**Philanthropy And Disparities: Progress, Challenges, And Unfinished Business**

**ABSTRACT** Philanthropy has invested millions of dollars to reduce disparities in health care and improve minority health. Grants to strengthen providers’ cultural competence, diversify health professions, and collect data have improved understanding of and spurred action on disparities. The persistence of disparities in spite of these advances has shifted philanthropic attention toward strategies to change social, economic, and environmental conditions. We argue that these evolving perspectives, along with earlier groundwork, present new opportunities for funders, especially in combination with progress toward universal health coverage. This article looks at how philanthropy has addressed health disparities over the past decade, with a focus on accomplishments, the work remaining to be done, and how funders can help advance the disparities agenda.

The Institute of Medicine’s 2003 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* galvanized many into action with its conclusion that because “racial and ethnic minorities...receive a lower quality of healthcare than non-minorities,” they experience measurably worse health outcomes.\(^1\)\(^2\) At the time the report was released, several foundations already supported programs to reduce or eliminate disparities. After its release, philanthropic organizations awarded millions of additional dollars to address various aspects of health disparities and minority health.

This article looks at how philanthropy has addressed health disparities over the past decade, with a focus on accomplishments, the work remaining to be done, and how funders can help move the disparities agenda forward.

**Rising Concern About Disparities**

**CULTURAL COMPETENCY** During the early 2000s research interest in health disparities—specifically in the relationship between race and health—accelerated rapidly.\(^3\) Several national and local foundations funded programs in this area, using the increasing availability of data to inform their work. Efforts at the time focused, broadly speaking, on cultural competency—that is, care tailored to patients’ values, beliefs, and behaviors;\(^4\) the minority health professions workforce; access to care; and quality of care.

For example, the Commonwealth Fund supported studies on increasing access to care, health care use, and the quality of care for minorities. The California Endowment supported programs to increase providers’ cultural and linguistic competence and the diversity of the health care workforce. Several funders—including the Hogg Foundation for Mental Health; the Josiah Macy, W.K. Kellogg, Henry J. Kaiser Family, and Robert Wood Johnson Foundations; and the Commonwealth Fund—supported programs for minority faculty and professional development and minority health policy leadership.\(^4\)

The publication of *Unequal Treatment*\(^1\) in 2003 reinforced the focus on the role that changes in health care delivery could play in reducing disparities. In particular, the report stressed the need for cross-cultural education in the health professions to increase cultural competence and the need for increased diversity of the health care workforce.

Examples of foundation activities related to these recommendations around the time of the report’s publication include the Aetna Foundation’s grants for health care provider training and for a cultural competency teaching tool to use in telemedicine. The Commonwealth Fund supported the development of a Tool for Assessing Cultural Competence Training, or TACCT, a self-administered assessment for medical schools to use in examining components of their curricula. In Minnesota the Otto Bremer Foundation made several grants for training and staff capacity building related to cultural competence.

The California Endowment awarded grants for cultural competence in health care delivery in that state. A few years
later, to improve care in a diverse patient population, the Oregon Community Foundation awarded a grant to promote self-assessment of cultural awareness among nurse leaders.

Evaluation of the effectiveness of these and other cultural competency programs has proved challenging. The variables to be measured are complex and include the quality of the instruction, whether providers learned the material and used it, changes in providers’ attitudes, patient satisfaction, and changes in the quality of patient care.

One evaluation, conducted at the University of Medicine and Dentistry of New Jersey—Robert Wood Johnson Medical School, found that the cultural competency training program run by two large urban family practices effectively increased physicians’ self-perceived knowledge of cultural competency as well as patient satisfaction. Because of the variety of outcomes that studies have examined, however, it is difficult to generalize about the effectiveness of cultural competency programs in reducing health disparities.

Diversity in the Health Professions Unequal Treatment also called for a more diverse health professions workforce. This recommendation derived from evidence that minority health professionals are more likely than whites to practice in minority communities and from studies showing that minorities have more confidence in providers of their own background.

