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Impact on Urban Health

Emerging Lessons from the COVID-19 Pandemic for Building Urban Health Equity

5 Pathways for Cross-Sector Action

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The COVID-19 pandemic has made explicit the health disparities that have long existed worldwide, exposing their roots in systems of exclusion and power. Since the novel coronavirus first hit cities across the globe, we have seen drastically different local and national responses, levels of risk and vulnerability, and emergent supports—in response to both the health crisis and the accompanying economic downturn. These dual crises have disproportionately affected health outcomes for people of color at a time when they are already marked by disparities. This has created an important reflection point, allowing us to better comprehend the strengths of and gaps in the drivers of systems of urban health, understood not only as the ability to deploy formal health care services in urban neighborhoods but also the social determinants of health that compound vulnerability during a crisis. Because of its reach and depth, the pandemic has turned the world's attention to the ills that affect health outcomes and provided societies with the opportunity to be ambitious in how they invest in post-COVID-19 recovery.

Cities play an undisputed role in shaping the health and well-being of residents. The built environment can facilitate or constrain opportunities for residents to maintain good physical health, air quality influences susceptibility to diseases, and the urban environment shapes vulnerability to violence and its impacts on people's sense of connectedness to their communities.[1] Neighborhoods have social and physical features, often interconnected, that affect individual and community health. Structural and systematic factors such as housing markets and quality, access to transportation, and public safety

shape these features that affect health (Diez Roux 2020). As dense centers of population and economic activity, cities around the world were also exposed first to the spread of COVID-19.

The COVID-19 pandemic has shone a light on structural racism and its impact on health outcomes. In many countries, rates of exposure, hospitalization, and mortality because of COVID-19 vary significantly by race and ethnicity. In the United States, American Indians and Alaska Natives were 2.6 times more likely than white people to die from COVID-19; for Black people/African Americans and Hispanic/Latino people, that multiple was 2.8.[2] In the United Kingdom, morbidity is similarly skewed: COVID-19 mortality rates are persistently higher among people of color. As Michael Marmot of University College London and coauthors (2020) explain, much of this disparity has to do with socioeconomic characteristics and the conditions of places where people live, with structural racism as the root cause. Because of structural racism, people of color face distinct disadvantages across the social determinants of health—and this is true not only in the United States and United Kingdom but also in racially diverse cities across the globe. This disparate impact on people of color is connected to systematic barriers to health-assuring supports.

The pandemic's economic consequences have also had a differential impact on social determinants of health such as health access, food security, stress, and social exclusion. Some communities of workers have been hit hard (with job losses, reductions in work hours, or elimination of their work sector altogether), while others have remained largely unscathed. The job losses alone will have intergenerational effects that will far outlast the current crisis. For example, in the US, 40 percent of parents with children younger than 6 have suffered economic fallout from the pandemic. This fallout has taken the form of food insecurity (23 percent of households) and forgone health care for a child (32 percent), among other challenges (Gupta, Gonzalez, and Waxman 2020). On account of the pandemic, cities have seen their revenues plummet, resulting in fewer and constrained resources to provide health-promoting services. These constraints are likely to have immediate and long-term implications for the emotional, neurological, and biological development of children, with potential consequences for their human, social, and wealth capital in the long term.

The pandemic has created momentum for change and presents an important reflection point for reimagining societies to build urban health equity. Although no consensus exists on the definition of "health equity," a working one would emphasize the fair and just opportunity for everyone to be healthier, including the removal of barriers to health such as poverty and discrimination and their consequences (Braveman et al. 2017). Using a social determinants of health framework to understand the connections between the socioeconomic systems that generate and reproduce health disparities and the structural drivers of those systems is important for designing policy solutions. The crisis has already led to a significant rethinking of health equity and innovations that recognize the interplay of systems and their impact on health. There are chances to lift up these lessons, adapt them, and scale them where applicable. Also, new questions are arising that offer opportunities to learn.

Impact on Urban Health, a UK-based charity focused on urban health in the Lambeth and Southwark boroughs of London, invests in, tests, and builds on global and local experiences that show how neighborhoods can be shaped to support better health outcomes. As part of Impact on Urban

Health's global learning, it worked with the Urban Institute to convene three dialogues of experts in health, urban development, and social change to consider whether the pandemic offers an opportunity to address the systems that embed the disparities which are especially apparent in our cities. The dialogue series, held in November and December 2020, brought together leaders from academia, nonprofit organizations, philanthropy, and private health practice to exchange scholarly and practical insights into the pandemic's impacts on urban health equity, the links between local actions and system-level solutions, and the potential for innovative approaches to address the challenge (box 1).

BOX 1

Dialogue Series Participants

The Urban Institute and Impact on Urban Health are grateful to the following experts for their participation in the dialogue series and the insightful comments from which this brief draws:

- Karabi Acharya, Robert Wood Johnson Foundation
- Michael Adamson, British Red Cross
- Laudy Aron, Urban Institute
- Mary T. Bassett, Harvard University
- Kieron Boyle, Impact on Urban Health
- Charles Cadwell, Urban Institute
- Kitty Hsu Dana, National League of Cities
- Ana Diez Roux, Drexel University
- Rowena Estwick, Impact on Urban Health
- Elsa Falkenburger, Urban Institute
- Neal Halfon, University of California, Los Angeles
- Peter Long, Blue Shield of California
- Peter Margolis, Cincinnati Children's Hospital Medical Center
- Michael Marmot, University College London
- Faith Mitchell, Urban Institute
- Andy Ratcliffe, Impact on Urban Health
- Qiana Thomason, Health Forward Foundation
- Margery Austin Turner, Urban Institute

This brief shares insights from the dialogue series. It presents five key lessons from the conversations and identifies five opportunities for action (box 2), recognizing that the change that is needed hinges on addressing systemic factors that underpin the inequities that COVID-19 has laid bare

in cities around the world. A central message emerged from this effort: achieving urban health equity requires leadership and collaboration among different actors in society.

