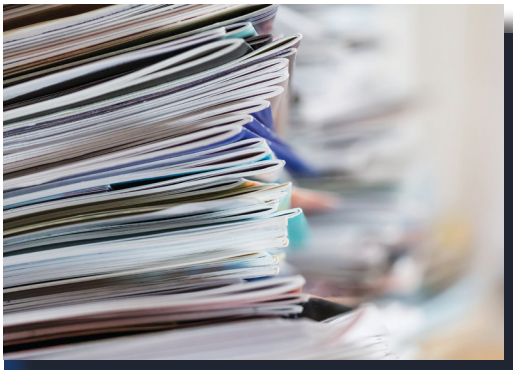

Equity from a Cross-Sector Alignment Perspective: *Findings from a Literature Review*

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Introduction

In the time since the passage of the Affordable Care Act in 2010, organizations in health care, public health, and social services have increasingly used collaboration as a tool for improving population health and reducing health disparities. While there have been some gains, the results have not met expectations. In response, the Robert Wood Johnson Foundation (RWJF) drew on its experience in the field to develop the Cross-sector Alignment Theory of Change (ToC) to improve the effectiveness of collaborations.* At the root of the ToC is the idea that collaboratives must move toward the development of lasting aligned structures across sectors, and in order for aligning to be successful in improving health outcomes and reducing health disparities, several factors must be present, including a focus on equity.

The Georgia Health Policy Center (GHPC) is working with RWJF to test and further develop the ToC. A core element of the work at GHPC is to synthesize the existing literature on cross-sector collaboration and draw out key learnings that will help develop the ToC and ultimately help practitioners align across sectors. One of the objectives for literature review is to identify common barriers to equity and solutions for overcoming those barriers. The purpose of this brief is to share findings from this component of the literature review.†

The studies we reviewed tended to discuss equity in demographic terms, focusing most often on race, ethnicity, sexual orientation, gender identity, indigenous identity, age, immigration status, and socioeconomic status. Equity was defined in many different ways, but two ways of discussing equity were particularly prominent. The first was in terms of procedural equity — the ways in which the power to shape collective action is shared among parties within the collaborative. The second was in terms of health disparities — the differences in health outcomes between different population groups. Equity was also discussed at different levels. This brief highlights several barriers, and potentially useful strategies for overcoming those barriers, at the individual, organization, and systems level.

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* More details on the ToC can be found at ghpc.gsu.edu/download/cross-sector-alignment-theory-of-change/.

† The review involved a scan of relevant journals, a scan of 1,600 articles in two academic search engines, and a purposive scan for relevant materials using common search engines and professional networks at RWJF and GHPC. We identified 571 studies written since 2010 that address cross-sector collaboration between the health care, public health, and social service sectors. These papers were coded for key contributions and then coded again for their relevance to the ToC, including any explicit and substantial discussion of equity as determined by a team of coders. Within the subset of studies explicitly discussing equity, we identified barriers to procedural equity and barriers to reducing health disparities. We also identified the strategies proposed to address these barriers. This brief presents those barriers and strategies in narrative form.

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Individual Level

Barriers

A key barrier to equity in the context of alignment is that the individuals involved in program planning may not prioritize equity. A study of public health, health care, and social service leaders found that when those individuals were presented with several options for a community health project, whether a project was targeted to particularly vulnerable populations or not had little impact on whether the project was selected.[1]

There are also knowledge gaps. Participants in collaboratives may not understand the historical and contemporary roots of current inequities, how socioeconomic inequities can produce health inequities, or how health inequities are continually reproduced in a wide variety of settings. This lack of understanding can limit a collaborative's capacity to address many forms of inequity.[2]

Strategies

Equity training within partnerships can potentially address knowledge-gaps among collaborators.[3] It may be particularly helpful to include in such trainings an orientation to the link between socioeconomic development and the reduction of health disparities.[2] Helping collaborators understand the historical drivers of inequity and the resulting structural challenges can help provide a groundwork for acting on inequity.[4-5] There is evidence that equity training can also improve the understanding of biases within collaborating organizations, promote effective community involvement in partnerships, and help shape a collaborative's outward-facing activities.[6]

