



***White Papers: Best Practices and Recommendations to Inform the Culture of Health Initiative***

***Shared Values of Health and Social Cohesion Considerations***

***Effective Multi-sector Collaborations and the Need for Further Research to Promote Equity***

***Using Health Equity Data to Inform Policy, Programing and Actions***

From the UCLA Blum Center  
Michael Rodríguez, MD MPH  
Center Director

## Executive Summary: White Papers on Principles, Best Practices and Recommendations Related to Shared Values of Health, Social Cohesion, Multi-Sector Collaboration, and Health Equity Data to Inform the Culture of Health Initiative

### Introduction

Within this trio of White Papers, the UCLA Blum Center on Poverty and Health in Latin America presents information, perspectives and commentary gleaned from international participants of its Second Annual Conference held in May 2014. Four of the conference sessions focused attention on the three fundamental principles of a culture of health: shared values of health and social cohesion, multi-sector collaboration and using health equity data to inform policy and programming. A plenary session, *Advancing Stakeholder Engagement: Innovative Approaches for Cross-Disciplinary Collaborations to Advance a Culture of Health*, moderated by Alonzo Plough, PhD, MPH, included three experts in international health programming: Maryam Farzanegan, PhD (UNICEF), David Mayer, PhD (CIDE-Mexico) and Gisele Almeida, DrPH, MSc (PAHO). Three working sessions were held subsequent to the plenary session, with each working session dedicated to one of the three topics as described below.

For each of these three topics, the resulting White Paper provides information relevant to the Robert Wood Johnson Foundation's Culture of Health Initiative (RWJF-COH) through discussions on 1) a discussion of the topic as an essential factor in achieving a culture of health; 2) summary of conference proceedings; 3) global promising programs as potential models cited by conference participants; and 4) recommendations for future research to further elucidate how these three fundamental principles of health should be incorporated into programming and policy for the RWJF-COH.

### Key Messages: White Papers

***Shared Values of and Social Cohesion.*** This paper explores the meaning of shared values of health and social cohesion while citing literature that defines how these two elements work together to promote health, how they are manifest in the community, and why they are important in building a culture of health. Based on the working session, *Values and Social Cohesion: Major Trends in Societal and Individual Awareness of Health and Well-Being* guided by Timothy Brewer, MD, MPH, UCLA, vice provost of Cross Campus and Interdisciplinary Affairs, the topics in this paper provide examples of how specific strategies can be used for increasing the connections between values, social cohesion and a universal culture of health. Social cohesion is discussed as an integrating factor that spans community engagement, social inclusion, collective action, policy and advocacy. It also examines the importance of consideration of cultural preferences and how a shared value system must be crafted carefully to avoid exclusion, especially of marginalized populations. The concept of using a multicultural and intercultural approach is presented as a method for uniting individuals, sharing knowledge, and developing strategies; examples from conference participants' experiences are given.

***Multi-Sector Collaboration.*** Within this paper, the nature and benefits of multi-sector collaboration are examined within the context of addressing health inequities to build a successful culture of health. The conference working sessions *Multi-sector Collaboration: Moving all Sectors of a Community toward Policy and Programs that Work*, was guided by David Mayer-Foulkes, PhD, and professor, Centro de Investigacion y

Docencia Economicas (Mexico) elicited rich comments, examples and perspectives that are captured within this paper. Set against the backdrop of the economics of a culture of health, the narrative explores how the US market economy has failed to promote health and implications for future health interventions. Participant comments focused on a culture of health vs a culture of medicine, the role of the community, doctors, government and others to achieve multi-sector collaboration. A few promising programs are also briefly presented for consideration as model programs; they include: A Promise Renewed, CARMEN, Oportunidades Conditional Cash Transfer Program and Programa Sumar. Recommendations are made for future global work on multi-sector collaboration that can inform the RWJF-COH.

**Using Health Equity Data to Inform Policy, Programming.** The selection of appropriate methods and metrics to measure and track health equity is an essential strategy for the RWJ-COH. This paper presents selected experiences from Latin America in collecting and utilizing health equity data to inform policy decisions. The centrality of equity in defining and achieving a culture of health is discussed along with how the multi-dimensional nature of health equity requires *a priori* decisions about which dimensions of equity are most important to the specific clinical, research or policy context. Conference participants of the working session, *Putting Data in the Driver's Seat to Steer Policy and Systems to Promote High-Quality, Equitable Health*, facilitated by Steven Wallace, PhD, chair, Department of Community Health Sciences, UCLA Fielding School of Public Health provide experiences from Latin America and international communities to illuminate lessons on measuring and ameliorating health inequity. Several other themes emerged from conference discussions and include: the use of instruments to establish baseline goals for health equity; evidence-based social change; examining health indicators, defining and understanding health equity; Convincing communities that health matters; and community approaches to utilize data. This paper also highlights persistent knowledge gaps and presents recommendations to develop and select measurements of health equity and quality relevant to the RWJF-COH.

### **Summary of Recommendations**

Within the three papers, the UCLA Blum Center recommends that RWJF consider several research efforts that would provide the RWJF-COH model with data, results-based strategies, and approaches to policy and program development. Research is needed to:

- learn more about the challenges and opportunities in translating equity data into real-world clinical or policy decisions;
- gain knowledge about the selection of metrics or their pairing with specific health challenges;
- test health equity measures to inform policy decisions;
- examine and test programs that reduce poverty and/or health inequities (e.g., conditional cash transfer programs)
- design initiatives to address diet, nutrition and food insecurity through multi-sector collaborations
- explore global policies aimed at fostering social cohesion;
- assess the effects of international migration.

These concepts are further explored in a forthcoming document: *Recommendations for Immediate Research Needed to Inform the RWJF-COH*. The UCLA Blum Center welcomes a conversation with the RWJF to advance these concepts in preparation for the development of a comprehensive proposal.



***Shared Values of Health  
and Social Cohesion Considerations  
for the Robert Wood Johnson Foundation's  
Culture of Health Initiative***

Michael Rodríguez, MD MPH

Kenneth G. Wells, MD, MPH

Jennifer Binstock, MPP

Timothy Brewer, MD, MPH

Anne M. Dubois, BA

Brandon Stark, BS

September, 2014

## Shared Values of Health and Social Cohesion: Considerations for the RWJF Culture of Health Initiative

### Abstract

The objective of this paper is to summarize and analyze proceedings of the Second Annual UCLA Blum Center Conference on Poverty and Health in Latin America – *Connecting International Partners to Strengthen Health Systems and Respond to Health Inequities*. Specifically, this paper discusses feedback from conference participants of the working session on *Values and Social Cohesion: Major Trends in Societal and Individual Awareness of Health and Well-Being*. In this paper, we focus participant experiences in Latin American and global programming as it relates to the Robert Wood Johnson Foundation’s Culture of Health Initiative (RWJF-COH). First, a background on the principles of shared values of health and social cohesion is presented. Second, we provide a summary of participants’ international perspectives and examples of international programs addressing shared values of health and social cohesion approaches. Third, we identify international programs that have emerged as promising models for consideration in advancing a culture of health. Finally, we provide recommendations for future research to inform shared values of health and social cohesion strategies to support the RWJF-COH.

From the UCLA Blum Center on Poverty and Health in Latin American (MAR, KGW, JB, TB, BS, AMD); UCLA David Geffen School of Medicine (MAR, KGW); UCLA Cross Campus and Interdisciplinary Affairs (TB).

## Introduction

The United States lags behind other high-income countries in life expectancy and other health outcomes while facing the persistent challenge of inequities in health among US subpopulations. Health inequities are due to the unequal distribution of a wide range of social determinants of health, often referred to as factors related to where we are born, grow up, live, go to school, and work. In that health inequities are strongly influenced by the actions of governments, stakeholders, individuals and communities, they are preventable. Action to reduce health inequities requires addressing the factors that cause the inequities, especially as they occur in subpopulations of a society. Many of these factors can be prevented or changed through public policy and programming. To address these factors, the RWJF has rolled out the Culture of Health Initiative, which is grounded partly in the principles of shared values of health and social cohesion, to promote the health of **everyone** across the nation, regardless of socioeconomic status or ethnic background.

