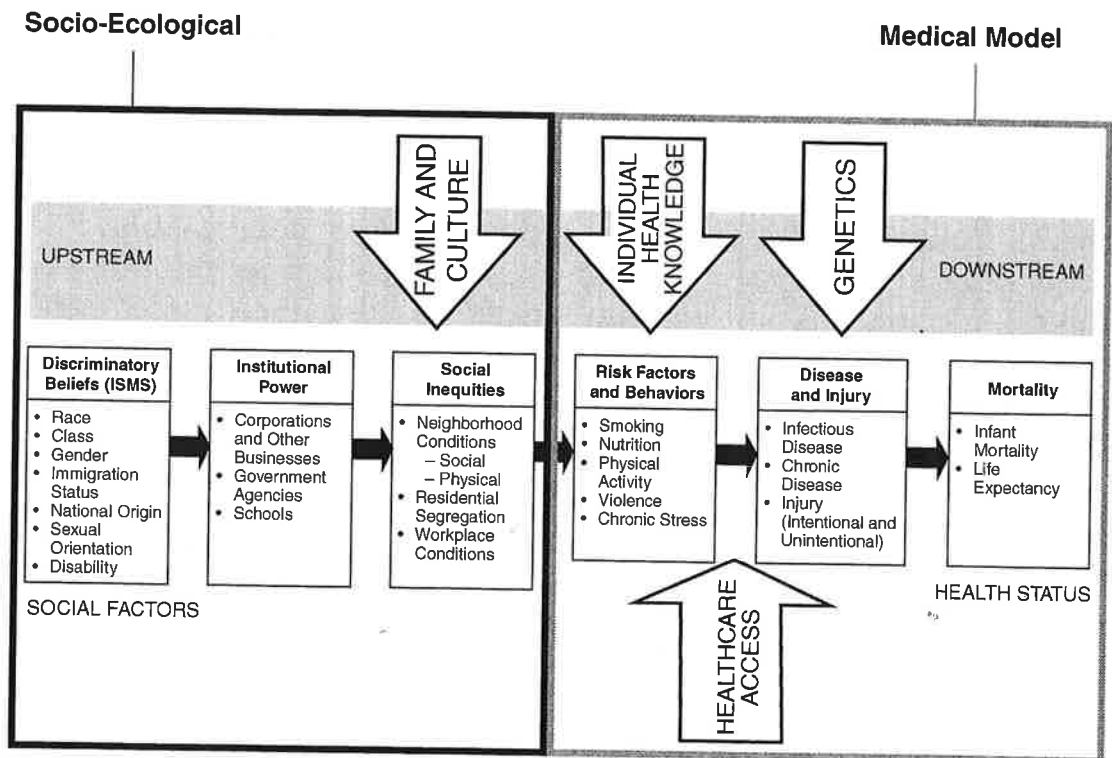


Figure 6.2 A Framework for Health Equity

social inequities (e.g. inner cities, barrios, and reservations) are the product of past and current policy (redlining, racially restrictive covenants, and housing policy) that ultimately derives from a narrative that values different people differently as a result of a set of well entrenched “isms”. A simple example is how a narrative of racism produces policies like racial segregation that lead directly to inner cities, a stark and outrageous social inequity. The BARHII framework acknowledges that within the medical model we have defined interventions for each of the boxes: emergency rooms to prevent death, clinical care to treat and manage disease, and health education to help change behaviors. However, within public health practice, we have no organized interventions to improve neighborhood conditions, change unhealthy policies, or change the overarching narrative about health.

At the California Endowment we have translated the upstream elements of the BARHII framework into a public health practice focused on improving community environments by changing policies and systems and re-shaping the narrative and power structures that influence those policies.

IV. Building Healthy Communities

Building Healthy Communities (BHC) is a holistic attempt to help reweave the fraying fabric of low-income communities by harnessing the latent power and potential of their residents. It is a ten-year, \$1 billion, place-based initiative, launched in 2010, that aims to transform fourteen communities by building *power* (social, political, and economic), implementing proven health protective *policy*, and changing the *narrative* about what produces health (beyond just health insurance and individual behavior). The idea is to revitalize local democracy so as to transform these environments into places where everyone has the opportunity to thrive. In short, BHC’s strategy is grounded in the belief that health is fundamentally political. The BHC model envisions these fourteen low-income communities as proving grounds for community-driven policy and practice innovations that will serve to inform and advance statewide health policy and systems change.