BOX 2

Key Lessons from the Pandemic for Urban Health Equity

- Structural drivers underpin disparities in COVID-19 incidence and mortality.
- The pandemic exposes how interconnected systems generate and reproduce health disparities in urban contexts.
- Solutions to urban health disparities must be multisector, but these approaches are difficult to pursue.
- Cities and neighborhoods are where systems intersect and the impacts of structural inequalities are visible.
- Local leadership matters for health equity but cannot easily fill gaps left by a long-standing lack of investment.

Key Actions for Building Urban Health Equity

- Define the vision for urban equity with a focus on the social determinants of health.
- Narrow economic inequality through engaging leadership from multiple sectors.
- Build partnerships for action at the intersections evident in urban settings.
- Engage with communities in ways that build their voice and power.
- Change the aperture for measuring structural challenges, and build accountability for results.

Lessons from the Pandemic for Urban Health Equity

The health disparities that the COVID-19 pandemic has exposed are not new, nor are the causes unknown. What is unique about this moment, however, is that the pandemic has heightened the attention on the disparities and their causes. Against this backdrop, the dialogue series converged toward two interwoven ideas: the importance of the urban context for health and the interconnectedness of systemic factors that have long undermined the health and well-being of people with low incomes and people of color globally. In the face of these challenges, cities and neighborhoods are not only places where systemic challenges intersect but also spaces where innovation occurs. Local action can contribute to change, but it cannot readily fill gaps left by a persistent lack of investment in national systems crucial to health and well-being. And basing policy and practice on a framework that treats health care as the primary means to address health is no longer tenable.

Structural Drivers Underpin Disparities in COVID-19 Incidence and Mortality

Dialogue participants noted that the pandemic has highlighted the links between structural drivers and health equity. Among the drivers is structural racism, defined as the ways in which societies foster discrimination through mutually reinforcing inequitable systems (Egede and Walker 2020). Kitty Hsu Dana of the National League of Cities described racism as a chronic, systematic issue that pervades the context in which people live, work, learn, play, and worship and predates the COVID-19 pandemic. Structural racism not only is a function of formalized institutions but also manifests through unconscious bias and norms.

The statistics on the disparate impact of COVID-19 on people of color are stark, and the links between structural racism and health outcomes are well-known, most explicitly around life expectancy. Two experts who participated in the dialogue series, Margery Austin Turner of the Urban Institute and Qiana Thomason of the Health Forward Foundation, noted that these disparate outcomes are directly linked to place. As an example, Thomason shared that in Kansas City, "the economic and racial dividing line for us is Troost Avenue, and there's about a 15-to-20-year difference in life expectancy in a three-block gap between Troost Avenue and what's on the east and west side of that."

In the UK, the existence of a national health care service has not prevented similar magnitudes of COVID-19 deaths and hospitalizations among people of color as in the US, underscoring that health disparities point to structural factors such as racism, rather than simply disparate levels of access to health care. Reports published recently in the UK have emphasized structural racism in explaining the differential outcomes from COVID-19 (Lawrence 2020; Public Health England 2020). In the dialogue series, Michael Marmot said the COVID-19 pandemic pierced a "delusion" that racial inequity was not an issue in Britain. And in his recent report, he noted that clear links exist between economic deprivation and structural racism, including that the most economically excluded communities align with communities of color (Marmot et al. 2020). Marmot argued in the dialogue series that structural racism cannot be addressed by simply targeting deprivation. He quoted Mayor of Bristol Marvin Rees, who has talked about a "robbery of resilience"—a historical violation that builds over time and which affects the confidence, identity, and well-being of people subjected to structural racism.

From the legacy of residential segregation to long-standing disinvestment in the health and education of residents in communities where people of color are the majority, the intersecting drivers of urban health disparities have systemic racism as their underpinnings. As a result, solutions that create progress toward health equity must also be systemic, with policies activated and resources mobilized to tackle structural racism.

The Pandemic Exposes How Interconnected Systems Generate and Reproduce Health Disparities in Urban Contexts

Dialogue participants argued that the systems proving to be particularly pernicious during the COVID-19 pandemic are residential segregation and neighborhood disparities in access to urban amenities,

occupational segregation, and unequal access to health care. These connected systems affect people's likelihood of developing COVID-19 and their ability to protect themselves from it.

These systems have affected the likelihood that people get the disease, but also the extent to which they are able to respond and protect themselves.
—Ana Diez Roux, Drexel University

The overlap between neighborhood disparities, inequality, and structural racism has been further illuminated by the pandemic's disparate outcomes: areas populated by people with low incomes have experienced greater exposure to COVID-19 than wealthier communities (Marmot et al. 2020). Early evidence from the US indicates that counties with high levels of residential segregation between white and nonwhite people have more COVID-19 cases, after controlling for other factors (Yang, Choi, and Sun 2021). Residential segregation and neighborhood disparities have contributed to the spread of the coronavirus in several ways. First, the historical lack of investment in certain neighborhoods has created housing-quality issues such as a lack of ventilation that have made it easier for the virus to spread. Second, communities with limited access to outdoor public spaces are less able than communities with more space to socially distance to protect themselves. Finally, communities have different levels of access to health care services, especially to COVID-19 testing, which has been crucial to containing the virus.

Occupational segregation and workplace exposure are also connected to COVID-19 mortality and infection rates, and experts argued during the dialogue series that the public discourse around disparities related to COVID-19 has largely overlooked workforce exposure. Because of varying workplace conditions and protections, people in different occupations have different levels of exposure to the virus. People who cannot work from home, who work in close proximity to others, or who cannot afford to stop working have suffered higher levels of infection and fatalities (Marmot et al. 2020). A lack of personal protective equipment, poor ventilation, and inadequate cleaning in workplaces can also contribute to vulnerability. These vulnerabilities are significant for people of color, women, and older people (Marmot et al. 2020). Also, people who are at higher risk for exposure to COVID-19 at work risk exposing their families, which can lead to additional community spread in neighborhoods with high concentrations of essential workers.

The way precarity has overtaken the workforce seems central to the vulnerability we have seen.
—Mary T. Bassett, Harvard University

Differential health care access has also influenced vulnerability to COVID-19. Residents of low-income communities have limited access to health resources because of low levels of investment in health care facilities in their neighborhoods, among other reasons. This is true even in countries like the UK that have publicly funded health care systems, as well as those like the US that have private systems. In the US, occupational segregation also affects health care access; people in jobs that are at high risk for COVID-19 exposure are likely to have limited or no health insurance and consequently poor health care access (Garcia et al. 2020). In the context of the COVID-19 pandemic, this is likely to affect who can access testing and treatment. In addition, access to testing and guidance on quarantining (and the ability to do so) varies by community, which has affected susceptibility and spread of the virus.