In Latin America and elsewhere, the concepts of shared values of health and social cohesion have been advanced (e.g., social medicine) and applied to promote health through approaches that address social conditions. This paper focuses on some of these successes as reported by participants of the Second Annual UCLA Blum Center Conference held in May 2014 as well as exemplars demonstrated in the literature. The conference explored international perspectives, with a focus on Latin America, and efforts to promote health as they might apply to the RWJF Culture of Health Initiative (RWJF-COH). A plenary session, *Advancing Stakeholder Engagement: Innovative Approaches for Cross-Disciplinary Collaborations to Advance a Culture of Health* was moderated by Alonzo Plough, PhD, MPH and included three experts in international health programming: Maryam Farzanegan, PhD (UNICEF), David Mayer, PhD (CIDE-Mexico) and Gisele Almeida, DrPH, MSc (PAHO). A subsequent working session, *Values and Social Cohesion: Major Trends in Societal and Individual Awareness of Health and Well-Being* complemented the plenary session and elicited comments from international participants guided in discussion by Timothy Brewer, MD, MPH, UCLA vice provost of Cross Campus and Interdisciplinary Affairs. In the sense that the conference played a pivotal role in bringing together leaders and stakeholders from many Latin American countries to build solidarity around the issues of health disparities, shared values of health and other concepts, one could argue that the conference, in itself, was a social cohesion intervention.

This report seeks to further inform the RWJF-COH and provides a recap of these conference discussions. It begins with a brief review of the role of shared values of health and social cohesion in advancing a culture of health. We then summarize the conference proceedings, provide insights gained from participant feedback, and share their implications for the RWJF-COH. A few promising programs are briefly presented that may serve as models for consideration. Finally, recommendations are made for how future global research on shared values of health and social cohesion can inform the RWJF-COH.

## **I. Shared Values of Health and Social Cohesion in the Context of a Culture of Health**

Shared values of health, for the purpose of this paper, means health is placed as a fundamental, core social value that unites the individual, families, communities, and society at-large. Health, in this context, refers to the WHO definition (an active state of health and not just the absence of disease)<sup>1</sup> and includes opportunities for health in terms of the physical and social environment, as well as preventative and lifestyle factors (e.g., eating well, exercising, etc.) and creating healthy family environments. Valuing health in this broader sense can be a driver for a range of individual and collective actions, such as: voting for policies that would improve health; considering a neighborhood's healthy living conditions when home-buying; or regularly seeking out and using information on prevention and treatment. Further, valuing health from a community or societal perspective also refers to the concept of maintaining an awareness of, and concern for, the fair distribution of health outcomes and variables that affect health across the population, including a fundamental concern for health equity/inequity and a concern for one's self/family/neighborhood.

Social cohesion is a community's development of shared values and goals based on a sense of trust and the hopes of all individuals within the community. Social cohesion could be considered as an integrating factor that spans community engagement, social inclusion, collective action, policy and advocacy. Various definitions of social cohesion include the concepts of social capital and collective efficacy.<sup>2,3</sup> Literature documents that social cohesion manifests in several ways (e.g., stronger social networks exist, neighbors trust neighbors, communities work in a trusted way with government, communities build resilience and solidarity) and is an important part of promoting health, which, in turn, can result in increased volunteerism in, and the health of, neighborhood groups.<sup>4</sup>

Scholars of social cohesion have identified it as a concept used in various academic fields where it encompasses a range of definitions consistent with diverse perspectives on what generates well-being and innovation.<sup>5</sup> Social cohesion is influenced by various factors including globalization, diversity and community characteristics. Actors that typically facilitate improved social cohesion include civil society, workers, employers, families, as well as economic and social policies that invest in children, jobs, neighborhoods, local partnerships, etc. Social cohesion is also typically linked with health and economic outcomes.<sup>6</sup> Frequently, the literature views social cohesion as comprising social networks and social capital, defined as community resiliency and interrelated trust, cooperation and coordination that is a foundation of innovation and well-being.

In addition to the academic fields, the concept of social cohesion is actively operating in policy communities by framing complex policy issues.<sup>7</sup> Literature demonstrates a strong association between social cohesion and a range of social and economic outcomes<sup>6</sup> but also reports that the connection between economic intervention and social development is not strong enough to fix the economy without also intervening on social cohesion.

The topics presented in this paper provide examples of how specific strategies and metrics can be used to increase the connections between valuing health, social cohesion and economic outcomes. We focus on Latin American and other global model policies and programs that are promoting health equity by incorporating a framework for valuing health and social cohesion into programming.

## **II. Summary of Conference Proceedings on Valuing Health and Social Cohesion**

Many of the discussions held during the conference working session on valuing health and social cohesion echoed some of the fundamental roots of Latin American social medicine during the 1930s, inspired by Virchow<sup>8</sup> and championed by Salvador Allende, late president of Chile and a pathologist. Allende advanced a model of illness as a disturbance of the individual fostered by social conditions of underdevelopment.<sup>9</sup> He was the first in Latin America to report on the association between tuberculosis and poverty, as well as the relationship between housing density and infectious diseases. He advocated social, rather than medical, solutions to health problems. With this perspective and that of other Latin American models of health care delivery and access, those at the conference commented on their



experiences and approaches to reducing health inequities and the importance of valuing health and social cohesion to reap higher levels of population-wide health.

**a. PLENARY SESSION 2: *Advancing Stakeholder Engagement: Innovative Approaches for Cross-Disciplinary Collaboration to Advance a Culture of Health***

On the first day of the Second Annual UCLA Blum Spring Conference, panelists in Plenary Session 2 explored the main pillars of the RWJF-COH. The discussion largely revolved around the acknowledgment that culture, values and community play a vital role in health, across a range of principles and institutional approaches. Panelists agreed that a values-based approach that utilizes social cohesion strategies to achieve health outcomes is dependent upon the establishment of both a universal and inclusive definition of health, as well as shared goals for outcomes.

The plenary session emphasized the importance of multi-sector collaborations to solve health problems, and participants stressed that these types of collaborations must be built upon shared values. For example, the Pan American Health Organization (PAHO) has successfully brought together their 35 member states to identify priority values for PAHO's work, including but not limited to: equity, excellence, solidarity, respect, and integrity. The significance of these values was described as imperative to driving not only the work and agreed-upon goals of the member states but also the collaborations between them. The importance of trust, relationship building, and shared goal setting should be priorities in establishing shared vision among all stakeholders. Communities must also look at health challenges by acknowledging shared health problems and moving beyond political boundaries. Improving health problems requires addressing society and its range of social issues; an analysis of social issues is the key to unlocking strategies for preventative care.

During the audience discussion, one participant raised the topic of diversity and multicultural populations in the United States as a barrier to building social cohesion. Citing Los Angeles as an example of a large region with race, ethnicity, gender, and socioeconomic inequities, challenges in promoting the idea that "we are all in this together" may be difficult, given that so many parts of a population experience marginalization and share different sets of values from one another. Educational tools and communication strategies were identified as potential strategies for building cohesion.

Another thought emerging from the plenary session included the diversity of multicultural populations, which has previously been identified as a potential threat to social stability and achieving social cohesion.<sup>10</sup> Ethnic or racial exclusion affects many in Latin America, including more than 40 million indigenous people and 150 million people of African descent, who are overrepresented among the very poor. Because all societies experience inequities among social variables (e.g., socioeconomically, spanning from extreme poverty to extreme wealth), social cohesion can be put at risk. Given that diversity and disparities exist, the questions become: 1) what are strategies that build a culture of health, how must these strategies consider distributional concerns, and what resources and policies put these strategies into action? and 2) how do you build on strengths of diversity within and across groups?

**b. WORKING SESSION 1A: *Shared Values of Health and Social Cohesion: Major Trends in Societal and Individual Awareness of Health and Well-Being***

An engaging conversation about shared values of health and social cohesion took place during this working session and centered on the themes of: 1) a culture of health vs. multicultural vision of health; 2) what builds social cohesion; and 3) merging different cultural approaches and perceptions of health.

**1. A Culture of Health vs. Multi-Cultural Vision of Health**

One of the richest conversations of this session was around the challenges perceived in building a cohesive and universal culture of health. Participants explored the meaning of health and recognized that differences in backgrounds, training, experience, social position, and cultural values all influence health values. Participants discussed the idea that, because incentives and outcomes are not universal, any culture of health vision must address variation in groups. Ultimately, participants agreed on the importance that all strategies to achieve a culture of health must be derived from a range of perspectives that come from the greater population and that achieve a mutually acceptable agenda. A few participant ideas and examples to support an inclusive culture of health follow.

- ***Considering Cultural Preferences, from Ecuadorian participant***

Because the Ecuadorian culture has a unique perception of health, communities are less likely to embrace health institutions and/or programs and more likely to view treatment through the lens of their belief that well-being is based on an equilibrium with nature, people, and oneself.