BHC is grounded in the sobering reality that the odds are heavily stacked against low income Californians, particularly communities of color. To achieve TCE’s mission of improving the health status of all Californians, it is not sufficient to just help a handful of low income Californians beat the odds. We must change the odds. Consistent with the BARHII framework, due to a legacy of racial and economic segregation, anti-immigrant policy and a host of other historical “isms”, there are many communities in California where residents are mired in environments that conspire to injure their health. Like Boyle Heights, these environments lack basic health protective amenities like parks, grocery stores, decent

schools, functioning transportation systems, affordable and decent housing, living wage jobs, and even potable water in some instances. These same environments concentrate risk such as liquor stores, fast food, payday lenders, environmental pollution, and crime. In these environments, community residents are forced to constantly navigate multiple risks without the benefit of significant resources.

These neighborhood and community environments are not natural, they are manmade, and they can be unmade. Building Healthy Communities is an effort that enlists the very residents who have been the targets of exclusion, stigma, and discrimination in remaking their environments through holding local, regional, and state systems accountable for creating healthy and equitable community environments.

The BHC theory of change is about building community capacity (increasing social, political, and economic power and changing the narrative about health), to change policy and systems, in order to create healthy environments that will (over time) improve health status. The targeted policy and systems change is multi-level: local, regional, and statewide. BHC is particularly focused on improving the social and health outcomes of populations that have been under threat, such as Boys and Men of Color (BMOC), immigrants, LGBTQ, and formerly incarcerated individuals, and consequently BHC has a special focus on strategies that enhance opportunity structures for these populations.

BHC operates by creating unprecedented space for community organizing, leadership development, and sustained multi-sector collaboration by enabling residents, community groups, and institutional leaders to collaborate across all sorts of boundaries, such as race, ethnicity, age, as well as the boundary that can exist between local communities and external professionals. Across all fourteen sites, the approach focuses on five drivers that we believe are necessary for propelling the priorities forward: building people power, youth leadership development, multi-sector collaboration and policy innovation, leveraging resources and partnerships, and changing the narrative.

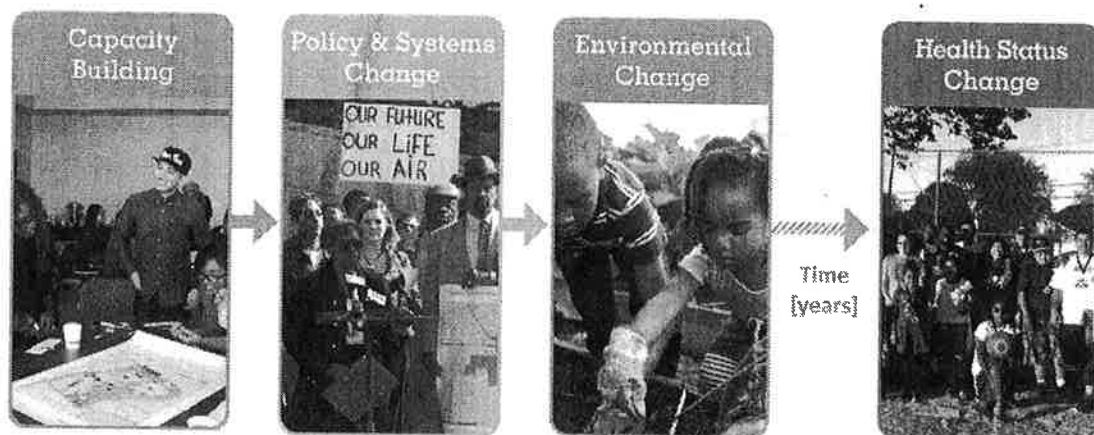


Figure 6.3 Building Healthy Communities: A Theory of Change

While the approach is the same across all of the sites, how it manifests depends on the local circumstances. In Fresno, for instance, the work is taking the form of unlikely alliances between community and environmental groups all interested in ensuring the city grows sustainably, whether for the people who live there or the environment. In East Salinas, the community is coming together with public servants to transform the way the city governs so that racial equity is at the forefront of all policies, practices, and procedures. While a significant portion of the plan involves “place-based” attention in fourteen communities across the state, of equal importance is how the reality tested the strategy; the collective learning and energy from these communities contribute to statewide policy and systems change to promote health, health equity, and health justice for all Californians. BHC is a place-based strategy, but with an orientation toward statewide change – we call it “place-based-plus”.