Neighborhood disparities, occupational segregation, and health care access all intersect to exaggerate the vulnerability of people of color to COVID-19, leading to higher mortality and incidence of infection. Neal Halfon of the University of California, Los Angeles, noted that these systems are designed to allow this to happen and said that "the failure in the development scaffolding in our societies multiplies vulnerability."

Solutions to Urban Health Disparities Must Be Multisector, but These Approaches Are Difficult to Pursue

Experts reflected on the importance of upstream strategies to address social determinants of health. A core element of such strategies is multisector collaboration, which calls for deliberate and sustained alliances among multiple actors (e.g., government, civil society, and the private sector) and, importantly, across sectors that can affect health outcomes (e.g., education, housing, health, transportation, and environment).

Several dialogue participants emphasized that the pandemic has brought renewed attention to the importance of actions beyond the health care sector to improve health and reduce urban health disparities. A multisector approach consolidates efforts across policy domains and rests on an understanding that the health care sector alone cannot get the job done. With such an approach, however, come challenges, including figuring out how agencies can better coordinate to improve health outcomes for residents within existing budget constraints. It means seeking a better understanding of how policies and programs in different sectors affect health at the individual, family, and community levels, with an implicit theory of change that people and their communities would be better off if actors worked more collaboratively and pooled their resources at the neighborhood level. A siloed approach, on the other hand, risks leaving individual and community health needs unmet because of a lack of coordination in assessing needs and organizing priorities to meet them.

Despite their potential to improve health outcomes, multisector approaches have proved difficult to achieve for a couple of reasons. As experts noted, one barrier is the lack of a shared vision on outcomes that could focus a wide range of actors on the goal of achieving health equity. Although the question of what the term "equity" means recurred throughout the dialogue series, significant progress has been made in measuring health disparities, both within and between neighborhoods and cities.

Much is also now known about the root causes of those disparities (Alper 2016). Yet, it is not evident that health equity metrics alone can frame a shared understanding of the problem, let alone incentivize an alignment of efforts for collective impact on the different factors that affect well-being.

Crucially, the assumption that health care is the primary means of addressing health has been so strong that it has constrained the cross-cutting coordination and integrated action across policy domains needed to improve health and reduce health disparities in cities across the globe. This barrier has persisted since long before the pandemic's arrival. When health care is the dominant frame through which key stakeholders consider health, those operating in other sectors are unlikely to recognize the important roles they must play in promoting better health outcomes for people. Speakers at the dialogue series noted that many people appear stuck in a framework that treats health and health equity as issues exclusive to health departments or health care systems.

This assumption, that achieving health equity is the job of a particular sector, constrains local action and innovation. City leaders often face resistance when trying to engage stakeholders who believe their department's mission does not include promoting health (National League of Cities 2015). Mary T. Bassett, a former New York City health commissioner, said that such resistance can undermine the building blocks for integrated work, particularly the alignment of city agency budgets and priorities. In other words, differences in the values, vocabulary, and priorities of relevant sectors—shaped by stakeholder interests—can be a significant barrier to collaboration (Kohli and De Biasi 2017).

Going forward, actors in the urban health ecosystem need new and better ways to collaborate on advancing health equity. However, we need to learn more about the practical steps that work for fostering collaboration among the various sectors that affect health. Challenging the health care–centered framework will be an important part of this process.

Cities and Neighborhoods Are Where Systems Intersect and the Impacts of Structural Inequalities Are Visible

The structural inequalities that drive health disparities are complex and difficult to change. Acknowledging this can be overwhelming and lead to inertia, leaving actors in the urban health ecosystem without a sense of where to start and how to address such deep-seated issues. According to the experts who participated in the dialogue series, however, focusing on cities and neighborhoods could be one way to overcome this inertia.

Participants emphasized that in urban environments, the connections between structural inequalities and the social determinants of health are clear. As a result of discriminatory policies and practices, some people are sorted into resource-rich neighborhoods, while others are sorted into neighborhoods that lack health-promoting assets like high-quality schools, housing, and employment opportunities. This sorting is based mainly on race, ethnicity, and socioeconomic status and therefore produces significant differences in the opportunities that residents have to reach their full health potential.

Focusing on how urban areas have fared during the pandemic provides additional insight into the ways that places shape virus transmission and people's ability to cope with the pandemic. For example, overcrowding in housing, especially among low-income communities, has made these communities susceptible to COVID-19 transmission within the household. In many of these communities, parks and green spaces, which positively affect people's physical and mental health, are scarce. This imbalance further illustrates why people in disadvantaged communities have poorer health and why the pandemic's impacts have been so devastating in those areas (Fedorowicz, Schilling, and Bramhall 2020; South et al. 2015; Tzoulas et al. 2007).

One of the powerful advantages of zooming into a neighborhood is this: that's where the intersections between different policy domains are so concretely evident…and that creates real opportunities to do the cross-silo work that is so incredibly difficult.
—Margery Austin Turner, Urban Institute

Experts explained that focusing on urban areas also reveals how market forces and public policies combine to promote or limit opportunities for people to be as healthy as possible. For example, consider the corporatization of the food system, which has led to the proliferation of ultraprocessed foods that despite being harmful to health are more affordable than healthy options. At the same time, "there has been an unwillingness of governments to intervene and protect a healthy food supply for people," Bassett said. Residents of cities' high-poverty neighborhoods, which often do not have high-quality grocery stores, bear the brunt of these intersecting challenges because, unlike residents of wealthier areas, they do not have the power to control their food supply. These disparities are partly why neighborhoods with lower incomes have higher incidences of childhood obesity.