Building on this knowledge, the California Wellness Foundation has used several strategies to improve access to and quality of care in that racially and ethnically diverse state. Grant making has included an awards program recognizing leadership in increasing the diversity of the health care workforce; the Welcome Back program, to help internationally trained health professionals get additional education and language skills needed to enter the US health workforce; and support for community college programs to train allied health professionals, such as laboratory technicians, nurse aides, respiratory therapists, and medical secretaries.

Recently, the California Wellness Foundation has used social media to inform underrepresented minority students about health careers, and public opinion polling to measure support for diversity in the health professions.

**Data Collection** Other funders concerned with health care disparities focused on data collection to build the evidence base or to provide a baseline for measuring progress. For example, with Commonwealth Fund support, the Health Research and Educational Trust created a web-based tool kit so that health plans, hospitals, and other providers could collect information about patients’ race, ethnicity, and primary language. Many health care organizations do not currently collect such data in a systematic way. These data on patients could also be used by health care organizations to monitor quality of care by linking to clinical measures and targeting appropriate interventions to specific groups.

Another Commonwealth project, Racial and Ethnic Disparities in U.S. Health Care: A Chartbook, helped policy makers, academics, researchers, and practitioners begin to understand disparities in their communities and formulate solutions. Aligning Forces for Quality Evaluation, a national program funded by the Robert Wood Johnson Foundation, includes the collection of data on patients’ race, ethnicity, and primary language as a way to identify promising methods to improve the quality of care provided in physician practices.

Through these efforts and others directed at health care settings, philanthropy has contributed to our understanding of the causes of disparities in health care, how disparities differ between and within groups, trends in disparities, and the impact of various interventions. Foundation-supported research and program evaluations have contributed to the knowledge base about promising interventions and the care settings in which interventions are most likely to be successful.

In a definitive literature review conducted in conjunction with the Robert Wood Johnson Foundation’s Finding Answers: Disparities Research for Change program, three strategies were identified as contributing to successful interventions: targeting specific agents of change, such as providers, patients, and the community; using culturally tailored materials, such as posters and pamphlets, for patient education and for increasing the cultural competence of health care professionals; and giving nurses, who spend more time with patients than physicians do, leadership roles in interventions. The review found that when they are effective, interventions improve health care quality for patients with diabetes, depression, breast cancer, and cardiovascular disease.

These advances notwithstanding, the persistence of health disparities within our communities and their human and societal costs continue to challenge philanthropy.

**Broadening Understanding Of Disparities** Grant makers are learning from mounting evidence that disparities in health care are only one reason why minority groups experience worse health outcomes than white Americans. From birth to death, race and class have an effect on rates of disease risk, exposure to environmental hazards and socioeconomic stressors, and access to health necessities such as healthy food and safe housing. Studies are beginning to document the pathways through which genetics and everyday environments and behaviors interact to shape health.

For example, Columbia University’s Mothers and Newborns Study is following pregnant African American and Latino women from low-income New York City neighborhoods and assessing the health of their children from infancy onward. The findings have linked the children’s health and development with diverse factors, such as the mothers’ exposure to traffic-related pollution, indoor pesticides, tobacco smoke, and poverty-related stresses, as well as with interactions among stressors and genetics. Numerous other studies are finding that people who experience multiple stressors and exposures tend to have poorer health outcomes than the general population.

Foundations concerned about populations with the poorest health outcomes thus face a complex array of forces that lie inside and outside health care settings. These considerations have led some funders to reexamine their disparities strategies and have attracted other funders, especially those already oriented toward prevention and popula-
tion health, into the disparities field. Many of these funders find the framework of what are commonly called the “social determinants of health” helpful in organizing their thinking about health status disparities and in identifying niches for funding.

The World Health Organization Commission on the Social Determinants of Health defines such determinants as societal conditions that shape how fairly health is distributed. These conditions include access to health care and education; the distribution of power, income, and goods and services in a community; and other conditions at work, at home, in neighborhoods, and in the surrounding environment.

The commission’s 2008 report concluded that health care is a health status determinant but that what puts people most at risk for disease—or protects them against risk—is the environment in which they are born, grow up, live, work, and age.16 Actions recommended by the commission to reduce health disparities include improving daily living conditions; tackling the inequitable distribution of power, money, and resources; and measuring and understanding the problem of disparities and assessing the impact of action.