V. Defining BHC Success

How are we defining “success” for BHC? For us, the key BHC goals will not be limited to an arbitrary ten-year timeline. They will be achieved when three things happen to benefit the health of young people in low-income communities in California:

- 100% coverage and access to health-promoting and prevention-focused health services
- 100% of California’s schools with wellness and school climate policies and practices designed to enhance the social and emotional health of all children
- 100% of California’s cities and counties establishing health-promoting policies, particularly in youth development, land-use, and criminal justice

The thinking behind these three targets for policy and systemic change is that the wellness of young people is optimized when the primary “systems” they encounter—the health and social service systems, the school, and the neighborhood—are supporting what families want for their children’s health and well-being. True success, however, will come when the power dynamics in the communities have shifted to such an extent that families are able to hold local officials accountable for full, ongoing implementation of these policies. Healthy communities are inclusive, democratic, and allow all community members to participate.

A. *What Has Been Achieved To Date?*

Ascribing positive impact to a specific grant, a set of grants, or a grant making strategy is fraught with important issues of “attribution” vs.

“contribution”. BHC works in deep and extensive partnership with organized community residents, advocacy groups, service providers, media, and policy-makers. The successes described below are shared successes to which BHC has contributed. That said, the extent and timelines of many of these wins would likely not have been possible but for BHC. The following is a top-line listing of key results where BHC grantees, with TCE in partnership support, have made a significant contribution towards impact. Perhaps most importantly, each of these provides powerful evidence of deep community transformation. These achievements would not have been accomplished without the bravery of traditionally marginalized residents leading waves of change.

1. Improved Health Coverage for the Underserved

BHC grantees and partners fought for and supported the successful implementation of the Affordable Care Act and the expansion of Medicaid in California. Due to these efforts, there are more than four million new Medi-Cal enrollees since 2010.

2. Strengthened Health Coverage Policy for the Undocumented

BHC grantees and partners successfully crafted and led the Health 4 All Campaign, paving the way for state-supported health coverage for undocumented children and preserving county-level health access for undocumented adults. 250,000 children are newly eligible for coverage, and thousands of undocumented adults maintain access to healthcare.

3. School Climate, Wellness and Equity Improvements

Local BHC youth identified school discipline as a priority issue. Local and statewide BHC grantees, partners, along with youth, led or supported efforts across the state to reform harsh school discipline and suspension policies, and are working to successfully implement school equity funding formulas. School suspensions are down by 40% since 2009–10.

4. Local and Regional Progress: Health in all Policies

The physical, social, and political environments in BHC communities are being transformed by the work of residents that are advocating, innovating, and crafting new local policies and system changes that promote a strong culture of “health in all policies”. More than one hundred new policies, including those that foster more walkable communities, fresh food access, park space, and access to clean drinking water, have been adopted.

5. Public-Private Investment and Policy Changes for Boys and Young Men of Color

BHC grantees joined with other coalitions supporting outcomes improvement work among young men of color, bringing improved public policy and civic attention to the issue, and resulting in the creation of a Boys and Young Men of Color Select Committee in the state legislature.

6. Prevention and Reform Support in the Justice System

BHC grantees and partners led advocacy support for health- and prevention-oriented justice reform, and are leading Prop 47 implementation efforts statewide and locally; one of the key objectives is to funnel prison savings into prevention strategies. One million Californians are eligible for reclassification.

VI. What Has Been Learned?

We commissioned independent reviews of our progress from three respected entities: FSG; the University of Southern California PERE Center; and the Center on Effective Philanthropy (CEP). (To be precise, we were approached by CEP as part of their “Philamplify” initiative, and agreed to cooperate with their assessment tool on social change philanthropy.)

The three reports were generally consistent in their findings. In addition to describing significant levels of activity in each of the BHC communities, they also pointed out the challenges inherent in such a complex undertaking, such as maintaining clarity regarding operational priorities and the alignment of understanding and effort across all the diverse participants in the enterprise.

Through our experience in BHC, we have learned a great deal about how to capitalize on key policy developments—some anticipated, others not—affecting our communities, such as the implementation of the Affordable Care Act (ACA), the advent of the Local School Funding Formula, and upheavals in immigration policy such as DACA. Along the way, BHC has grown into a dynamic, continuously evolving hybrid of locally driven work and state-level policy campaigns. That makes it a particularly challenging entity to evaluate in simple terms.

