Equity, Public Health, and Philanthropy in the South

By Ann Rosewater

Introduction

How can we ensure that all Southerners enjoy health in healthy communities? This critical question has received far too little attention; focus has been placed on stemming "disease," rather than on "health" and on individuals rather than on populations and communities. As we learn more about what contributes to "healthy people and healthy communities," philanthropy can and must play a central role in achieving them.

I. Equity and Public Health

Equity and public health are two related but separate concepts. While they are often joined, it is important to understand each independently before seeking to explore their connections. Equity in the context of public health is a goal—where race, gender, poverty, social status and geography are no longer factors in access, quality, treatment and health outcomes. The South has a long way to go to reach equity.

In 1988, the Institute of Medicine (IOM) defined public health as "… what the society does collectively to assure the conditions for people to be healthy." By 2002 the IOM had expanded its framework by accepting the vision in the decennial report of the U.S. Surgeon General: "healthy people in healthy communities."

Public health was traditionally centered on disease eradication. These efforts involved surveillance, screening, sanitation and treatment. That focus has expanded greatly in the late 20th and early 21st centuries; from the 1970's through the1990's public health began to encompass prevention of injury, intimate and community violence, smoking and substance abuse. More recently, public health has broadened to include preparedness for global pandemics and for the health effects of bioterrorism. More and more, the focus of public health is on promoting "health," not only obliterating disease.

As commerce, communication and travel have become global, society is dependent on a strong public system to protect and promote health and well-being. Agencies charged with addressing public health are found in every state and most counties. Most large urban communities also operate a public hospital system, and in some instances satellite clinics, providing medical treatment and services to the wide array of individuals who use public insurance such as Medicaid or Medicare, or who number among the 43 million uninsured Americans or are underinsured; These agencies constitute the traditional public health assets in a community.

For decades, biology and medicine were viewed as the principal determinants of individual health. This is no longer the case. There is strong evidence that behavior and environment are responsible for 70 percent of avoidable mortality, and health care is only one of several

determinants of health. The other determinants may include income, education, race and ethnicity, as well as insurance, housing, environmental quality, and geography. Further, the health of individuals is affected significantly by the health of the population and the geographic community in which the individual resides. Disparities in the health of different population groups are likely to be a consequence of a combination of factors, including health practices, social and psychological stress, environmental exposures, discrimination and access, as well as social and economic status.

Government data consistently report disparities in health outcomes based on these factors as well as other social and structural determinants of health. Low-income people are much more likely to be in poor health and less likely than their more affluent peers to have used many types of health care; they were also four times more likely than non-poor people to report serious psychological distress. People living in rural areas are less healthy than their peers who live in metropolitan communities.

Racial and ethnic disparities are not only evident in health outcomes and in the social and economic conditions in which large proportions of minority and low income people live. What is less well understood is that these disparities appear as well in clinical, diagnostic and therapeutic care of chronic diseases, preventive care and mental health services. In addition, communication between health provider and patient has been shown to influence compliance with a medical regimen, satisfaction with care, and the patient's health outcome. Too often, when cultural, racial and ethnic differences are not taken into account, stereotyping and biased treatment may result.

Equity in health, then, is a complex matter. It speaks to access to health care services, the quality of the services received and the likelihood of achieving positive outcomes. It also speaks to environmental and other conditions of the community that affect daily living. Public health leader William Foege asserts that public health is also grounded on the notion that "the truths of science will be used to benefit everyone. Therefore, the philosophical basis of public health is social justice." All too often many or all of these elements of equity in health are compromised, resulting in serious health disparities among different groups—by income, race and ethnicity, gender, age and disability and geography.

The South has traditionally been challenged economically and socially, and it remains so. But there is also considerable hope, arising from the region's modernization as well as from general improvements in education and advances in public health across the nation. In moving from a focus on disease to a focus on health, a much wider range of community actors, organizations and social resources are needed to contribute to changing the dynamic of both individual and community health. From these developments emerge many opportunities for private stakeholders to stimulate and influence significant activity that can both continue the South's progress, and make a marked difference in the quality of life and opportunity for its people.