Simply put, when we focus attention on cities and neighborhoods—places where people live, work, play, and age—the what, who, and why of health equity become apparent, revealing opportunities for action. Viewed through an urban lens, the challenges underscore the importance of interventions in specific places, at the city and neighborhood level, that explicitly take on conditions that undermine health and well-being. In addition, they may reveal concrete avenues for the multisector collaboration that has proved difficult to advance and which the pandemic has made even more pressing. It then becomes essential that actors in the urban health ecosystem have the right conversations, focused on what each might need to do differently, within their capacity and in coordination with others, to advance health equity.

However, because health equity challenges have structural roots, one cannot assume that breaking out of traditional silos will be enough to drive change. For Michael Marmot, addressing health disparities ultimately requires tackling "inequities in power, money, and resources at the urban level."

Doing that involves taking actions that lie beyond the city and neighborhood level, however, because the policy tools and resources to address the myriad challenges that neighborhoods face do not all sit within the boundaries of the neighborhoods concerned (Turner 2014). For instance, federal investments in place-based programs can not only direct resources to disadvantaged neighborhoods but also build the capacity of neighborhood leaders to influence state, local, and national policies that promote health.

Local Leadership Matters for Health Equity but Cannot Easily Fill Gaps Left by a Long-Standing Lack of Investment

During the pandemic, local organizations have provided much-needed support to disadvantaged communities, especially in places where national responses have been weak, in part because of political polarization and low investment in public health systems. These local actors cut across public and private sectors and include community-based organizations, mutual aid groups, small businesses, mayors, public health departments, and academic institutions. They have backed a wide range of activities, including the provision of cash, food, and sanitary materials to those in need. For example, in the UK, the mayor of Greater Manchester, Andy Burnham, launched a £5 million fund to shelter and provide services to people experiencing homelessness.[3] In the US, cities like San Francisco stalled evictions of tenants unable to pay rent because of COVID-19-related job losses.[4] Taken together, these efforts aim to address community needs and to make up for a lack of robust national action. Although local initiatives may not address every problem, they are a useful starting point and allow for experimenting, organizing, documenting, and leveraging for change.

Crucially, during the pandemic, local actors have been stepping into roles that are traditionally the purview of public health systems, which, according to dialogue participants, are weak after years of low investment. One example of a service that organizations have come together to offer is real-time provision and analysis of data on the virus's spread. These groups have played an important coordinating role for various entities—such as public health departments, nonprofits, and schools—that require such information to respond to the virus and meet community needs. At the dialogue series, Peter Margolis of the James M. Anderson Center for Health Systems Excellence at Cincinnati Children's Hospital Medical Center highlighted one effort that has been crucial in managing COVID-19 response in Ohio (box 3).

BOX 3

Leveraging Hospital Data Infrastructure for Collaboration and Learning: Spotlight on James M. Anderson Center for Health Systems Excellence

Housed at Cincinnati Children's Hospital Medical Center, the James M. Anderson Center for Health Systems Excellence has been leveraging its data capabilities to facilitate a collaborative response to the COVID-19 pandemic in Cincinnati and the tri-state region (Ohio, Kentucky, and Indiana). According to Peter Margolis, "data systems have been degraded dramatically over the last 10 years," and that has made city-level data difficult to come by. Moreover, the data emerging from the public health system

were at too large a geographic scale to allow local leaders to understand how high-poverty areas were faring during the pandemic. In response to this challenge, the Anderson Center manually integrated data from various sources across sectors, providing in real time community-level views of community spread, health system capacity, and impacts on nursing homes and schools. The center also partnered with Kroger, one of the largest US grocery store chains, to map high-need areas and locate food distribution channels so children could have access to school lunches.

A learning network is slowly emerging around the Anderson Center's data infrastructure; the data have proved instrumental in driving conversations with key leadership groups, including among community and public health leaders. The learning network and data are helping them see the interconnectedness of their work, improve motivation to collaborate productively, and, importantly, build a sense of shared purpose around meeting community-wide needs.

Despite the valuable ways that local actors have helped fill key gaps, the bottom line is that persistent underinvestment in public health infrastructure has exacerbated the current crisis and its impact on urban health. Core public health capabilities—including the capacity to track community health and to detect, monitor, and respond to health emergencies such as COVID-19—have been insufficient (Benjamin 2020; Bilinski and Emanuel 2020). Also lacking have been the capacity to understand the needs of populations at the greatest risk of harm and the ability to coordinate across jurisdictions and work with community stakeholders to address public health and health equity issues (Farberman et al. 2020).

The pandemic has placed public health systems around the world under enormous strain, and it is not sustainable to depend on community initiatives and leadership to fill capacity gaps. As Karabi Acharya of the Robert Wood Johnson Foundation put it, "without a solid public health system, we are left with an approach that is really dependent on local initiative and local leadership in a way that is not necessarily efficient." Despite their important contributions, local-level initiatives do not typically operate at a scale and with the level of resources needed to drum up—and sustain—a system-wide commitment to achieving health equity in urban areas. And because of the uneven distribution of power and resources among people and neighborhoods, an approach that hinges on local initiatives risks worsening preexisting health disparities: communities with more power can collaborate to influence public policy for their benefit in ways that communities with less power and fewer resources cannot.

A robust public health system is a core element of the systemic solutions the current challenge demands and is needed for the coordinated national action required to advance urban health equity (Maani and Galea 2020). Such a system is necessary not only to improve disease prevention and health promotion but also to boost preparedness for future health crises. Recognizing that many factors that influence health come from outside the health sector, a well-resourced and empowered public health system can help make the case and provide frameworks for meeting basic needs such as affordable housing, high-quality education, public safety, and recreational facilities that are crucial for health. Local initiatives cannot substitute for the large, sustained national investments in public health systems that are required. However, to make an impact, those national-level investments must build on the innovations taking place at the local level.

5 Opportunities for Action to Build Urban Health Equity

Lessons from the COVID-19 pandemic have already led to strategic thinking around building equitable health systems. Some of this is happening in real time as political and community leaders and other stakeholders in philanthropy and the private sector are forced to innovate to respond to unprecedented health and economic crises. Many leaders now recognize the importance of urban health equity and the links between the social determinants of health and health outcomes. The problems are largely structural, and although they have proved challenging to uproot, the experts reflected a growing recognition that the pandemic has created space to address issues that were previously difficult to take on through partnerships that previously were unlikely and by shifting power among stakeholders. Through the dialogue series, participants coalesced around five opportunities for action to build urban health equity.