We also have some feedback from our grantees through the Center for Effective Philanthropy survey, where we learned that our strengths lie in the realm of public policy and policy change, but we need to improve in grantee relations. Finally, an internal survey of program staff revealed a consensus desire to build on BHC’s developed strengths and community capacity to drive systemic change in service of healthier communities.

A. Overall, we learned the following about our progress:

- The top-line lesson for us has been a crystal-clear affirmation about the importance of leaders in underserved and low-income communities wielding the civic and political power required to effect health-promoting systems change. For all of the attention heaped upon the importance of “good data”, “research effectiveness”, and “innovative approaches” to drive public policy, the building of healthier communities is fundamentally a game about power, voice, and advocacy. Plugging the voice of community into the right kind of political power grid will do more to create health and wellness than any other single intervention.
- Our “theory of change” to help communities and health advocates assert power in economically challenged communities actually works. We have invested a substantial amount of grant dollars funding key “Drivers of Change” for grantees at the state and local levels: People Power, Youth Leadership, Collaboration, Partnerships, and Narrative Change. Community engagement has ranged from solid to excellent across the BHC spectrum, levels of trust between communities and our foundation are improving, and we have some local and statewide results to show for it.
- Local BHC and statewide campaigns have taken off. Locally, residents and leaders have led efforts to shape “health in all policies” approaches, scoring more than one hundred victories across the sites in land use planning and walkable communities, healthy eating and wellness policies in schools, public health emphases in municipal and county General Plans, and new skate parks, soccer fields, and after school programs for children and youth. Institutionally, we have developed a sharper understanding about the role a private foundation can play in supporting a community-driven and community-engaged campaign.
- On the statewide front, local BHC residents and youth leaders joined hands to advance healthier school climate policies, educate and enroll uninsured residents into the ACA and Medicaid expansion opportunities (we are proud to have contributed to California’s success in ACA and Medicaid expansion enrollment), successfully advocate for undocumented residents to have access to healthcare, and push for more prevention-oriented law enforcement and criminal justice reforms.
- All fourteen BCH sites have experienced progress at varying levels. Early struggles experienced in several sites were managed through a combination of patience, improved communications, candor, and trust-building. Any fears experienced about needing to “drop” any troubled sites have been discarded. As a result, we are now trusted across the sites to stay the course and not flee at the first sign of

difficulty. Our approach works in both heavily urban and under resourced rural sites.

- Youth engagement in and across the fourteen sites has been a particular strong point. All sites have young people meaningfully engaged at the table, and youth organizing to promote health is emerging as a signature hallmark of BHC. That said, we have also learned, through young people directly communicating their experiences—backed up by the data—that they, and their families, are coping with substantial levels of stress, adversity, and trauma in their daily lives. The depth of the issues of toxic stress, exposure to trauma, and resiliency in young people of color—and their collective effects on wellness—represents a major “discoverable” in the BHC journey. Based on the combination of the emerging science and the emerging voices of advocates for young people of color, exposure to trauma and stress is a substantially under-recognized public health crisis in this nation.

B. Creating Health Equity: A Story From Fresno BHC

Like Boyle Heights, South Fresno is park poor. Residents in South Fresno have one fourth as much park space as residents of wealthier North Fresno. Community residents in South Fresno came together through BHC to change that.

They studied the city’s Master Plan and used the data in that plan to shine a light on the disparity between the wealthy and poor parts of town. They organized a campaign to get the City to commit to rectifying the clear park disparity and update the city’s Master Plan. The Parks4All