II. The Southern Context: Burdensome Legacy, Emerging Opportunity

In the South, where income, education and race have long been connected to inequality of opportunity, they similarly have been factors in health outcomes. Two other intertwined regional characteristics lead to poorer health outcomes in the South than elsewhere: high rates of poverty

and extensive rural areas that lack the assets that contribute to health. These regional attributes are exacerbated by Southern states' unequal and insufficient public investment in a wide range of municipal, social, educational and health services.

Vast numbers of individuals, especially low income African Americans and Latinos continue to bear a disproportionate burden of disease and ill health. This is evidenced in increased levels of morbidity and mortality, in poor educational outcomes, in persistent poverty, in impediments to sustained work opportunities, and in family instability. Despite recent economic growth, the Southeastern states lag behind in many indicators of well-being including maternal and infant health, hypertension and overweight, dental care and several chronic diseases.

The increasingly diverse composition of the South's population is also challenging the health care system and related services. Newcomers bring language and cultural issues and needs that Southern states are only beginning to struggle to meet. Combined with inadequate health insurance coverage for people of color, and under-representation of minorities in the health professions, the barriers to achieving positive health outcomes for all of the South's people are significant ones.

As this paper undergoes completion, the aftermath of Hurricane Katrina brings into bold relief the poverty, income disparities and their consequences for many Southerners, especially people of color. The Gulf Coast of three states was ravaged by the storm, scattering hundreds of thousands of its residents to other parts of those states as well as to most of the other states in the region. The public health emergency created by the hurricane and its devastation is fundamental—ensuring potable water, food, clothing, shelter and sanitation for the emergently homeless—and complex—evacuees need jobs, housing, cash, and medical, mental health and social supports in the communities where they return or settle. With the organizational infrastructure which was weak to begin with now in tatters, vast rebuilding and renewal of lives and communities is a profound necessity.

Adults

Adults in the region suffer serious health problems disproportionate to those in other regions. Overweight and obesity are useful examples; they contribute to many chronic and disabling diseases such as diabetes and heart disease yet are largely preventable. In five Southeastern states, more than 59 percent of the population in 2002 met the definition of "overweight or obese"; another five states had between 56-59 percent of the population who met these criteria. At the same time, no Southeastern state had more than 51 percent of its adults who met recommended guidelines for physical activity; in seven states, fewer than 44 percent met them. These are not the only troubling health indicators. The region had the highest percentage of serious psychological distress among adults 18 years of age and older. And adults in the South lag seriously in receiving routine dental care.

Rural adults suffer increased hardship. In Georgia, for example, heart disease, cancer and diabetes occur more frequently among rural residents than those in urban areas. Appalachia, which crosses several southern states, is also faced with the twin challenges of poverty and isolation and its residents exhibit poorer health outcomes than others in their states.

All of these problems are compounded for adults of color in the South. The high rate of cardiovascular disease and stroke, for example, has earned areas of the Southeast the nickname, "The Stroke Belt." African Americas are nearly one and a half times more likely to die of stroke than whites. One study found marked differences in physician office visits and health care expenditures between African-Americans, Hispanics and whites in 17 Southern states. Lower rates of physician office visits can lead to lower rates of diagnoses of significant diseases, or diagnoses only at advanced stages of diseases. Minorities are also more likely to report being diabetic and having hypertension.

Children and Youth

The South's children, who are often characterized by poverty, are particularly vulnerable. Three states had between 24.5 and 30 percent of their children in poverty in 2003 while another four had rates between 19 percent and 24.5 percent. On key measures of health status and access, the region's children are similarly at risk. Seven of the states had among the nation's highest teen death rates. The South has the highest percentage of emergency room visits for children under age 18; more than 12 percent of children under age six and 7 percent of youngsters ages 6-17 made two or more visits to the emergency room within the previous 12 months. Children under age 6 in the South were most likely to lack a usual source of medical care and the South had the lowest percentage of children with a dental visit in the previous year.