For example, an indigenous individual is uncomfortable navigating personal questions during a

doctor's visit and as a result holds an overall dislike for hospitals. Many questions from the provider, in the view of the indigenous individual, imply that a treatment specialist lacks understanding and intuition of their ailment and experience. Instead, their preference is to visit the shaman who refrains from asking questions during treatment, with the implication being that the shaman intuitively senses their imbalance and illness.

- ***A Multi-Culture of Health, from UCLA faculty member and other participants***

Some concern was expressed that achieving a culture of health, if executed poorly (e.g., the colonial value system of spreading shared values) could act as an oppressive paradigm. While cohesion can be achieved if the act of spreading values is meaningful and sensitively adapted to local cultures, the promotion of a shared value system can exclude others. Participants recommended that RWJF explore a more explicitly multicultural approach to defining culture and shared values of health. As an example, Ecuadorian participants cited the success of the transformation of their nation's constitution in 2008. The new constitution defines Ecuador as a multi-national country and explicitly recognizes the rights and voice of the Indigenous Peoples, who are now consulted when considering projects that affect their territory, livelihood and collective rights. Since this new constitution has been in effect, Ecuador has made progress, including a substantial decrease in the percentage of the population who consider income distribution to be unfair or very unfair, from approximately 88% in 2002 to 55% in 2011.<sup>11</sup>

## ***2. What Builds Cohesion?***

Another theme that emerged from Working Session 1A was the importance of identifying what contributes to social cohesion and building strategies that facilitate greater cohesion between groups that will result in shared health values and actions. Relationships were considered highly important for building shared trust and understanding across cultural backgrounds and perspectives. Strategies that promote social cohesion should be prioritized as they facilitate health promotion.

To build social cohesion, participants discussed using both a multicultural and intercultural approach. One participant shared the idea that while much variation exists within multicultural communities, the idea of an "intercultural vision" could provide a space for uniting individuals, sharing knowledge, developing shared strategies, and ultimately leveraging both a multicultural and an intercultural

approach. Language, both in the literal and cultural sense, cultural traditions, longevity and a commitment to a community were also cited as critical for building cohesion. Issues of mistrust and cultural insensitivity were cited as emerging from community perceptions that nonlocal health professionals are not truly invested in long-term strategies to improve health locally. Turning to community leaders, incorporating their wisdom, and involving them in long-term planning not only creates cohesion in the short-term but institutionalizes improved health outcomes in the long-term.

### **3. Merging Cultural Approaches and Perceptions of Health**

Participants shared insights and examples of strategies that achieve cohesion and support improved health outcomes. Examples include:

- ***Integrating Indigenous Values into Health Systems***

This example was cited by a participant who works with an NGO to build health programs throughout Latin America. El Salvador and Nicaragua met success from their approaches to bring midwives into hospitals to help with birthing procedures, and also by inviting shamans to visit clinics so that they may be included in helping to shape treatment plans. By integrating indigenous values and stakeholders into health systems, programs achieved greater patient comfort while improving sanitation and health outcomes.

- ***Conducting Community Appraisals***

One participant spoke to the value of conducting community appraisals with representatives from all populations in order to build relationships, facilitate inclusive planning, and set shared priorities and goals.

- ***Framing: We Are All in this Together***

RWJF-COH's framework built on the sentiment, "we are all in this together," may be best applied on a small scale, as it speaks to the importance of personal connections and relationships in providing care. On a more complicated macro scale, this sentiment potentially fails to address issues of inequality and cultural differences in many ways. It is important to understand the varying attitudes, approaches, and understanding behind the statement "we are all in this together" as it applies to different-sized populations in varying settings.

### III. Recommendations for Further Research on Shared Values of Health and Social Cohesion

#### Approaches

The persistent health inequities and related failures of public institutions, the market or civil society to promote a healthy society for **all** is at the root of reflections on social cohesion. Major current issues including poverty, ageing, restructuring health care systems, food insecurity and uneven development can only be addressed by a broad collaboration involving policy makers, communities, and academia among others. Policies aimed at fostering social cohesion are a major concern in Latin America, Europe, and the United States. The current global economic crisis and emerging health problems (e.g., Ebola outbreak) provide a backdrop and opportunity to target strategies to promote social cohesion and other approaches to improve global health (e.g., accountable care systems, health financing systems, patient engagement, cultural dynamics that foster innovation in global care).<sup>12</sup> These economic and health problems not only affect the health of populations but also have an impact on labor markets, migration, gender and family relations as well as consumption of services. At the same time, we are facing increased urbanization, which focuses additional attention to cities. Within this framework and specific to social cohesion and shared values of health, the UCLA Blum Center recommends further study in the following areas:

- a. ***Measuring and Operationalizing Social Cohesion.*** Social cohesion is a powerful concept with a deep literature base and the potential of high utility in the policy arena. Because of this, measurement is critical to operationalize social cohesion and understand its effects and causes. Social cohesion can be defined in terms of patterns of distribution that consider measures of inclusion-exclusion; others define social cohesion in terms of social bonds and rates of participation, membership and trust, as well as a characterization of social networks. Research is needed to study how different countries have developed measures, decided which definitions and metrics to use, and operationalized these definitions and metrics in practice. This research might involve two components: one that identifies measures and one that develops an understanding of what relationships exist between measures and health outcomes, social determinants of health, and/or changes in health and health disparities.
  
- b. ***Evaluation of Policies on Social Cohesion.*** Social cohesion is not universally embraced as a key societal goal and its utility is often challenged by those who do not prioritize investments in

collective well-being. Unfortunately, the decision to invest in social cohesion is as influenced by political leanings and goals as much as it is by scientific evidence. Research is needed to: 1) analyze how and why social cohesion policies have evolved; 2) determine successful strategies for engaging vulnerable communities that increase their involvement and participation; and, 3) understand what cultural, social, and political factors contribute to the prioritization (or lack thereof) of social cohesion strategies in policy.<sup>13</sup>

- c. **Achieving Cohesive Societies.** Despite progress, a long road lies ahead if more cohesive societies are to be achieved. Research in the operational arena includes assessing how to move from good design to good implementation, improve and expand evaluation, and strengthen and shore up institutional capacity. Research in these areas would result in a roadmap to achieving improved and sustained institutional capacity.
- d. **Overcoming urban fragmentations.** Study is needed to identify different styles of participation, and community initiatives that are emerging to overcome urban fragmentation. This research would answer the questions: 1) How do processes of collective action and modes of governance respond to promote social cohesion? and 2) How can society overcome social isolation and lack of structural cohesion in rural areas?
- e. **Bridging the Gap between Research and Policy Development.** Research in this area would examine how to implement the intent of policies to address social cohesion and diversity. It would identify how Latin American nations have diverse policies regarding disparities, health services provision, health insurance coverage, and social inclusion? It would build on variations in policies, social cohesion and health infrastructure across Latin American nations and US communities. Results would include best practices and practical steps for policy makers and community stakeholders.
- f. **Assessing Effects of International Migration.** Comparative research is needed to assess the increasing social and ethnic diversity introduced through international migrations between countries. This movement may be a cause for new forms of segregation, lack of social cohesion and social divide, from which new forms of integration may arise. Research questions that need

to be answered include: 1) How does international migration affect social cohesion, both for the migrating groups and for the broader communities? and 2) How deeply are immigration/migration issues featured in health policies, health disparities, and social cohesion?

#### IV. Conclusion

In sum, several successful programs and strategies based on shared values of health and social cohesion have emerged from Latin America and other regions of the world. The UCLA Blum Center on Poverty and Health in Latin America is in a unique position to conduct further research into promising programs and approaches that would inform initiatives within the RWJF-COH. We propose further study to answer the following research questions: 1) What lessons can be learned from examining the variation in policies to promote social cohesion in different countries? 2) How have policies to promote social cohesion systematically been evaluated to understand their contributions to outcomes related to social cohesion, health and health equity? 3) What are the challenges in implementing policies focused on social cohesion? 4) How does migration affect social cohesion and how are immigration/migration issues featured in health policies, health disparities and social cohesion?