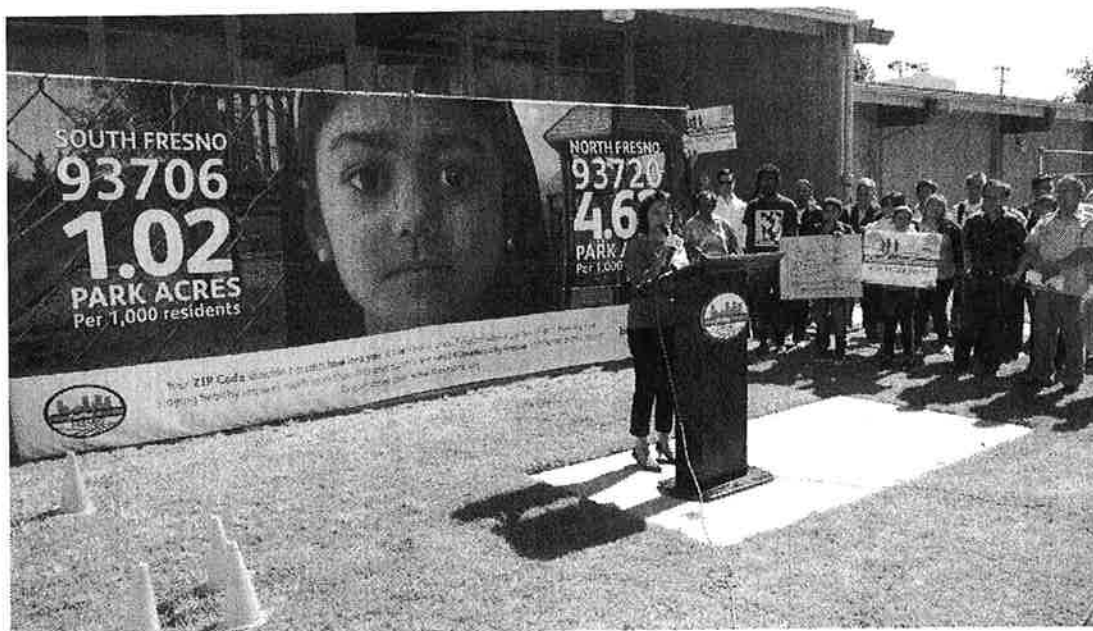


Figure 6.4 Fresno Building Health Communities

campaign mobilized hundreds of South Fresno residents and youth. To raise the profile of this issue these organized residents began calling their City Council members, writing letters to the editors in the local press, holding press conferences, and attending City Council meetings. They did extensive research and polled the community. They found that more than two-thirds of all Fresnans wanted more parks and recreation services for youth and greater funding for the Parks and Recreation Department. They designed and displayed billboards, bus shelter ads, and newspaper ads. Soon newspaper editorial boards began editorializing in support and political cartoons were published mocking the Mayor and the City Council for their intransigence. In September 2015, after months of concerted advocacy from South Fresno residents, the Fresno City Council voted unanimously to allocate \$450,000 to update Fresno's twenty-six-year-old Parks Master Plan. This success was driven by low-income young people and their families in South Fresno.

VII. Our BHC Strategy Moving Forward: Building on Progress

Based on our experience and the voices of resident and youth leaders across our fourteen BHC sites, the complex matter of 'health equity for all' cannot be achieved unless: 1) we build on the health coverage success of the ACA to undertake health reform 2.0, which involves moving dollar expenditures from outrageously costly back-end care, upstream into new and expanded wellness/ prevention/population health funding streams; 2) health and public health leaders join forces with advocates and activists to dismantle the incarceration superhighway and move incarceration dollars into behavioral health treatment and jobs; 3) health system leaders, health workforce/health professions schools and schools of public health reimagine training with communities and population health at the center of a more prevention-minded health system; 4) local and state political and civic leaders come to grips with the reality that meaningful civic engagement and civic participation is good for the nation's health, and exclusion and marginalization is lethal; and 5) local, state and national philanthropy must be more assertive in the recognition of the relationship between political power and health outcomes, and be more willing to fund advocacy, civic engagement, and power-building at the level of community.

A. Key Lessons For Designing A Health Equity Practice

Health equity requires us to ask the simple question: How did we get here? It is impossible to move forward to correct health inequity if we do not understand how we created it. Our history reveals how we have discriminated against poor people and people of color in California in ways that impair health for generation after generation. This discrimination

was mediated through policy and politics. In 2016 we are still repairing the damage of those decisions, while struggling against efforts that would do further damage. So in that way we recognize that health is political. One definition of politics is “the struggle over the allocation of scarce and precious social goods”. When it comes to community health, these scarce and precious social goods may be a park or a grocery store. In the process of implementing BHC, we have noticed many salutary benefits of helping communities to develop their social, political, and economic power. An important recognition is that power, or agency, is good for your health. Both individual agency and collective agency have salutary health benefits, particularly for young people.

Another emerging learning point is that discrimination injures people in ways beyond denying them resources. Discrimination and exclusion injure a person’s sense of belonging and connectedness. When people feel isolated and disconnected from their community, their health suffers. When whole communities feel like they do not belong, there is a collective trauma that can have profound and intergenerational effects. One important strategy in helping heal that trauma is by organizing the very people who have been traumatized and enlisting them to help rebuild their communities by holding systems accountable for equity and restoring health and justice. Building Healthy Communities is one foundation’s model for trying to build health equity. Over the next five years we plan to continue to build and refine this model.

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