Minority children face even higher risks. The infant mortality rate for black babies remains nearly or more than twice as high as that for whites in the South Atlantic, East South Central and West South Central states. In 2003, Louisiana had the lowest immunization rate for toddlers ages 19-35 months, the prime time for crucial vaccinations against preventable diseases. Mississippi has the highest rate of overweight and obese children of any state in the country and the other Southern states are not far behind.

The South's Assets

While the South continues to confront many challenges borne of a legacy of unequal investment, disparate conditions and discrimination, it also has many important sectors and institutions that can be critical components of efforts to improve the public's health. Many southern states have strong academic centers, including schools of public health, medicine, nursing, social work, law and public policy, which are training people who will lead these states in coming years. Two of the nation's three minority medical schools—Meharry and Morehouse—are located in these states and train most of the African-American doctors who practice in the region.

Business and commerce comprise a vibrant and growing sector of the economy in the region, and have the capacity to improve policies and practices for their own employees and workplaces. They have the capacity to use their leadership and leverage not only for their employees, but also to strengthen the health of the communities in which they operate. Another well-established and underutilized sector is the web of faith institutions that reach wide and deep across the communities of the southern states. These institutions, their pastoral and volunteer leaders, their communications vehicles and their outreach provide opportunities to reach diverse communities.

Finally, there is a growing new sector of philanthropy in southern states. During the past few decades, the conversion of hospitals and health insurance companies from public to private entities has spawned new foundations as a byproduct. These foundations are built on the profits from the sale of the companies, and the resources are targeted for community betterment. While many of these new organizations have very specific geographic boundaries, they are both new community-based leaders and, taken together, constitute a significant potential resource for the region as a whole.

III. The Philanthropic Context

Philanthropy is the sector that has the opportunity and the responsibility to be visionary and bold. While broadly accountable to the "public" for the privilege of its tax exemption, and with a requirement as a result to be a good steward of its resources, philanthropic institutions are not subject to the pressures of voters, shareholders or "rank and file members." Private foundations are independent, possess unique histories and receive funds from donors who have put resources in "trust" for the public good. The opportunity that foundations enjoy as a result is to tread where others—government, business, and academia, for example—are either unwilling or unable. Foundations can take the long view, identifying a need or issue and building the necessary climate and structures to address it. But no foundation has the resources, capacities or credibility to solve social problems alone.

The immediate crisis and the long-term regeneration of communities resulting from Hurricane Katrina call on philanthropy for both compassion and capacity. It requires both short-term and stopgap infusions of resources provided with sensitivity to individuals and families as well as long-term visioning, collaboration and investment in entire neighborhoods, communities and the Gulf Coast as a whole. At the same time as Katrina has created dire needs, it also provides an extraordinary illustration of philanthropic opportunities and challenges. Foundations' leadership roles in their communities and in the region offer them the chance to serve as respected conveners of a wide range of stakeholders, institutions that can use their resources with relatively little red tape and for activities in which the outcomes are not necessarily pre-determined. They may use their community position to identify needs, including when new institutions or organizations should be established for specific purposes and when the non-profit sector as a whole needs to be drawn together to increase impact. They may serve as a model for data-driven decision-making or provide the training ground for emerging local leadership. It is these attributes that go beyond direct funding that may have particular resonance and urgency as a result of Katrina but provide a model for philanthropy that goes far beyond these needs.

Public health is, by definition, population-focused. Addressing the health of populations requires cooperation and collaboration across a range of actors. Philanthropy is particularly well suited to foster this collaboration by convening stakeholders, developing awareness and understanding of new or under-addressed concerns, galvanizing new attention to effective interventions, evaluating and disseminating what has been learned over time, and advocating for change in the public arena. As we learn more about the multiple and interdependent determinants of health and well-being, and the importance of social and civic engagement in advancing both well-being and opportunity, investments

designed to strengthen civic capacity and social fabric are new arenas in which philanthropic initiative can bear fruit. Foundations need partners in strategic efforts to transform the culture of communities to foster positive outcomes for all citizens.