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***Effective Multi-sector Collaborations and the Need  
for Further Research to Promote Equity and to Inform  
the Robert Wood Johnson Foundation's  
Culture of Health Action Model***

David Mayer-Foulkes, PhD  
Michael A. Rodríguez, MD, MPH  
Brian Cole, DrPH  
Anne M. Dubois, BA  
Maryam Farzanegan, PhD  
Stephania Olamendi, BS

September, 2014

## Effective Multi-sector Collaborations and the Need for Further Research to Promote Equity and Inform the RWJF Culture of Health Initiative

### Abstract

The objective of this paper is to summarize and analyze proceedings of the Second Annual UCLA Blum Center Conference on Poverty and Health in Latin America – *Connecting International Partners to Strengthen Health Systems and Respond to Health Inequities*. We present feedback from conference participants in the working session on *Multi-sector Collaboration: Moving all Sectors of a Community toward Policy and Programs that Work*. In summarizing the proceedings, we focus particularly on discussions related to the Robert Wood Johnson Foundation’s Culture of Health Initiative. The discussion presented here begins with a brief synopsis of the driving forces creating health inequities, including market-based economic forces. Second, we provide a summary of participants’ perspectives and examples of international programs employing multi-sector collaborative approaches. Third, we identify four international programs that have emerged as promising models for consideration in advancing a culture of health. Finally, we provide recommendations for future research to inform multi-sector collaborative strategies to support the RWJF Culture of Health Initiative.

From the UCLA Blum Center on Poverty and Health in Latin American (DMF, MAR, BC, AMD, MF, SO); UCLA David Geffen School of Medicine (MAR); Centro de Investigación y Docencia Economicas, Mexico (DMF); USC Keck School of Medicine (MF); UCLA Fielding School of Public Health (BC).

## **I. Introduction**

In the last few decades, countries both within and outside the United States have made a continuous effort to address inequities in health and other dimensions of wellbeing. International experiences can provide useful insights for their possible application in the United States and can inform methods for working constructively with the limitations of market-based policies.

The Second Annual UCLA Blum Center Spring Conference, held on the UCLA campus during May 6-7, 2014, featured several sessions that explored international, especially Latin American, perspectives on health promotion and reducing health disparities. Throughout the conference, themes important to the RWJF Culture of Health Initiative (RWJF-COH) were raised repeatedly. A working session, *Multi-sector Collaboration: Moving all Sectors of a Community toward Policy and Programs that Work*, complemented a general session *Advancing Stakeholder Engagement: Innovative Approaches for Cross Disciplinary Collaborations to Advance a Culture of Health*. The working session elicited comments from 40 international participants guided in discussion by David Mayer-Foulkes, PhD, professor of economics, Centro de Investigación y Docencia Economicas, Mexico.

This report synthesizes these conference discussions and draws out important lessons with the aim of further informing the RWJF-COH Initiative with conference attendees' perspectives rooted in research and practice. It begins with a brief review of the role of the economics of health and the market economy in advancing a culture of health with an emphasis on health equity. The report summarizes the conference proceedings, provide insights gained from participant feedback, and share their implications for the RWJF-COH. A few promising programs are briefly presented which may serve as models for consideration. Finally, recommendations are made for future global work on multi-sector collaboration that can inform the RWJF-COH Initiative.

## **II. Economics of a Culture of Health**

How does a culture of health develop in a market economy? Participants in the UCLA Blum Center Spring Conference Working Session discussed this important question for the RWJF-COH Initiative. This question is important because a market economy, complemented by democratic governance, is the context within which the RWJF-COH plan of action will be implemented. It also shapes the landscape for developing multi-sector collaborative approaches. The current successes in U.S. health care are, to a great extent, due to the ability of the market economy and its players to coordinate the preferences and

actions of millions of individuals.<sup>1</sup> On the other hand, this context has also given rise to many of the current inequities in health, which are not sufficiently remedied by current law or by other public or community action.<sup>2,3</sup> The RWJF-COH Initiative seeks to address these inequities.

The RWJF-COH model can be understood as an initiative to address the failure of the U.S. market economy to organize actors to promote health. Health interventions designed specifically to address these failures may contribute to larger efforts to construct a more equitable and democratic society. When the provision of goods and services is well-coordinated by market interactions, these interactions proceed smoothly. In contrast, market forces are less effective at assuring a broad equitable distribution of other goods and services, such as health care and many other health-promoting services. Remedying market failures for health care and other health-promoting services requires substantial effort and additional resources. Enhanced multi-sector coordination for promoting the public's health, a major emphasis of the RWJF-COH Initiative, can help assure that sufficient resources are brought to bear in efforts to remedy these market failures.

Equity and efficiency are central elements of at least four of the 10 principles forming the foundation of the RWJF-COH vision for the nation's health and health care systems:

- Optimal health and wellbeing flourishes across geographic, demographic and social sectors;
- Everyone has access to affordable, high-quality health care;
- No one is excluded; and
- The economy is less burdened by excessive health care spending.

The RWJF-COH Initiative is driven by the recognition that current conditions fall unacceptably short of the ideals expressed in this vision. While this may be partly based on high transaction costs (e.g., full geographical coverage is not being achieved), a better explanation may be that improved levels of coordination are necessary. Why has the market mechanism failed to provide the goods expressed by these principles in the past, when, in fact, we believe that these objectives are feasible?

One explanation is found by examining the welfare theorems of economics, which combine the static or dynamic elements that are brought together in market exchange and suggest the type of optimality that can be reached under specific conditions. For example, while individuals may value collective wellbeing and equity, it can be difficult to express these preferences for collective goods when purchasing private goods. The promotion of collective values benefits from policies and actions to reshape market interaction (e.g., empowering a community to purchase for their collectivity or investing in improving

the conditions in the community in which people live, learn, work, and play). Secondly, welfare theorems assume that competition is strong enough to drive profits to zero. However, where there are profits, it is well-known in economics that inequity and inefficiency result. Finally, welfare theorems show that market interaction does not directly reduce or increase equity. The reasons behind inequity must be understood and solved in actions to address the inadequate distribution of resources, the promotion of collective values and the development of a market place with institutions and players that fosters equitable health for all.

### **III. Summary of Conference Proceedings on Multi-Sector Collaborations**

Discussions during the conference working session on multi-sector collaborations emphasized health deficiencies that the RWJF-COH seeks to address, such as approaches to reducing health inequities and improving multi-sector coordination and health prevention that are necessary for achieving new levels of population-wide health. Several programs, including those driven by low incomes and diminished access to health care, have been applied in Latin America and are further explored in this section.

#### **Participant Suggestions for Consideration in Advancing the Culture of Health Initiative**

Multi-sector collaboration is a strategy that has been used for addressing non-communicable diseases (NCDs). For example, review of the World Health Organization's (WHO) Global Action Plan for the Prevention and Control of NCDs, including its Global Strategy on Diet, Physical Activity and Health and several other advances and different strategies being implemented across countries can inform the RWJF-COH exploration of multi-sector experiences and strategies employed in Latin America. The following efforts, gleaned from working session participants, illustrate alternative ways to provide public goods that do not require government (or, solely government) involvement and that supplement what typical market interaction can achieve.

##### **a. Solicit endorsement by national spokesperson; Emphasize individual responsibility**

One example cited by participants was the national program implemented when Central America was swept by a dengue epidemic in 2013. Participants emphasized lessons learned from this experience, one of whose central element was the elimination of puddles and other water accumulations where the disease vector could reproduce. Two critical elements were cited for the success of the program: 1) with the participation of the each nation's president, the program was brought into the national

consciousness as a national priority; and 2) the emphasis on individual responsibility, even in the presence of a national program, taught individuals that it was their responsibility to keep their living areas and communities free from the dengue vector.

#### **b. Culture of health vs. culture of medicine**

While a culture of health is clearly meant as a wider concept than a culture of medicine, medicine itself plays a very strong role in modern culture. For example, participants from Guatemala discussed how nutritional guidelines for children are marketed as a prescription treatment, therefore strengthening them in public perception. This approach points to the potential benefit for the RWJF-COH Initiative to have both a medical and a preventive focus to address the social as well as the physical determinants of health. A new culture of health could thus be promoted by a shift from a narrow culture of clinical medicine to a culture that includes social determinants of health and prevention.

#### **c. The role of community**

An important component of a culture of health is education. For example, conference participants reported that many parents around the world do not know what the best nutritional diet is for their children. Participants discussed community approaches to change this. They emphasized that these approaches must be tailored both to the existing governmental culture as well as to those actors and variables acting outside government that collectively make up the political environment for health promotion within a country. National plans with different components and interdisciplinary collaboration with other organizations beyond the health agencies are needed. The private sector must actively participate to illustrate that health is not just at an individual level but also at a collective community level. The private sector, particularly small enterprises, could be incentivized to bear the cost of collaboration by seeing such collaboration as a donation or even investment in the health of their current and future workforce and potential clients.