There is also evidence that social workers in particular can help collaborations identify and address practices that contribute to inequity.[7] In several studies of collaboratives, social workers were found to offer relatively high support for addressing health disparities.[8] Collaboratives that empower social workers at the decision-making level may be particularly well-positioned to design interventions that improve procedural equity and reduce health disparities.[7]

Organizational Level

Barriers

A key driver for health-oriented cross-sector alignment is the growing acceptance of the idea that organizations with the power to affect population health tend to be isolated and, relatedly, tend to fall short of their potential for improving population health outcomes. Consistent with this idea is the observation in several studies that the lack of coordination within and between organizations is, itself, a barrier to reducing health disparities. Lack of coordination may especially inhibit the development of a common approach to addressing health disparities,[2, 9] and differences in organizational responsibilities and program objectives may exacerbate this problem.[2]

Basic power dynamics also hamper collaboratives' efforts to promote equity. Collaborating organizations often find themselves in the relatively privileged position of having an inside view to how knowledge is being shared with communities. Organizations working with community groups may also be better positioned to determine what community groups they work with, and they may be better positioned to decide how equity problems and solutions are defined. Such power imbalances between collaborating organizations and the communities they are intended to help may result in the marginalization of community voice, and this could become a barrier to identifying and addressing barriers to equity.[6] Power differentials can also emerge between other types of organizations and even sectors, for example between health care and non–health care organizations. Organizations in the health care sector often have funding power or other resources that are less common among social service organizations in the same collaborative, and this can affect the relative influence of the social service organizations in these partnerships.[7]

Strategies

Strategies attentive to the power differentials that develop between organizations and community members are important for addressing equity.[7, 10] Several studies suggested that changing collaborative structures to include community voice may help improve procedural equity and reduce health disparities.[11-12] Going further,

several studies highlighted the importance of including community members in a collaborative's decision-making processes and in agenda-setting.[7, 13-14]

Collaboratives can also increase their transparency with communities and share information on a more continual basis.[13] Collaboratives are encouraged to build relationships with community leaders[15] and employ community health workers directly from the community in question.[16-17] Organizations can also designate resources for equity-focused collaborative leadership[18] and build equity into their mission statements, goals, and outcome measures.[19]

Systems Level

Barriers

As we know from research linking health disparities to the social determinants of health, many factors drive health outcomes. Policy can be an important tool for coordinating organizations across sectors and allocating resources. Accordingly, an important barrier to equity at the policy level is often a lack of political commitment to collaboration.[17] Policy itself may not be coordinated, for example, between different levels of government.[2]

Policy may need to be changed at a basic level. For example, a health care system that treats individuals differently based on their financial status reproduces inequities in socioeconomic opportunity.[7] Importantly however, policy focused only on health care is unlikely to address public health and social service issues that contribute to health disparities.[6] Weak health care systems, a lack of resources, and poorly coordinated resources can all contribute to health disparities.[17]

Strategies

Systems strategies can include implementation of Health in All Policies (HiAP) or health impact assessments that include community participation.[20-21] Solutions could include reforms in access and payment in the health care system,[22-23] and funding mechanisms can also be altered to require collaboratives to address equity, as in the case of the Accountable Communities of Health model.[24-26] Reflecting systems-level barriers to equity, many of which involve disconnects between different organizations or policies, another strategy for both improving procedural equity and reducing health disparities is to encourage or require cross-sector alignment through policy.

Conclusion

The literature on health-oriented, cross-sector collaborations identifies a number of barriers to increasing procedural equity and reducing health disparities. However, it also identifies many strategies for overcoming those barriers. These strategies can be implemented at the individual, organization, and systems level. As organizations transition from small-scale collaboratives toward systemswide alignment, these strategies may help participants reduce or eliminate persistent health disparities.

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Health Care + Public Health + Social Services

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