Define the Vision for Health Equity

In the recovery from the COVID-19 pandemic, achieving urban health equity will require a focus on the social determinants of health. However, dialogue participants acknowledged that no consensus exists on what "health equity" means or what it looks like in practice. Accordingly, health equity needs to be defined.

Leaders around the world have adopted "building back better" as the mantra of the COVID-19 recovery, but dialogue participants argued that this framing merits more scrutiny. They argued that "better" is not well-defined and that the slogan does not specify "better" for whom. What has become clear during the pandemic is that existing socioeconomic systems are flawed and require significant rebalancing to achieve equity. As an alternative, Michael Marmot and coauthors argue in their recent report for building back "fairer" (Marmot et al. 2020). To this end, they argue that there is a need "to build a society based on the principles of social justice; to reduce inequalities of income and wealth; to build a well-being economy…; to build a society that responds to the climate crisis at the same time as achieving greater health equity" (Marmot et al. 2020, 5). According to Marmot, an approach that emphasizes "fair" centers the most vulnerable people and incorporates a social determinants of health lens by focusing on the nonhealth sectors that determine health outcomes. Of course, "fair" and "fairer" can be interpreted differently, so building a consensus among stakeholders would be an important step in defining this approach. Neal Halfon noted that defining equity in the post-COVID-19 world will be important because it will help people envision the change to work for. Failing this, we risk building back to a society with worse disparities than we had before the pandemic. Peter Long of Blue Shield of California suggested that perhaps the revelations of COVID-19 suggest a reconsideration of the social contract. He argued that these revelations may require us to go back to society and test our starting assumptions, knowledge, and the initial anchoring point of what people define as a good life, well-being, and happiness.

How do we build back, and do we have an opportunity to build back systems in ways that are different? Because if we don't—if we just go back to the usual—I think it's going to be worse. —Ana Diez Roux, Drexel University

Defining the scale of the change required to achieve health equity is also important. Recognition is growing that health equity is central to the viability of society, so there may be appetite for transformational change. However, the pandemic and the fiscal capacity of national and city governments may dictate otherwise. Transformational change can also be intractable and difficult to mobilize around. Neal Halfon suggested adopting the "Three Horizons" framework that uses three orientations to the future in the present time to shape intentional change (Sharpe 2014). This framework and the outlined process could help define urban health equity now and in the future and could be integrated into a theory of change for all partners working in a local or regional urban health ecosystem.

Framing can be very powerful. How urban health equity is defined can be motivating, by mobilizing support and building consensus. Kieron Boyle, chief executive officer of Impact on Urban Health, shared one example: how the framing around childhood obesity can affect public support for action. When obesity is presented as a matter of individual responsibility, people blame individuals' behavior for the problem. Alternatively, when childhood obesity is presented in terms of the food options available to children, people shift the blame from individuals and focus on the systems that produced the outcome. Boyle further suggested that framing the goal around fairness may offer a way of building support for health equity, providing a "credible route to concrete action."

Philanthropy can play a significant role in the framing of health equity. Philanthropic organizations have unique power, through their resources and networks, to set agendas. Margery Austin Turner noted that as a catalytic convener, "philanthropy can challenge key actors in the community to change the way they're working." Also, through grantmaking and other processes, philanthropy can push for a particular goal and drive the framing of how society seeks to achieve urban health equity. This power comes through formalized interventions but can also be wielded informally through board members and broader networks.

Narrow Economic Inequality

The experts who participated in the dialogue series acknowledged the ways that differences in income and wealth affect health. Narrowing the resource gaps between people and places will help reduce health disparities and improve health and well-being. And there is some evidence that good health has a positive and sizable effect on economic growth (Bloom and Canning 2008; Bloom, Canning, and Sevilla 2004).[5]

As this discussion has shown, narrowing socioeconomic inequality and building multiple forms of capital will require an approach that addresses multidimensional barriers at the same time. Health equity is a downstream consequence of narrowing these gaps.

Many experts highlighted innovative approaches. Urban Institute researcher Faith Mitchell shared that a Louisiana health foundation with a mission to improve community health invests in areas such as education and employment that contribute to health. Kitty Hsu Dana talked about how mayors and city council leaders in the Cities of Opportunity initiative are working in a more systematic and holistic manner to push for multisector approaches and are putting racial equity at the core. Dana quoted one of the mayors as saying, "We should never talk about attracting more jobs for our city without at the same time addressing the fact that there needs to be sufficient affordable housing." The affordability and location of housing affect people's financial stability, which has direct implications for long-term savings and wealth. Dana highlighted how local political leaders in Cities of Opportunity are leveraging one source of "power" they can control, access to the city's land, to negotiate with developers about design elements that can address issues of social or racial equity.

Health Forward Foundation has begun a shift in its focus to poverty, inequality, and structural racism to reach health equity goals. Its approach is broad, and for 2021 strategic planning, it plans to look at the nexus between health and economic well-being and race equity. According to Qiana Thomason, this means "we will be looking at workforce development, education, affordable housing—all those factors that we know can improve income and create wealth-building opportunities and also improve health." To achieve these goals, the foundation is reaching out to businesses and policymakers to develop equitable asset-building policies and solutions that will improve health, social mobility, and economic well-being.

Building human, social, and wealth capital requires breaking down barriers that certain communities face. It requires understanding why previous efforts have been unsuccessful, particularly for people of color. Different stakeholders have different types of power that they can leverage to achieve these ends.

Build Partnerships for Integrated Action

To make progress toward health equity, many actors, including philanthropy, must step outside their comfort zone, which can be difficult. This may require shifting business models, partnership approaches, or roles. For example, Thomason reflected on lessons learned from a past role within a health plan in Kansas City that sought to build a social needs referral platform to connect primary health care providers with human services organizations focused on issues such as housing, transportation, and food security. Thomason's leadership of this endeavor recognized that the social sector is indeed part of a de facto health care ecosystem and should be included in value-based health care delivery and payment models. In practice, paying the human service organizations proved challenging within the traditional insurance reimbursement models. Such payment models are not consistent with the system, structures, or culture of the partner organizations. In an effort not to force social care into the medical model, the payer leveraged philanthropic approaches to payment, such as unrestricted grants, to

encourage collaboration, and this allowed the social care integration to gain traction. This model demonstrates how a health care–centric framework, without added flexibility, may impede collaboration in urban settings. Impact on Urban Health's work on air pollution similarly takes a cross-systems approach bringing together individuals and institutions that may not typically interact to address the complex challenge (box 4).