Participants looking at a sexual health program from Costa Rica that emphasizes individual responsibility on two levels. While individual approaches can play a key role (e.g., education on the use of condoms), individuals should recognize the implications of their personal choices for the community. That is, how does your choice of whether or not to wear a condom impact the community?

#### **d. Elements of a change of culture within a community**

How do you measure a change in culture within a community? Some of the working session discussion addressed a need to shift how we think about communities. Are they really “vulnerable”? Do they really need “empowerment”? Communities may have high levels human capital, but lack other resources due to skewed distributions of income, access and opportunities. Strength within a community should come not only from the academic setting or private sector but from within the community. One example cited was the *Promotoras* approach in which lay community members receive specialized training to provide basic health education in the community. Social and traditional media can also be used to strengthen the community and promote health and healthy behaviors.

For change to occur, all sectors of the community must be accountable for community health outcomes: government, NGOs, grassroots community organizations, individuals, and the private sector. From the private sector, financial support is necessary but, by far, the most important component is the alignment of the business practice of the corporation with a health initiative. Two examples cited of this practice were: 1) Coca Cola’s diabetes check-up program; and 2) the Disney Corporation’s efforts to reduce sodium and sugar content in all products displaying their logo and characters.

**e. The role of doctors’ training in promoting prevention and community participation**

Medical training programs in the United States could learn from the approach used by medical schools in Mexico and other countries where, as part of the medical school and residency training, students must dedicate one to two years on prevention education and primary care within their community. After this service, students can choose to specialize in a particular field of medicine; however, the emphasis on primary care, along with residents’ experience in primary care, results in a strong primary care practice in many Latin American nations.

**IV. Promising Multi-Sector Collaborative Efforts**

Several other multi-sector collaborative models were discussed as either the main focus of general sessions or were referred to by participants of the general sessions. The common elements of multi-sector collaboration, as discussed at the conference and elsewhere in the literature, are both enablers and barriers. These elements of multi-sector collaboration include: 1) shared vision and commitment; 2) leadership; 3) resources (financial, organizational and human); 4) structure; and 5) process.<sup>4,5</sup> Three programs that appear to be reaching population-level success in international communities by

positioning these elements as enablers are presented below.

#### **a. A Promise Renewed**

*A Promise Renewed* is a global, multi-sector collaborative initiative to end preventable child and maternal deaths. When the Millennium Development Goal to reduce the under-five mortality rate to two-thirds between 1990 and 2015 was in jeopardy, UNICEF and partners intensified their efforts. It was projected that the world would not meet the goals until 2028, resulting in a loss of an estimated 35 million children. In response, *A Promise Renewed* was launched in 2012 and mobilized 176 governments, civil society groups, private sector and international organizations. Its five priority actions included: 1) geographical prioritization that concentrates resources on countries and regions with the most child deaths; 2) increased efforts among high burden populations; 3) a focus on high impact solutions; 4) gender equality; and 5) mutual accountability. The initiative supports collective action within participating nations on three fronts: evidence-based national plans; transparency and mutual accountability; and global communication and social mobilization. In September 2013, 26 Ministers of Health from Latin America and the Caribbean Region with seven international partners signed the *Declaration of Panama* and pledged to end preventable child and maternal deaths by 2035; the partners committed to: 1) scale-up evidence-based interventions through national plans and strategies; 2) promote universal health coverage; 3) build regional cooperation and strategic alliances; 4) mobilize political leadership; and, 5) develop a roadmap to monitor milestones and identify gaps. Monitoring for equity is a critical component of this initiative. Lessons learned and methods for addressing shortfalls should be further explored to inform the RWJF-COH.

#### **b. CARMEN Initiative: *Conjunto de Acciones para la Reducción Multifactorial de Enfermedades No Transmisibles (Set of Actions for the Multisectoral Reduction of Noncommunicable Disease)*<sup>6,7</sup>**

The CARMEN Initiative is a multinational network of Latin American countries and institutions that promote collaborative strategies to decrease the prevalence of non-communicable diseases (NCD) in Latin America and the Caribbean. This initiative evolved from the 1990s European program CINDI (Countrywide Integrated Non-communicable Disease Interventions) and was tailored to a Latin American framework. It promotes the development of long-term partnerships to address the health needs of communities throughout Latin America. When implemented in 1997, this initiative endorsed a public health approach that engaged the social, private, and government sectors to prioritize



preventative strategies rather than treatment for NCDs. To ensure the sustainability of these collaborative multi-sector partnerships, CARMEN emphasizes the analysis and evaluations of initiatives for complementary policy implementation at a national level. This innovative multi-sector collaborative initiative demonstrates successful implementation of strategies to improve the health of communities.

One example of a nation-specific program within CARMEN is Brazil's *Observatory Chronic Non-Communicable Disease – National Food and Nutrition Policy (PNAN), 1999-2005*. This program emphasized the constitutional principle of “food as a basic human right.” The collaboration of the Ministries of Health, Planning, Social Development and Hunger Eradication, Education and others, encouraged an elevated degree of stakeholder convergence that facilitated the process of inter-sector policy development.

#### **c. Oportunidades Conditional Cash Transfer Program<sup>8</sup>**

The goal of this conditional cash transfer program is to support and improve the wellbeing of rural and urban populations in extreme poverty. Founded in Mexico in 2002, this program invests in human capital by engaging three main sectors: education, health and social development. The collaborative approach of this program has succeeded in improving the health of Mexicans on a number of fronts, most notably in the area of child development: decreasing the prevalence of childhood anemia; improving physical growth; and improving cognitive, language and socio-emotional development. By addressing the childhood determinants of health, this multi-sector program has strengthened the development of the next generation of adults.

#### **d. Programa Sumar<sup>9</sup>**

The results-based financing strategy of *Programa Sumar* (also known as *Plan Nacer*) aims at improving the health coverage of people without formal health insurance in Argentina. This initiative began in 2005 by strengthening health care access for pregnant women and children. It was later expanded to include women up to aged 64 years and men up to aged 19 years. It is projected to include all adults up to aged 64 years by 2016. The program is built on partnerships between the government and the health sector to resolve major concerns concerning health trends such as late pregnancy care and neonatal mortality. In these two areas alone, results are proving the strategies successful. For example, among *Plan Nacer* participants, more pregnant women are enrolled in pregnancy care than those without formal health coverage (64.5% vs 57.1%, respectively).<sup>10</sup> Neonatal mortality rate for newborns of mothers in *Plan Nacer* was 74%

less than those without the plan.<sup>10</sup> Drawing on resources from other sectors, this collaborative approach is leading to improvements in health care access and health outcomes for thousands of Argentinians.

## **V. Recommendations for Further Research on Multi-sector Approaches**

In addition to the promising programs cited above, conference participants cited other programs that can provide models for consideration. The programs call upon multiple sectors of a community for their success. Researching the development of the programs, the approaches and evaluation information would assist in refining approaches that could be applicable to and/or implemented more broadly in the United States.

### **a. Conditional Cash Transfer Programs**

Conditional cash transfer (CCT) programs aim to reduce poverty – or health inequities – by giving cash to individuals and households on condition that recipients continue to meet specified terms or milestones. These programs, well known in countries beyond the United States and featured at the UCLA Blum Center Spring Conference (e.g., Oportunidades above), are typically effective given a high level of trust in the institution delivering the program. Among the health benefits of these programs, they have been shown to raise cognitive development.<sup>11</sup> One application of this kind of program in the United States has been *Opportunity NYC*, a program launched in NYC by former Mayor Bloomberg. The program provided cash payments to families if they kept up with responsibilities and encouraged engagement in three multi-sector areas: education, health and work. Cash payments were linked to specific milestones in these three areas. However, results are not yet clear. Research and descriptive reports on conditional cash transfer programs that could be used as models for RWJF-COH programming in the United States are needed.

### **b. Diet and Nutrition Initiatives**

1. *Salt-Smart Americas*. Policies and guidelines established by the Pan American Health Organization (PAHO)<sup>12</sup> and also published in Legetic and Campbell<sup>13</sup> should be reviewed and considered for adaptation and adoption. This initiative demonstrates how multiple sectors, such as food manufacturers, retailers, governmental institutions and civil society, can be coordinated and mobilized to take action on public health priorities.