Strategic efforts at transformation must recognize but go well beyond the enormous pressure on foundations to provide "relief" or to support "services." The "service gap" is one that philanthropy can never fill. Foundations can be more effective, have a broader reach, and greater impact through more strategic and systemic activities and investments. This is especially true in public health, an arena in which most every locality has public agencies with specific responsibilities to provide services.

Highlights of Historic Philanthropic Investment in Public Health in the South

Although there has been relatively limited philanthropic focus on public health in the South, some pioneering efforts are notable. These have sought to eradicate pernicious diseases, organize and strengthen local and state public health agencies and institutions, and test new approaches to engaging low-income African Americans.

Eradication of Disease

An early and effective contribution to public health in the South was the Rockefeller Foundation's effort to address the hookworm epidemic. In the early1900's, the Foundation established The Commission for the Eradication of Hookworm to improve sanitation in the South's rural communities. This panel and, subsequently, Rockefeller's International Health Board, contributed to treating nearly 700,000 cases across eleven Southern states. They employed several strategies: charting the disease's prevalence, support for building outhouses to improve sanitation, establishing regulated state health agencies, generating cooperation between the medical profession and other agencies, stimulating research on a cure, and advocating change in training of health professionals.

Venereal disease was another scourge debilitating the population, especially its poorest individuals living in rural areas. Several foundations directed resources toward understanding, treating and preventing these diseases. A principal effort was led by Julius Rosenwald, the Sears Roebuck entrepreneur, who established a foundation focused heavily on improving opportunity for Southern blacks. When syphilis was recognized through research as devastating large numbers of people, and again through research on the white population, that intervention could make a difference, the Rosenwald Fund invested in a demonstration project in Mississippi addressing the question: can the rural black population be treated? Because government funds were limited, the Rosenwald Fund put up resources aiming not only to answer the question, but also to provide work for blacks and pursue joint government-foundation cooperation. The first initiative of the Z. Smith Reynolds Foundation in the 1930's also focused on venereal disease through investment in medical research, bringing Southern foundations into this arena. Seeking to stem the epidemic, the Foundation also supported education for youth about the transmission of syphilis and other venereal diseases.

Building Public Health Infrastructure

Following the great Mississippi River flood of 1927, the Rockefeller Foundation deepened its investment in local public health agencies. To build the infrastructure, the Foundation challenged county governments to put up a quarter of the funds if it would contribute the other three-quarters. By April1928 eighty local public health agencies had emerged in the flood-torn counties. Another notable personal legacy that helped build public health systems is that of Anna Harkness, who created the Commonwealth Fund in 1918. In its early work, the Fund played a role in the development of "progressive" public health departments in localities across the nation. In addition, throughout the 1920's, 1930's and 1940's, they helped build rural hospitals that met quality care standards, paving the way for enactment of the Hill-Burton Act, which included investment in hospital construction and improvement.

In the 1920's, when James B. Duke created the Duke Endowment, low-income people could not afford the $3 dollar daily charge for a hospital stay. The Endowment provided a third of the costs for indigent hospital care in North and South Carolina. With other foundations, including Rockefeller, the Endowment contributed to the creation of medical schools connected to universities by setting up the Duke Medical School. The Commonwealth Fund continued the development of new medical schools in the 1940's.

Rural communities continue to rely on public health structures, and a recent component—Area Health Education Centers, known as AHECS—has been developed through pilot projects sponsored by the Z. Smith Reynolds Foundation and the Kate B. Reynolds Trust. The AHECs, which are designed to increase the availability of physicians in rural communities, are now supported by federal funds.

Testing New Strategies to Address Public Health Issues

The late 1960's and early 1970's were noteworthy for making the connection between hunger and public health. Malnourished black children in Mississippi became the portrait of hunger not only through Senator Robert Kennedy's tour of the Delta, but also through the Field Foundation's support for several physicians' follow-up visit to actually examine the children. The doctors reported serious ailments such as rickets, pernicious anemia, and marasmus ("milk-leg"), which are entirely preventable with proper nutrition. The Senate established a special committee on hunger, propelling legislation that continues to provide basic nutrition to low-income pregnant women, infants and school children.