The Kresge Foundation is among a number of US foundations that have launched national initiatives focusing on these social and environmental factors shaping health. The foundation’s Advancing Safe and Healthy Homes Initiative helps promulgate policies, laws, and practices that improve health conditions in low-income housing. Also, in recent years the Consumer Health Foundation—a metropolitan Washington, D.C., grant maker—has increasingly focused its grants for reducing health disparities on what it terms “the social determinants of health equity.”17 This funder has a particular interest in supporting organizations that use advocacy to explicitly link health with other social and economic factors.

For many grant makers, the social determinants approach is appealingly holistic, but they are finding it challenging to implement. With such a broad array of potential health determinants, where should foundations focus their efforts and finite resources? What evidence base should guide decisions? The size, complexity, and long-term nature of social determinants interventions all complicate decisions about grants and evaluations of their effectiveness.

Health grant makers have used a range of strategies to find their niche in this work, sometimes investing alone but more often collaborating with others inside and outside health philanthropy. With growing philanthropic interest in a broad framework for addressing health disparities (see the online Appendix18 for a graphic depiction of a health equity framework), one sees more funding of “upstream” strategies—for example, improving housing or increasing access to education—alongside continued “downstream” work to improve health care.

**Targeting Determinants Of Concern**

Numerous foundations have chosen to focus on improving conditions of daily life that have been flagged by a solid evidence base as necessities for health or, conversely, as contributors to disease and disparities.

Housing, for instance, is attracting funding because it is a nexus of many public health and equity issues. The Kresge Foundation, St. Luke’s Foundation of Cleveland, the Community Foundation for Greater Buffalo, the Wells Fargo Foundation, and other funders have recently formed a Healthy Housing Funders Collaborative, which convenes grant makers, funder networks, and federal government officials to strengthen investments at the intersection of housing and health.19 The Annie E. Casey Foundation is among numerous public and private partners in the Green and Healthy Homes Initiative, which has projects in several low-income communities.20

Food is another focal point for health and equity giving. There are so many low-income neighborhoods with little or no access to grocery stores or fresh produce that they have been mapped as “food deserts” by the Department of Agriculture.21 National foundations such as the Kellogg Foundation, as well as place-focused philanthropies such as the Colorado Health Foundation, are making grants to help improve food access and the systems involved in getting healthy food from the farm to the table.

Food is also part of a major philanthropic collaborative to promote healthy eating and active living. The Convergence Partnership—currently led by the Kellogg, Robert Wood Johnson, and Kresge Foundations; Kaiser Permanente; Nemours; and the California Endowment—has catalyzed a wave of national interventions to improve food access and nutrition, increase exercise, and promote changes in the built environment that enhance safety and encourage physical activity.22

Toxic exposures and other environmental hazards, such as air and water pollution, tend to be disproportionately prevalent in minority and low-income communities and thus are attracting millions of dollars in environmental health and justice grants yearly.23 Studies demonstrating improvements in health outcomes following remedial action on environmental hazards, such as the Columbia University Mothers and Newborns Study,15 have encouraged further investment to create healthier environments.

Local environmental justice investments often address multiple health determinants of concern to a particular community. In metropolitan Los Angeles, for example, the California Endowment and the Nathan Cummings, Kresge, and Liberty Hill Foundations have supported residents, nonprofits, and academics collaborating to assess the environmental health “riskscape,” including links between toxic exposures, race, income status, and commu-
Interest is growing in building an evidence base about ‘upstream’ determinants.

context of connecting families to jobs, high-quality early education, and opportunities for civic engagement and leadership.26

Methods For Decision Making

Multiple factors may be at play in an observed disparity, including societal factors, community conditions, behavioral choices, and individual risks for disease. The health equity framework shown in the online Appendix18 illustrates the relationship of these factors to each other, and their combined effect on health status. In deciding where to direct their finite assets within this range of options, funders face questions about how to measure returns on their investment in a project and how to assess whether an intervention is successful. These questions have spurred interest in strengthening evidence bases, methods, and models.