2. *A Healthy Diet Initiative for the Americas*. Considerable literature exists on diverse measures to take for implementing healthy diets. Many studies have been conducted on the impact of labeling, taxes and subsidies, consumer information and more. The role of marketing in promoting unwholesome foods is summarized by Mayer-Foulkes.<sup>14,15</sup> PAHO also reports on a meeting on Expert Consultation on the Marketing of Food and Non-alcoholic Beverages to Children in the Americas.<sup>16</sup> In the U.S. supermarkets play a key role for purchasing food and facilitate the majority of market interactions between individuals and food producers. Focusing on supermarkets for achieving healthy diets may offer diverse possibilities to community policy makers. Because supermarkets can negotiate with healthy food producers, the community could offer subsidies for healthy foods. For example, transportation subsidies for healthier food purchases may be important in some geographical areas and could be offered through supermarkets. Also, supermarkets could offer their clients an accounting of the nutrients in their purchases. In turn, this could provide an incentive for food producers to fully label and make the nutritional content of their products electronically available. These efforts could also help community policy makers know what foods are being consumed and for what reasons.

To achieve this, participants recommended that the RWJF-COH Initiative embrace additional research and efforts to establish *A Healthy Diet Initiative for the Americas*, which could also have a component to address food insecurity among the most impoverished. Changing to a healthy diet involves considerable changes in agricultural production and may therefore have macroeconomic and trade impacts. Since there may also be regulatory issues involved, such as taxing unhealthy foods, one way to promote both the scale and the coordination of these changes would be through the proposed initiative. Utilizing the market force of the community (e.g., the supermarket, as discussed above), healthier diets may be achieved. The macroeconomic impact of a change to a healthy diet has already been studied by Thomassin and Mukhopadhyay,<sup>17</sup> using the Global Trade Analysis Project database and has found positive impacts on income. However, additional research is needed to support a proposal to develop *A Healthy Diet Initiative for the Americas*.

## **VI. Conclusion**

In sum, several successful programs and strategies based on multi-sector collaboration have emerged from Latin America and other regions of the world. The UCLA Blum Center on Poverty and Health in Latin America is in a unique position to conduct further research into promising programs and approaches that would inform the RWJF-COH initiative. We prioritize the need for further research as

follows: 1) a feasibility study of conditional cash transfer programs in the US context; 2) effective and efficient methods for developing healthy food initiatives; 3) addressing food insecurities in vulnerable populations through multi-sector collaborative efforts; 4) operational research on multi-sector approaches to effectively promote RWJF-COH among the most under-served and vulnerable groups; and 5) a comprehensive review of the effectiveness and impact of selected multi-sector collaborations in global health to distill relevant, evidence-based lessons to inform the RWJF-COH Initiative.

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***Using Health Equity Data  
to Inform Policy, Programing and Actions  
within a Culture of Health Framework***

Adam Richards, MD, PhD

Michael Rodríguez, MD, MPH

Gisele Almeida, DrPH

Jennifer Binstock, MPP

Anne M. Dubois, BA

Stephania Olamendi BS

Steven Wallace, PhD

September, 2014

## Using Health Equity Data to Inform Policy, Programming and Actions within a Culture of Health Framework

### ABSTRACT

This paper reviews key considerations in the selection of methods and metrics to measure and track health equity that will be most relevant for the national RWJF-led initiative toward a Culture of Health (RWJF-COH). The paper presents selected experiences from Latin America in collecting and utilizing health equity data to inform policy decisions, with an emphasis on topics discussed at the Second Annual UCLA Blum Center Spring Conference (the Conference hereafter). Our discussion provides a brief review of the centrality of equity in defining and achieving a culture of health. Next, we highlight how the multi-dimensional nature of health equity requires *a priori* decisions about which dimensions of equity are most important to the specific clinical, research or policy context. The third section of this paper draws on the experience of Conference participants to illuminate lessons on measuring and ameliorating health inequity from Latin America and international communities. The fourth and final section highlights persistent knowledge gaps and presents recommendations to develop and select measurements of health equity and quality relevant to the RWJF-COH.

From the UCLA Blum Center on Poverty and Health in Latin American (AR,MAR,JB, AMD,SO,SW); UCLA David Geffen School of Medicine (AR, MAR); UCLA Fielding School of Public Health (SW); and the Pan American Health Organization (GA).

## Introduction

The UCLA Blum Center’s Second Annual Spring Conference provided two opportunities for invited speakers and participants to share their experience translating equity measures into policy, and to comment specifically on how equity measures might inform the culture of health. Plenary Session 2 on the first day of the conference was entitled *Advancing Stakeholder Engagement: Innovative Approaches for Cross-Disciplinary Collaboration to Advance a Culture of Health*. The Working Session on day two, facilitated by Steven Wallace, PhD, chair, Department of Community Health Sciences at the UCLA Fielding School of Public Health was entitled *Putting Data in the Driver’s Seat to Steer Policy and Systems to Promote High-Quality, Equitable Health*. This white paper draws primarily from comments made during the Plenary and Working sessions at the Conference and integrates outside material to elaborate key points relevant to shaping a health equity agenda for the Culture of Health.

### I. Introduction: Health Equity – an Essential Factor in Achieving a Culture of Health

A culture of health requires the reduction – and eventual elimination of -- health inequities. Robust health equity measures are key for prioritizing targets, designing interventions, and documenting progress toward the realization of a culture of health. The principles of the RWJF-COH explicitly include equity in its goal for health care (which should be “efficient and equitable” goal #7), and equity is implicitly linked to other aspirational RWJF-COH principles including the principles that “optimal health and wellbeing flourishes *across geographic, demographic, and social sectors*” (goal #1); “opportunities to be healthy and stay healthy are valued and accessible to *everyone across the entire society*” (goal #2) and that “Americans understand that *we are all in this together*” (goal #10, emphasis added). In order to ensure that the benefits of the RWJF-COH extend to everyone in a society, irrespective of social categories, it is necessary to collect information not only on the processes related to the opportunities to be healthy and the outcomes that collectively capture optimal health and wellbeing, but also on how these processes and outcomes are distributed between groups and individuals. Documenting and tracking the distribution of health and its determinants are the sine qua non of health equity measures that are indispensable to the RWJF-COH.

If health equity is integral to a culture of health, then measuring the achievements of the RWJF-COH involves two fundamental challenges: agreement as to what defines health equity, and agreement on the level of its importance relative to other goals. This paper addresses each of these areas.



### **a. Defining health equity**

Some define health equity as “the absence of systematic disparities in health (or its social determinants) between more and less advantaged social groups”<sup>1</sup> and health inequity as “a difference or disparity in health outcomes that is systematic, avoidable, and unjust.”<sup>2</sup> Yet, numerous definitions of health equity have been proposed, partially due to the diversity of approaches to distributive justice.<sup>3</sup> The challenge of defining health equity was addressed by Conference participants who spoke with conviction about:

- whether equity should focus primarily on procedural fairness (i.e., the opportunity to be healthy) or on results (i.e., outcomes);
- whether priority should – or should not – be given to the less well off; and
- who should participate in the decision to define health equity.

Although this diversity of perspective imperils the prospect of achieving consensus on a single definition of health equity, Amartya Sen suggests a strategy and theoretical framework for accommodating differences by focusing on shared opinions. In his book, *The Idea of Justice*,<sup>4</sup> Sen forcefully articulates a theoretical foundation for this approach by providing multiple examples of how people with divergent perspectives of justice can achieve consensus about the relative fairness of specific policy options. As discussed by Conference participants, taking a similar approach to equity within the RWJF-COH model may assist with maximizing synergies and minimizing potentially polarizing differences as diverse communities strive together to measure and achieve health equity.

### **b. Health equity: how should we measure it to achieve a culture of health?**

The centrality of equity to efforts that will build the RWJF-COH movement and track its success holds immediate consequences for the collection and analysis of health data and may require a transformation in our approach to comparative- and cost-effectiveness studies. Comprehensive reviews of health equity methods have illuminated four broad recurring themes to keep in mind when measuring health equity.<sup>5-9</sup> The first is to ask, “*inequity between which groups?*” to select the population of interest and to collect data necessary to document any inequities. For example, despite tremendous recent improvements in overall health status in Latin America, large equity gaps are apparent both between and within countries. Brazil and the United States were cited as particular examples of countries where indigenous communities continue to have disproportionately higher mortality rates than other populations (e.g., indigenous communities in Brazil have a mortality rate that is 1.5% higher

than the general population; Native American communities in South Dakota have a life expectancy of 48 or 49 years old).