While the public health infrastructure has developed remarkably during the last century, there is still much to be done, from the most basic to the most sophisticated. The DuPont Foundation, for example, demonstrates the next generation of some of the earliest Rockefeller Foundation work on sanitation; in Virginia, it started a decade-long project to install indoor plumbing for very low-income black and white families that still use outhouses. Yet this work has taken on an advocacy component as well, to address the hurdles of new and relaxed federal rules allowing human sludge on farmland.

As the issues and scope of attention have expanded and become increasingly more complex, and the contributors to health and ill-health more numerous and interdependent, future efforts to foster the public's health depend on collaboration with a wide range of community, regional and national stakeholders. There is no sector better poised to mobilize change than the philanthropic sector, and as the South's foundations become increasingly robust, there may also be less need for the South to rely solely on northern philanthropy for transformative vision and initiative. With Hurricane Katrina's consequences bearing down on the South, lessons can be drawn directly from the past about how philanthropy acted individually and collaboratively to build public health infrastructure and capacity, eradicate disease, and involve low-income individuals and communities in the work that it developed.

IV. Strategic Opportunities: Looking to the Future

If public health truly means "healthy people in healthy communities," the South has a long way to go. This means there are ample entry points for foundations to help local communities as well as the region as a whole achieve this vision.

The cadre of Southern philanthropy that could turn its resources to strengthening public health is substantial. Many private foundations in the region place priority on improving the wellbeing of low-income and minority populations. It is essential to respect the autonomy, geographic boundaries and uniqueness of each foundation, and to take these attributes into account in any rendering of an agenda to address public health and equity. Yet, regardless of the size or location of the foundation, in this region, the needs are compelling and the opportunities great for a variety of philanthropic investments

With more than 60 "health legacy foundations" in the South and the number growing steadily, there is also a strong base of foundations for which improving health is central. In the communities in which they operate many of them are the most significant philanthropic player in town. Taken together, they command about 10 percent of all foundation assets in the South. The Southeastern Council of Foundations is aiding their development individually and as a network through regular meetings among the professional leadership and with the trustees. In this way, the foundations are learning from each other, building capacity, and evolving ways to collaborate.

The nature of the emerging opportunities includes investments in the public health system, and investments in public health. Many foundations that would be reluctant to invest directly in the public health system would be eager to invest in the range of activities that, taken together, strengthen and sustain public health. These range from building awareness and understanding of issues, which is something that foundations have traditionally done well, to mobilizing a range of sectors to commit energy, resources, leadership, visibility and vision to meeting a specific goal over time, something that is much more challenging for foundations but is desperately needed.

Working Locally

At the community level it is possible to identify entry points by health condition, by vulnerable population group, or by place. A few examples include:

- A health condition—overweight and obesity in children. Mississippi tops the states with the highest rate of overweight and obesity among children, and one health legacy foundation has created a partnership with three school districts, the community college, a health insurance company foundation, and a national foundation to institute a healthy lifestyles program. The multi-year, multi-faceted school-based program will work with both faculty and students and include curriculum, development of outside areas to improve physical activity, health screenings, and individual plans to focus on wellness. In gaining the school districts' participation, the local foundation also successfully challenged the school systems to eliminate sales of junk foods through vending machines during the school day.

- A population group—Latinos and new immigrants. As the influx of Latino newcomers accelerates, health providers and others who interact with Latino adults and children need to dramatically improve their capacity to ensure a linguistically familiar, culturally friendly, and accessible environment for meeting their health needs. This may require community education, engagement of community leaders, assessments of need, and other investments in understanding who the newcomers are, their level of health knowledge, their health and lifestyle practices, and the development of indigenous health educators and patient advocates. To address a nursing shortage in the area which is compounded by the growing immigrant population, one health legacy foundation, in partnership with a consortium of nursing schools, is supporting an initiative to recruit, educate and retain ethnic minorities as bilingual nurses.