Bridging gaps among actors operating at different scales and domains is also important for effective action on health equity. Specifically, gaps between the national and local levels and between civil society and government need to be bridged. For Kitty Hsu Dana, mayors contribute to this goal by using their convening power to bring together partners from across the urban health ecosystem (residents, businesses, political institutions, nonprofits, etc.) to set goals, develop accountability, pool resources, and commit to action.

Bridging gaps between national and local and between civil society and government can lead to more intelligent deployment of resources—to the areas that most need it and areas of greatest health inequality.
—Michael Adamson, British Red Cross

Additionally, the intersecting nature of health problems and the challenge of multisector partnerships speak to a need for underlying infrastructure for health equity in urban neighborhoods. Current models in the US and UK make schools the primary conduit for cross-cutting, health-promoting services. Experts, however, argued that this model is neither sustainable nor resilient. School quality mirrors underlying disparities in community resources. And during the COVID-19 pandemic, school closures have left millions of children whose families are low income at risk of being cut off from school meals, a crucial safety net. Instead, a single organization (often known as a "backbone" organization) can be designated to play a coordinating role, providing leadership and facilitating collaboration across stakeholders.[6] Much is at stake when a backbone organization is absent. As Peter Long said, "without stronger leadership and stronger guidance, we're going to do some good, but we're not going to be transformative." However, the reality is that many organizations in urban neighborhoods do not have the expertise, financial stability, or legitimacy to undertake this anchor role, and strengthening that capacity where it is lacking is another opportunity for philanthropic action.

BOX 4

Working across Systems to Address the Health Effects of Air Pollution

Air pollution disproportionately affects the health of people living on lower incomes, and this inequity cannot be addressed by working with just one sector or community. Impact on Urban Health is working across systems to address the health effects of air pollution—working with community researchers to better listen to the voices of communities that are often not heard on environmental issues; working with schools and hospitals to protect environments those most at risk spend their time; and working with businesses in the construction and freight industries to find equitable solutions to addressing the root causes of air pollution.

Build Community Voice and Power

Those worst affected by health inequities in urban areas must have the agency, voice, and power to set the agenda for change. However, policymakers and practitioners often engage with communities in ways that can be disempowering—for instance, by limiting their ability to influence decisionmaking and delivering services without accountability to residents. Dialogue participants said philanthropic actors can model good practices for community power building by sharing power with communities, valuing local expertise, and changing harmful narratives.

People want the power to be self-determined and make their own decisions, not forced to make choices between choices they have versus the choices they want.
—Qiana Thomason, Health Forward Foundation

One way to share power with communities is institutionalizing opportunities for people to shape the design and implementation of solutions (i.e., build with, not for, communities). Health Forward Foundation, led by Thomason, is taking such an approach in its policy and civic engagement grantmaking to organizations focused on issues such as affordable housing, access to health, and health equity. Local organizations set the priorities and decide how resources are deployed to advance those priorities. Building community power can also mean providing infrastructure (e.g., funds, capacity building, information) necessary for community-level collaboration without centering organizational brand or claiming credit, said Michael Adamson of the British Red Cross. However, this can be a difficult practice to adopt if organizational boards place a premium on visibility and brand impact.

Building power requires a lot of trust, and deliberate efforts to value local knowledge can help develop it. Urban Institute researcher Elsa Falkenburger explained that communities are not passive

witnesses of the inequities in their neighborhoods; rather, residents define problems in their own terms and craft visions for change. Yet policymakers, researchers, and philanthropic institutions often place greater value on objectivity and technical evidence, discounting on-the-ground knowledge and lived experience, which ultimately impairs the work of power building. In addition, those that generate technical evidence have struggled to share data with communities in a way that meaningfully supports local action. The Urban Institute's Data Walks are one approach to bridging the gaps between researchers and communities (box 5).

BOX 5

Data Walk: An Innovative Way to Share Data with Communities

Urban Institute researchers developed Data Walks as an interactive way for community stakeholders and researchers to engage with one another on research findings about a community. In a Data Walk, residents, service providers, and researchers review data in small groups, interpreting what the data say and drawing on their individual and collective knowledge to improve policies and programs. This tool supports programmatic planning and data analysis on public health projects, offering an avenue for improving services, empowering communities, and increasing resident engagement.

Source: Brittany Murray, Elsa Falkenburger, and Priya Saxena, *Data Walks: An Innovative Way to Share Data with Communities* (Washington, DC: Urban Institute, 2015).

The tendency of policymakers, researchers, and philanthropies to describe and engage people and communities on the basis of their deficits, rather than their assets, further erodes trust. "The way we think about people drives narratives and the resources that people receive," Thomason said. "In philanthropy, part of our role is to build power and agency through advancing narrative change." This observation underscores how narratives can contribute to unequal power relationships between social groups in cities. For policymakers, philanthropy, and other actors, the language used to describe people and their health challenges warrants greater intentionality. In engaging with communities, philanthropic actors should assess the power dynamics implied in their language, consider what changes to their language could alter power dynamics and help build trust, and document actions they can take to change power dynamics that deepen health disparities (Moffatt and Fish 2013).

Only when individuals and communities have power can they assert greater control over the social and economic factors and policies that have long undermined their health. Margery Austin Turner noted that "communities can shake institutions out of their intellectual frameworks when they have real power and voice," creating space for solutions that reflect community needs, values, and priorities.

Change the Aperture for Measuring Structural Change and Its Contribution to Health Equity

What is measured significantly influences how organizations define health equity challenges, what they prioritize in their strategies, and how they deploy resources. Against the backdrop of recent progress in developing measures of health equity, philanthropic actors can help shift the dial on leveraging existing metrics to galvanize a system-wide focus on achieving health equity.