A commonly accepted, but far from comprehensive, list of social categories for equity analyses is the PROGRESS framework (place of residence, race/ethnicity, occupation, gender, religion/culture, education, socio-economic status, social capital/networks) and now PROGRESS-PLUS (adding disability, sexual orientation, age, etc.).<sup>10</sup> Being attentive to multiple dimensions of stratification in society is important because of the frequent interaction between them (e.g., race and SES) as well as the fact that one dimension may underlie the dynamics attributed to another (e.g. culture and ethnicity). One particularly promising effort to expand data available for equity analyses in the United States is the current IOM Committee on Capturing Social and Behavioral Domains in Electronic Health Records (EHRs),<sup>11</sup> which will make recommendations on social variables to be included in definitions of “meaningful use” of EHRs. Although the RWJF-COH will likely focus its efforts on ameliorating inequities experienced by disadvantaged groups, it may also be worthwhile to include one or more measures of “total inequality” that describe overall variation in health. While these measures ignore potentially important categories of social group membership, they avoid normative choices about social hierarchy and rank, and they facilitate unambiguous comparisons over time and place.

A second recurring theme in health equity measurement relates to the multi-dimensional nature of health inequity that may require calculating a suite of equity measures to capture the inherent complexity. Because each measure of equity has its benefits and limitations, and the choice of which measure to prioritize is not value-neutral, it is important to specify *a priori* which measure will be most important to a given situation. However, it is also important to acknowledge that it is not possible for a single “summary” measure to provide a comprehensive description of the full scope of health inequities. Selecting inequity measures requires making multiple, normative choices about which dimensions of inequity to prioritize. These dimensions have been reviewed elsewhere<sup>12</sup> and include, for example, which group at what time point will serve as the comparison (baseline) group, and whether and what type of weights to apply (e.g., by size of population or social rank).

A third recurring theme is that health inequity must be measured within the context of overall health achievement, which can be accomplished through quantitative approaches that combine health inequity metrics with measures of overall health.<sup>8, 13</sup> However, as others have described,<sup>9, 12</sup> alternative plausible

scenarios exist that demonstrate how relative measures may be at least as important as measures of absolute health inequity. It is crucial to acknowledge that health equity is a multi-dimensional concept and that equity metrics exist to describe these various dimensions of observed patterns of health in society. Alternative metrics can, in isolation, lead to seemingly discrepant conclusions about whether progress has occurred, and when used in concert can provide a robust assessment of the dimensions of most importance to a specific situation.

A fourth theme centers on the need for qualitative studies to complement quantitative research. Understanding the health experiences and world health views of different populations provides insights into their priorities, the processes that impact their health, and the most effective strategies for promoting health in ways that would improve equity. Qualitative research is also important for promoting social participation in initiatives that seek to understand systematic differences in health and health care and to translate results into policy.<sup>14</sup>

### **c. How important is health equity?**

A casual canvassing of US residents would reveal that most agree that striving for health equity is important; however, few would agree on *how important* it is. As previous authors have noted, the inability to agree on how much weight to give equity concerns may have contributed to the under-utilization of quantitative health equity metrics in research studies and policy circles.<sup>15</sup> For example, Conference participants provided examples from Latin America to illustrate the potential for paralysis and highlighted an opportunity for improved analysis. Many interventions are more costly to deliver to disadvantaged populations, and this creates what is commonly referred to as an equity-efficiency tradeoff that requires making explicit value judgments about the importance of equity relative to overall health. It is possible that even when stakeholders agree that equity holds value and that some part of the overall health intervention budget should be applied to address the inequity (in exchange for slightly smaller impact on health overall), it may be difficult to agree on how many resources to allocate to inequity.<sup>i</sup> The Conference highlighted a potential way to circumvent this challenge by incorporating

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<sup>i</sup> Some interventions avert this potential tension because they are both more progressive (i.e., provide greater benefit to the less well off) and more efficient (more effective and less costly), in which case they would be supported or preferred by equity-naïve analyses that ignored the impact on the distribution of health in society. When interventions are both more progressive and efficient then an equity analysis does not modify the policy decision, but it provides further supportive evidence to promote it – and conducting an equity analysis is the only way to know whether the intervention is in fact more progressive.

alternative valuations of equity into the calculation of health equity metrics. Quantitative approaches exist that allow users to calculate health equity metrics across a range of values for equity itself. One example cited was to calculate the concentration index across a range of values for the equity aversion parameter.<sup>13</sup> This would reflect alternative valuation of equity, analogous to conducting a supplementary “sensitivity analysis” for a comparative- or cost-effectiveness study. In this approach, the inequity aversion parameter varies across a range of values: from 1 (equity is not important, reflecting the utilitarian status quo for most comparative effectiveness research) to 5 or 8 (equity is very important, and health benefits experienced by disadvantaged groups are given much more weight than benefits to those better off). Empirical evidence of whether and how the impact and costs of two interventions compare when society is more (or less) concerned with equity provides a tool to facilitate the public discourse described by Amartya Sen in *The Idea of Justice*.<sup>4</sup>

## **II. Measuring and Ameliorating Health Inequity in Latin America**

This section highlights lessons from three Latin American initiatives to ameliorate health inequity and translate data into policy at multiple levels: at the local municipal level (social medicine in Mexico City); in a sub-region of Latin America (Salud Mesoamerica 2015 Initiative), and across the entire Pan-American region (PAHO/EquiLAC).

### **a. Achieving equity through universal access to health care in Mexico City: the Plan for Free Medicines and Medical Services**

Health care in Mexico in the early 2000s was perhaps even more fragmented than the US health care system; this fragmentation contributed to large health inequalities across the country.<sup>16</sup> The response of the Mexico City government suggests several possible approaches for the RWJF-COH in promoting equity in clinical care in the United States. In 2000, Mexico City launched the Plan for Free Medicines and Medical Services (PFMMS) to address inequity in health care and provided universal access to municipal services. The reform included four key components: 1) free medicine and health services; 2) the introduction of new service models; 3) the strengthening, expansion and improvements of services; and 4) legislation to ensure that the city government upheld the right to health care enshrined in the federal Constitution.<sup>17</sup>

Among many achievements of PFMMS, at least four stand out for their potential contribution to promoting a culture of health in the United States. The first is the important role of public participation,

which has been cited as one of the elements contributing to the program's success. The Health Department created hundreds of neighborhood health commissions, which were given power to define a community health diagnosis and an action plan and to supervise services provided in health centers. The second lesson from PFMMS is that when universal approaches are successful, they can simplify requirements for data collection and analysis. For example, as long as PFMMS continues to achieve 100% coverage of skilled attendance at birth (i.e., all deliveries were attended by a trained medical provider)<sup>17, 18</sup> there is no need to measure the distribution of this particular indicator. PFMMS also reduced mortality in all age groups, as well as among people living with HIV and AIDS, suggesting widespread benefits of the program. However, it is unlikely that any program achieves 100% coverage across all process indicators, and reporting results disaggregated for disadvantaged subgroups is necessary to ensure that important subpopulations are not being left behind. The third lesson is the value of prioritizing universal programs that include everyone and in which everyone (that is, all citizens) have a stake. While universal access to clinical care would not necessarily produce the greatest impact on health inequities, it was felt that providing clinical care to all would have the greatest potential to unify the city because it is visible to everyone and most strongly indicates the essential belief that "we are all in this together". The tagline for PFMMS captured the concept of leveraging inclusion to reduce inequity: "For the Wellbeing of All; First, the Poor." The fourth lesson relates to the use of legal instruments to establish baseline goals for health equity. Conference participants highlighted how Latin American countries have adopted model legal instruments developed by the Pan American Health Organization (PAHO), UNICEF and others (e.g., PAHO's Health and Human Rights Resolution (CD50.R8), the Declaration of Human Rights and the Convention on the Right of the Child, and the UNICEF-driven Declaration of Panama) and leveraged them for data-driven policy to mobilize stakeholders, governments and others to come together to establish shared programming and action. The PFMMS exemplifies this use of legal instruments to raise awareness about shared responsibility of health: after five years of the PFMMS, 83% of residents knew the Mexican Constitution guaranteed a right to health care; and 78% agreed that health should be a government responsibility.<sup>17</sup>

**b. Equity and accountability through targeted, results-based financing: Salud Mesoamerica 2015**

In contrast to the universal approach to reducing health inequities championed by PFMMS in Mexico City, the Salud Mesoamerica 2015 (SM 2015) Initiative takes a targeted approach that prioritizes the poorest 20% of households of the seven Central American countries, and the nine southeastern states of Mexico, by focusing geographically on the poorest states or regions of each country. SM 2015 provides

an example of a results-based financing model whereby funding for clinical and public health services is provided by national and local government as well as international donors (Bill and Melinda Gates Foundation, the Instituto Carlos Slim de la Salud and the Inter-American Development Bank) whose support is tied to achieving pre-specified targets of specific indicators of service coverage and health outcomes. The independent evaluation includes qualitative and quantitative data from multiple complementary sources such as population-based (client-, patient- or household-) questionnaires and health facilities surveys and medical records review. The program promotes accountability through transparent reporting of indicators that local communities can leverage to demand results from government administrators.