- A workplace sector—Newcomers working in hazardous industries. Many of the low-wage jobs taken by immigrants and newcomers are in particularly risky business sectors such as poultry plants and textile mills across the region. In many instances, the health needs of the workers are neglected, or worse, jeopardized by lax practices. Initiatives that seek collaboration with employers, support education and organizing among workers, raise awareness of and test ways to improve safety, and support advocacy to strengthen regulatory and enforcement policies can protect a growing group of the South's newest workers and advance health and safety within communities.

- A neighborhood or rural community—Access and care for the underserved. Concentrations of underserved counties are found throughout the Southern states where the numbers of health professionals, hospitals and clinics have been dwindling, severely diminishing opportunities for care for thousands of low-income, low-wage and uninsured workers and their families. Initiatives in Georgia are building networks of care across counties and utilizing public and private health and human services organizations and activities in a coordinated strategy to strengthen access to and availability of care, create a focus on healthy living, and save dollars. These efforts involve a committed collaboration among health agencies, local higher education institutions, civic leaders, community-based organizations including state and local philanthropy.

Working Regionally

Given the South's poor track record on so many health indicators, there are also a myriad of goals that could be adopted for the region as a whole. Joining together collectively to identify and bring attention to an agenda to improve the health of the region has the potential to set the stage for critical change in public and private sector policy and practice as well as personal lifestyles and behavior and garner broad-based commitment from regional, state and community leadership. Engaging leadership across various sectors is one of the key means of influencing their policies and actions. Such influence emerges through convening stakeholders, developing and widely distributing useful information, using polling and other techniques to gauge public understanding, perceptions and opinions and bringing into public discourse the voices of those who are less frequently heard or too often dismissed.

Some of the opportunities address enabling conditions that profoundly affect health. Others are more immediately related to stemming specific health conditions, and yet others speak to reversing the discrimination that impedes positive health outcomes for selected groups. A few examples of possible goals and strategies include:

- Putting the South on a diet and exercise regime
- Cutting the rate of African-American infant deaths by half and ensuring kids are healthy when they enter school
- Stemming the poverty of the next generation through comprehensive investment in early childhood development and health, including advocating for universal pre-kindergarten programs and reducing births to teens, and fostering pathways to success for youth by increasing the percentage of young people who successfully enter and graduate from postsecondary education
- Demystifying and de-stigmatizing mental illness so that the high rate of depression can be recognized, people can get help and participate more effectively in the economy and in raising their families
- Mounting a campaign to address race, ethnicity and poverty among primary care providers so that the troubling screening, treatment and care gaps can be closed
- Identifying the patterns of pollution, pesticide use, and other environmental insults that particularly affect low-income and minority communities and building a network of organizations and plan of activities to seek environmental justice

Addressing any one of these issues, and the many others that cry out for recognition, will take several steps. These may include developing a clearer portrait of the issue in the region, distributing that information widely to inform and educate a broad public, including policymakers. An important step involves finding and establishing partners from a range of sectors such as business, education (K-12 and university), faith-based organizations, media, civic elected and appointed leadership, community and grassroots leaders, and public health and medical officials. Some of the partners, including federal, state and local government officials, may both be partners in the work and the very actors whose policies and behaviors are the targets of change. Additional philanthropic steps may include making commitments and investments over a longer grantmaking period than usual, and significant, sustained leadership. Some issues require building public awareness and understanding. In many other instances, however,

successful interventions may require building the climate to effect changes in policy, practice, organizational relationships and community norms. This may call for investments in research, demonstrations, evaluation, coalition building, monitoring, public relations and advocacy. Investments of this sort will call upon foundation leaders to overcome some of their own hesitation to engage outside of their own service areas, and may also challenge their traditional ways of doing business.

Conclusion

Over the past century and a half, philanthropy has demonstrated its potential for expanded impact in advancing the health and well-being of people and communities in the South and doing so through a wide variety of strategies. With the burgeoning of foundation activity in the South, including a new cohort of foundations borne out of health-related enterprises, philanthropy has an opportunity to make bold advances in the next century and a half as well.

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