One line of action is to elevate health equity—however it is measured—as an explicit goal of public policy and programs, philanthropic initiatives, and commercial investments. The ambition is for each organization in the urban health ecosystem to continuously integrate health equity into its strategies, regardless of whether the organization's mission is focused on education, employment, neighborhood revitalization, or health care.

People aren't going to make change unless they have some sense of what building back better means.

—Neal Halfon, University of California, Los Angeles

As dialogue participants reflected, the COVID-19 pandemic has brought enough attention to urban health disparities that some organizations, like Health Forward Foundation, are realigning their focus to be at the nexus of health equity, economic well-being, and race equity. More of this needs to happen, and the current moment provides a window for organizations across the urban health ecosystem to rethink their performance measurement systems, with a goal of ensuring that they are asking the right questions and focusing efforts on issues that matter. Furthermore, health equity metrics can highlight relationships between the many social determinants of health, which can be instrumental in overcoming the challenges of diversifying partnerships, collaborating across sectors, and breaking free from the framework that centers health care systems.

Embedding health equity performance measures in organizational practices and leadership structures is another opportunity for action. Measuring outcomes for the most disadvantaged is a powerful principle for public health institutions, as well as CEOs of health care institutions, major employers, institutional investors, and other organizations. When organizations and their leaders are assessed on what they are doing—and how well they are performing—to advance equity, that may significantly strengthen incentives for action to address health disparities. Michael Adamson argued that it is not enough for philanthropies to assess CEO performance on the quality of operational delivery. Measuring performance in terms of systems change is also crucial.

Funders talk about health equity all the time, but they would be hard-pressed to define it, much less chart a path toward it.
—Faith Mitchell, Urban Institute

However, participants noted that measuring shifts in the structural systems (e.g., residential segregation) that underpin health disparities in cities is difficult. And to the extent that progress is made in shifting those systems, attributing those impacts to the interventions of actors working in the urban health ecosystem is even more difficult. This question of how to measure structural change is a conceptual challenge with broad practical implications and one that philanthropy can act upon in the current moment. Answering this question well would be a key contribution toward centering health equity in organizational practices and strategies, potentially shifting efforts away from activities with questionable impact.

Conclusion

The dialogue series was a unique opportunity amid the pandemic for experts from different corners of the urban health ecosystem to exchange insights and explore emerging lessons and pathways for action for those with a role in changing underlying systems of health, economic, and social inequity.

This brief is a synthesis of the three conversations and the issues that experts highlighted, with some reference to the emerging evidence of the pandemic's impacts on urban health equity. It also highlights the links between local actions and system-level solutions and the potential for innovative approaches to address challenges. This document is a contribution to the many discussions under way about how to ensure an equitable recovery from the pandemic.

The COVID-19 pandemic has laid bare the links between structural drivers—particularly structural racism—and the social determinants of health that have manifested in disproportionate mortality and morbidity for people of color. These patterns hold not only in cities in the US and UK but in cities across the world. For these experts, an important part of understanding what is happening is understanding the connection between place, structural racism, social determinants of health, and health equity. In cities, the disparate outcomes by location and race are not surprising, particularly because of the prevalence of residential and occupational segregation.

By bringing together health equity experts from the US and UK, the dialogue series documented lessons unfolding in real time. However, there is much to learn. Box 6 presents several unanswered questions worth considering as the push continues for a recovery with health equity at the center.

BOX 6

Crucial Questions for Future Health Equity Work

- To what extent does the COVID-19 pandemic change our understanding of urban health equity and the way we should work toward achieving it?
- To the extent that the pandemic has created a need for unconventional partnerships and new strategies to address health equity, what would it take to catalyze action in this direction?
- What policy and program solutions can address the structural factors (e.g., occupational segregation) that undermine health?
- How can philanthropy articulate an urban health equity learning agenda that supports local innovation, strengthens city-to-city learning, and informs replication on national and global scales?
- What practical tools and resources are needed to empower local leaders (public and private) to apply global insights locally?
- How can we refocus analytical work from studying causes of disparities to understanding paths to success in areas with better health equity outcomes to identify pockets of excellence?

Some actions for building urban health equity have come to the fore. The list is not exhaustive but includes defining urban equity with a focus on the social determinants of health; narrowing economic inequality, a process that requires leadership from multiple sectors; fostering new partnerships for action at the intersections evident in urban settings; engaging with communities in ways that build their voice and power; and changing the aperture for measuring performance of key stakeholders to strengthen the focus on structural challenges and build accountability for results.

For stakeholders who work toward health equity, the pandemic has created a moment in which more people are focused on addressing the challenges of health equity, as well as an opportunity to push an agenda focused on the social determinants of health. And even though the problems feel intractable, there seems to be a greater willingness to consider innovative solutions. Stakeholders are also more willing to explore leveraging their unique power to address obdurate social determinants.

Notes

1 The link between place and health can be conceptualized in four ways: (1) places as context for health, (2) places as causes or determinants of health, (3) places as reinforcers or moderators of interindividual health differences; and (4) places as integral components of the systems that give rise to health (Diez Roux 2020).

2 "COVID-19 Hospitalization and Death by Race/Ethnicity," Centers for Disease Control and Prevention, updated November 30, 2020, https://www.cdc.gov/coronavirus/2019-ncov/COVID-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html.

[3] "£5m Fund to Be Used with Immediate Effect to House 1,000 Rough Sleepers into Hotels," Greater Manchester Combined Authority, March 25, 2020, https://www.greatermanchester-ca.gov.uk/news/5m-fund-to-be-used-with-immediate-effect-to-house-1-000-rough-sleepers-into-hotels/.

[4] "The Temporary Eviction Moratorium," San Francisco Rent Board, updated January 13, 2021, https://sfrb.org/temporary-eviction-moratorium.

[5] Available evidence suggests that the effects of health on economic growth may be stronger in developing countries than in advanced economies.

[6] The "backbone" organization performs functions that can strengthen the collective impact of cross-sector efforts, including defining a collective vision, engaging vertically with actors at the city and regional level, integrating strategies and funding, building common metrics, and advancing evidence-based policy changes (Chandra et al. 2016; Turner 2014).