Important lessons to assess in the context of a culture of health in the United States include the selection of key indicators of coverage, quality and outcomes that balance potentially competing priorities for locally tailored vs. standardized metrics. Furthermore, indicators are selected through a highly inclusive process that encourages participation of stakeholders at multiple levels. While SM 2015 may provide a model for incentive-based public-private financing of equity-driven initiatives in the United States, translation to the US setting is complicated by less clear lines of accountability in the fragmented US health system, where the state traditionally has played a much less comprehensive role than in Mesoamerica. On the other hand, the US federal government could take a lesson from the project by shifting some formula-driven methods of medical care financing (e.g. matching dollars for state Medicaid programs) to results-based financing (there is a match only when benchmarks, like improved equity, are achieved; or an enhanced match occurs when they are reached). This mirrors the shift toward “value-based” reimbursement in the private health care system in the United States rather than simply a volume-based one.

**c. Standardizing health equity metrics: Equity in Health Systems in Latin America and the Caribbean (EquiLAC)**

The Equity in Health Systems in Latin America and the Caribbean (EquiLAC) project of PAHO has led a movement to systematically assess trends in health system equity, beginning with an initial set of studies in six countries: Brazil, Chile, Colombia, Jamaica, Mexico, and Peru.<sup>19</sup> The project uses data from multiple waves of cross-sectional surveys of nationally representative country populations to calculate a standard set of health equity measures, such as the concentration index, to explore potential factors that contribute to inequity (via use of decomposition analysis), and to track changes in equity over time.

Strengths of the project include its inclusion of multiple important health-related processes and outcomes, and the standardized approach that facilitates comparisons of changes in inequality within and between countries. Among the project's limitations are: 1) its reliance on retrospective household surveys that preclude real-time monitoring of inequities and are not large enough to precisely estimate inequities on a local scale; and 2) its exclusive estimation (to date) of income- and wealth-related inequalities, omitting other inequalities of potential importance (i.e., education, indigenous populations, urban-rural, etc.). As a potential harbinger of the challenges of translating equity data into policy, it also remains unclear how evidence on health inequities generated by EquiLAC will be translated into specific policy responses in any of the participating countries. Despite these limitations, these approaches have shown which countries were successful in reducing inequities and the different approaches to the organization and financing of their health systems during an important period of democratization, economic development, and health systems reforms in the region. Since health policies and programs to improve equity are unique to each country, much can be learned from the different approaches and results.

**d. Additional topics raised in the working session *Putting Data in the Driver's Seat to Steer Policy and Systems to Promote High-Quality, Equitable Health***

In addition to the themes highlighted above, the Working Session provided details on the following topics:

- 1. Convincing communities that health matters.** Some communities may perceive health to be relatively low on their hierarchy of needs or priorities. As one participant framed the question, "How can data help people see the benefits of improving their health?" That is, when the intrinsic value of health appears to be secondary to other needs, how can health be framed as an enabler of other life priorities. As Amartya Sen or might say – how can health be appreciated for its role in enhancing human capability? One suggestion was that data could be presented to explain the effects of where you live, go to school, work and play on health.
- 2. Community-based approaches to utilize data.** Participants agreed that strategies derived from a community are inherently more equitable due to their inclusivity. Thus, a preferable strategy for driving equity is to scale up and replicate community actions proven to have successful outcomes. One example from Panama suggests that data are utilized to reconcile the debate between "community" and "facility." Systematic data (e.g., that collected during

hospital visits) can help achieve policy and programming solutions that are culturally sensitive and address the community-defined needs. Another key aspect discussed in understanding community needs was the selection and use of indicators, which require community input. However, data collected from health care or other institutions does not capture those who do not have access to those institutions. Therefore, community-based approaches need to be triangulated, using administrative data as well as data from community and other health surveys that are representative of all people in the community, including those who do not have access to services. Ultimately, it is important for communities to have the power to select indicators just as they should select goals.

**3. Measurement and incentives.** Conference participants also discussed measurement strategies and the complexities surrounding them for researchers, policy makers, and health professionals. Some of the suggestions included:

- a. Involvement of business and other sectors of a community to engage in equity goals by utilizing data to demonstrate value of investments in health services
- b. Each participating sector has incentives. Although not all conference participants perceived a role for corporations in addressing health equity *per se* (apart from paying their taxes, paying a living wage and providing safe and equitable working conditions), potential incentives for businesses to participate in and drive equity goals that might align with their primary mission to maximize profits included:
  - i. healthier workers contribute to increased productivity
  - ii. social responsibility
  - iii. public relations
  - iv. peer pressure
  - v. responsibility to the home community

### **III. Knowledge Gaps and Recommendations for Further Research on Using Data to Measure Health Equity**

While the Conference has gleaned some information and models to review to further define health equity and ways to measure data within the context of the RWJF-COH, several gaps in knowledge have been identified. Below, we summarize these gaps and provide recommendations for further study.



**Knowledge Gap 1:** Although numerous research studies and policy initiatives have measured health equity, little is known about the challenges and opportunities to translating equity data into real-world clinical or policy decisions.

- **Recommendation 1A.** Conduct a review of clinical, public health, and social policy interventions outside the United States that successfully utilize data on health equity. Opportunities and challenges to translating this global experience to the US setting would be identified. From this research, models would be developed and presented for testing on US programming addressing health equity.
- **Recommendation 1B.** An optional comparative review of existing US efforts would examine how data shape policies on equity and accountability (ACOs, P4P and other incentive-based mechanisms) with models of accountability used abroad (e.g., results-based financing mechanisms that hold governments accountable at the national or state level). This research would define some of the similarities and differences between models of data-driven accountability used abroad while pointing attention to best practices.

**Knowledge Gap 2:** Despite the proliferation of methods to measure various dimensions of health equity, little evidence exists to inform the selection of particular metrics or their pairing with specific health challenges. As the RWJF and its partners embark on an inclusive process to define when and how to measure health equity, it will be important to transparently select measures and to balance potentially competing priorities for locally tailored vs. standardized metrics.

- **Recommendation 2A:** Conduct mixed-methods, community-based participatory research to ensure health equity metrics are comprehensible to, and reflect the values of, US society, particularly members of diverse and disadvantaged communities. The result of this research effort would be a suite of complementary health equity measures applicable to various scenarios of the RWJF-COH in the US.
- **Recommendation 2B.** In addition to identifying how measures are understood by communities, it is important to understand how policymakers and other key stakeholders perceive and use data on health equity. While there is a body of literature on how policymakers use data in decision making generically, there is little or no research on the best way to reach key stakeholders in the US with health equity

information. Working to better understand both communities and policymakers reflects a “grassroots to treetops” approach.

**Knowledge Gap 3:** Measuring health equity inherently involves making normative judgments based on potentially competing concepts of justice and fairness that historically have deeply divided the United States. Is it possible to agree to measure health inequity while continuing to disagree about specific concepts of justice and fairness in health? Is it possible to achieve consensus about which dimensions of health equity to measure? Amartya Sen<sup>4</sup> outlines a theoretical foundation for the type of empirically based deliberation that might apply to promote equity-related dimensions of the RWJF-COH.

- **Recommendation 3:** Using Sen’s<sup>4</sup> theoretical foundation, conduct a feasibility study or pilot program of health equity measures to inform policy decisions. Comparative- and cost-effectiveness analyses would be conducted to develop a framework of health equity measures specific to policy.

#### **IV. Conclusion**

In sum, experiences from international communities as well as published literature can be used to guide the formation of health equity measures in relation to the RWJF-COH. We propose more in-depth study of some of these systems and would prioritize future research efforts as: 1) Community-based research leading to the development of a suite of health equity measures suitable to US contexts; 2) Feasibility studies of health equity measures applied to specific policy decisions; and 3) Comprehensive review of international programs that have successfully used health equity data to develop, implement and evaluate interventions.

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