Thus, in addition to the long-standing interest of health philanthropy in filling data gaps on the “downstream” side of the disparities continuum, interest is growing in building an evidence base about “upstream” determinants. Examples are population-focused studies such as the Columbia University Mothers and Newborns Study, which is documenting the effects of public health interventions on environmental hazards,15 and the National Institutes of Health’s National Children’s Study,28 which will study environmental influences on the health and development of 100,000 children from birth to age twenty-one. (Although foundations are not directly funding this study, some have funded efforts advocating its approval and funding.)

Funders are also supporting work that uses available evidence to aid decision making about what contributes to health disparities and about potential actions to address them. An example is
the methodology used in Los Angeles for bringing into the local planning process information about pollution, poverty, demographics, health vulnerability, and their potential cumulative impacts.\(^2\) Initial philanthropic, state, and federal investments are helping advance the use of such methodologies and other tools for decision making.

Health impact assessments offer a further upstream approach. The Robert Wood Johnson Foundation, Pew Charitable Trusts, Blue Cross Blue Shield of Minnesota Foundation, and others are supporting the use of such assessments as a way of proactively bringing consideration of health, preexisting hazards, and health vulnerabilities into decision-making processes.

New Support For Reducing Disparities

Health philanthropy has historically invested substantial resources in addressing the health problems and inequities that the uninsured and underinsured face. Not surprisingly, there has been much philanthropic interest, and some strategic activity, supporting moves toward universal health care.

Objectives across the upstream and downstream points of the health equity framework (described in the Appendix)\(^3\) will be reinforced by the Affordable Care Act of 2010. Besides expanding health coverage, the act includes provisions for improving data collection on race, ethnicity, and other variables related to cultural competency. The act is also expected to reduce disparities through increased funding for the Indian Health Service, coverage of legal immigrants, disease prevention, and improved quality of care. Many foundations are actively supporting state-level implementation of the Affordable Care Act.

Continued US progress toward universal health coverage could present a unique opportunity for foundations whose commitment to vulnerable populations has been concentrated on care for people who fall through the health safety net. Several developments over the past decade may allow future funding to address disparities more effectively. These include the burgeoning evidence base about environmental, social, and economic contributors to disease and disparities; new approaches for evaluating cumulative effects and integrating health into policy and program decisions; and the growing number of funder collaborations that provide experience and infrastructure to support more-effective work as a sector on complex problems.

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No single foundation can create the conditions for good health and health equity, nor can philanthropy as a whole. Thus, the trend toward greater information sharing and collaboration among foundations is encouraging. Several funder networks and nonprofits are helping funders collaborate on issues such as healthy eating, active living, housing, transportation, energy, and toxic substances. These partnerships provide frameworks for shared learning and strengthening the collective impact of philanthropy. Individual funders tackle the part of a problem that aligns with their funding guidelines, while participating in a larger learning community.

However, too few partnerships support collaboration across the full health equity framework. Such gaps are especially notable between grant makers focused upstream (on improving the places where people live, work, and play, or on structural determinants such as lack of access to resources) and those focused downstream (on high-quality medical care and related issues). The trend toward cooperation and joint programming among funder networks reflects the interest in filling these gaps.

There also are too few relationships between philanthropy’s contributions to disparities work and the contributions of other key actors, such as government agencies, the private sector, academe, and communities. Encouragingly, some bridge building has begun. For instance, some funder collaboratives focused on specific determinants have established relationships with counterparts in federal agencies, such as the Environmental Protection Agency and the Department of Health and Human Services.

The complex, long-term nature of disparities suggests that a focus on sharing information and resources, complementing what others are doing, and building partnerships across stakeholder groups would greatly enhance philanthropy’s contributions to the field. Meanwhile, the influence and voice of philanthropy can help increase attention to health disparities at a time of many competing policy concerns and can remind decision makers that improving conditions that hit minorities and the poor the hardest would also improve conditions for all.\(^5\)

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NOTES


18. To access the Appendix, click on the Appendix link in the box to the right of the article online.