References

Alper, Joe. 2016. *Metrics that Matter for Population Health Action: Workshop Summary.* Washington, DC: National Academies Press.

Benjamin, Georges C. 2020. "Ensuring Health Equity during the COVID-19 Pandemic: The Role of Public Health Infrastructure." *Revista Panamericana de Salud Pública/Pan American Journal of Public Health* 44:e70. https://doi.org/10.26633/RPSP.2020.70.

Bilinski, Alyssa, and Ezekiel J. Emanuel. 2020. "COVID-19 and Excess All-Cause Mortality in the US and 18 Comparison Countries." *JAMA* 324 (20): 2100–102. https://doi.org/10.1001/jama.2020.20717.

Bloom, David E., and David Canning. 2008. "Population Health and Economic Growth." Working Paper 24. Washington, DC: Commission on Growth and Development, World Bank.

Bloom, David E., David Canning, and Jaypee Sevilla. 2004. "The Effect of Health on Economic Growth: A Production Function Approach." *World Development* 32 (1): 1–13. https://doi.org/10.1016/j.worlddev.2003.07.002.

Braveman, Paula, Elaine Arkin, Tracy Orleans, Dwayne Proctor, and Alonzo Plough. 2017. *What Is Health Equity? And What Difference Does a Definition Make?* Princeton, NJ: Robert Wood Johnson Foundation.

Chandra, Anita, Joie D. Acosta, Katherine Grace Carman, Tamara Dubowitz, Laura Leviton, Laurie T. Martin, Carolyn Miller, et al. 2016. "Fostering Cross-Sector Collaboration to Improve Well-Being." In *Building a National Culture of Health: Background, Action Framework, Measures, and Next Steps*, 62-81. Santa Monica, CA: RAND Corporation. https://doi.org/10.7249/RR1199.

Diez Roux, Ana V. 2020. "Conceptual Models and Frameworks for Understanding the Links between Urban Environments and Health." In *Urban Public Health: A Research Toolkit for Practice and Impact*, 1st ed., edited by Gina S. Lovasi, Ana V. Diez Roux, and Jennifer Kolker, 56–75. New York: Oxford University Press.

Egede, Leonard E., and Rebekah J. Walker. 2020. "Structural Racism, Social Risk Factors, and COVID-19—A Dangerous Convergence for Black Americans." *New England Journal of Medicine* 383:e77. https://doi.org/10.1056/NEJMp2023616.

Farberman, Rhea, Matt McKillop, Dara Alpert Lieberman, Daphne Delgado, Cecelia Thomas, Jonah Cunningham, and Kevin McIntyre. 2020. *The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations*. Washington, DC: Trust for America's Health.

Fedorowicz, Martha, Joe Schilling, and Emily Bramhall. 2020. *Leveraging the Built Environment for Health Equity: Promising Interventions for Small and Medium-Size Cities*. Washington, DC: Urban Institute.

Garcia, Marc A., Patricia A. Homan, Catherine García, and Tyson H. Brown. 2020. "The Color of COVID-19: Structural Racism and the Disproportionate Impact of the Pandemic on Older Black and Latinx Adults." *Journals of Gerontology Series B* 20 (20): 1–6. https://doi.org/10.1093/geronb/gbaa114.

Gupta, Poonam, Dulce Gonzalez, and Elaine Waxman. 2020. "Forty Percent of Black and Hispanic Parents of School-Age Children Are Food Insecure." Washington, DC: Urban Institute.

Kohli, Jitinder, and Anne De Biasi. 2017. *Supporting Healthy Communities: How Rethinking the Funding Approach Can Break Down Silos and Promote Health and Health Equity*. Deloitte University Press.

Lawrence, Doreen. 2020. *An Avoidable Crisis: The Disproportionate Impact of COVID-19 on Black, Asian and Minority Ethnic Communities.* London: Doreen Lawrence Review.

Maani, Nason, and Sandro Galea. 2020. "COVID-19 and Underinvestment in the Public Health Infrastructure of the United States." *Milbank Quarterly* 98 (2): 250–59. https://doi.org/10.1111/1468-0009.12463.

Marmot, Michael, Jessica Allen, Peter Goldblatt, Eleanor Herd, and Joana Morrison. 2020. *Build Back Fairer: The COVID-19 Marmot Review: The Pandemic, Socioeconomic and Health Inequalities in England*. London: Institute of Health Equity.

Moffatt, Hannah, and Karen Fish. 2013. *Let's Talk: Populations and the Power of Language*. Antigonish, NS: St. Francis Xavier University, National Collaborating Centre for Determinants of Health.

National League of Cities. 2015. *Addressing Health Disparities in Cities: Lessons from the Field*. Washington, DC: National League of Cities.

Public Health England. 2020. *Beyond the Data: Understanding the Impact of COVID-19 on BAME Groups.* London: Public Health England.

Sharpe, Bill. 2014. "Three Horizons and Working with Change." *APF Compass* (January): 6–8.

South, Eugenia C., Michelle C. Kondo, Rose A. Cheney, and Charles C. Branas. 2015. "Neighborhood Blight, Stress, and Health: A Walking Trial of Urban Greening and Ambulatory Heart Rate." *American Journal of Public Health* 105 (5): 909–13. https://doi.org/10.2105/AJPH.2014.302526.

Turner, Margery Austin. 2014. "Tackling Poverty in Place: Principles for a Next Generation of Place-Conscious Interventions." Paper presented at Innovating to End Urban Poverty conference, Los Angeles, March 27–28.

Tzoulas, Konstantinos, Kalevi Korpela, Stephen Venn, Vesa Yli-Pelkonen, Aleksandra Kaźmierczak, Jari Niemela, and Philip James. 2007. "Promoting Ecosystem and Human Health in Urban Areas Using Green Infrastructure: A Literature Review." *Landscape and Urban Planning* 81 (3): 167–78. https://doi.org/10.1016/j.landurbplan.2007.02.001.

Yang, Tse-Chuan, Seung-won Emily Choi, and Feinuo Sun. 2021. "COVID-19 Cases in US Counties: Roles of Racial/Ethnic Density and Residential Segregation." *Ethnicity & Health* 26 (1): 11–21. https://doi.org/10.1080/13557858.2020.1830036.

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