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Narrowing the Black-White Health Gap: Opportunities for Private Investment to Drive Progress in the United States

Nzinga H. Broussard
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Executive Summary

Race unjustly affects our health from the moment we are born until we die. Health disparities are numerous: the data show that Black people throughout the United States experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, and obesity when compared to their White counterparts. According to the Centers for Disease Control and Prevention (CDC), between 70 and 80 percent of all premature deaths are preventable and are attributable to inadequate clinical care and social, environmental, and behavioral circumstances.

The CDC defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health and no one is disadvantaged from achieving this potential because of economic, social, and other obstacles to health and health care. Achieving health equity in the U.S. will require an understanding of both the historic and contemporary determinants of health inequities.

This report provides an overview of the root causes of the Black-White health disparities in the U.S. and offers guidance to the private sector on investment strategies that will have a measurable impact on the Black-White health gap. Our intended audiences are impact investors, community development organizations, corporations, financial institutions, and others seeking to understand how to identify key features of a project or strategy that has the potential to effectively address the Black-White health gap.

Narrowing the Black-White health gap will require investments that address its root causes. The varying causes of the health gap offer numerous investment opportunities and areas for the private sector to consider, such as partnering with the public sector to address the social determinants of health (i.e., housing, education, wealth, and employment opportunities) that have disproportionately impacted the health of Black Americans, investing in innovative solutions that

> "...traditional means of addressing the Black-White health gap have failed and require a rethinking of how we pursue health equity."

mitigate the racial biases in clinical care, and investing in the expansion and construction of accessible and affordable health care clinics in Black communities.

Data indicates that traditional means of addressing the Black-White health gap have failed and require a rethinking of how we pursue health equity. This new way of thinking can be spearheaded by the private sector. We encourage impact investors to invest in solutions where evidence exists of their effectiveness in reducing the Black-White health gap and where additional capital flows will help the solutions and strategies scale.

In addition to backing evidence-based solutions, we encourage impact investors to participate in innovative opportunities, that can uniquely be accomplished by the private sector, given its appetite for risk associated with experimentation in exchange for both financial and social returns. When considering opportunities, we propose that the private sector take action to:

» **Diversify** the pool of decision makers and asset managers who determine what and who gets funded. This includes diversifying the governance and ownership of investments and decisions. Center the expertise of Black community members to create inclusive solutions that relate to the specific challenges and context of their communities. Allow them to define their own challenges and propose solutions that address key needs as defined by them. Fund those solutions.

» **Fund and scale** interventions that have demonstrated evidence of effectiveness. This includes expanding our definition of "evidence" to encompass community-defined evidence practices. Financial resources are scarce, so it is important that effective interventions are scaled to reach and benefit more people.

» **Invest in innovative solutions** that prioritize and benefit Black people. Solutions that disrupt existing approaches to health care and the root causes of the Black-White health gap offer substantial benefits. While the private sector may be limited in its ability to address the structural racism in health care policy, persistent racist medical practices and beliefs contribute to a Black-White health gap. Interventions that only target the economically disadvantage will be limited in their ability to narrow the Black-White health gap. Identifying solutions that can prevent the racial biases held by medical practitioners from impacting medical decisions can significantly improve health outcomes of all Black patients.

» **Generate evidence of effectiveness** in order to know which interventions work, understanding that the metrics to prove success will take time to generate. While in the short term there may not be any financial benefits of impact evaluations, these metrics can help free up financial resources from ineffective solutions and redirect them to effective efforts that deliver social and financial benefits.

Introduction

Despite being a socio-political construct without a biological basis, race unjustly affects our health from the moment we are born until we die. Health disparities are numerous: the data show that Black people throughout the United States experience higher rates of illness and death across a wide range of health conditions, including diabetes, hypertension, and obesity, when compared to their White counterparts. According to the Centers for Disease Control and Prevention (CDC), between 70 and 80 percent of all premature deaths are preventable and are attributable to inadequate clinical care and social, environmental, and behavioral circumstances.[1]

Achieving health equity in the U.S. will require an understanding of both the historic and contemporary determinants of health inequities. The CDC defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health and no one is disadvantaged from achieving this potential because of economic, social, and other obstacles to health and health care.

In the wake of the murder of George Floyd, the impact investing community has become increasingly interested in creating funds and financing innovations that address racial inequities in the U.S. An Urban Institute study estimated that between June 2020 and May 2021, racial equity commitments from companies and philanthropic institutions reached $200 billion.[2,3] For example, Johnson & Johnson launched Our Race to Health Equity, a $100 million commitment to help eradicate racial and social injustice as a public health threat. Jumpstart Nova was founded to invest in Black-founded and led companies in the health care industry. Similarly, Unseen Capital, created by racially diverse and historically underrepresented business leaders, funds and supports minority founders of early-stage health care companies building solutions for marginalized communities. Unlike the initiatives funded by grants, impact investing seeks financial returns alongside a social impact, which can incentivize the private sector to address societal issues, including racial health disparities. However, the field needs guidance to determine what type of investments will have a measurable impact on racial health disparities.

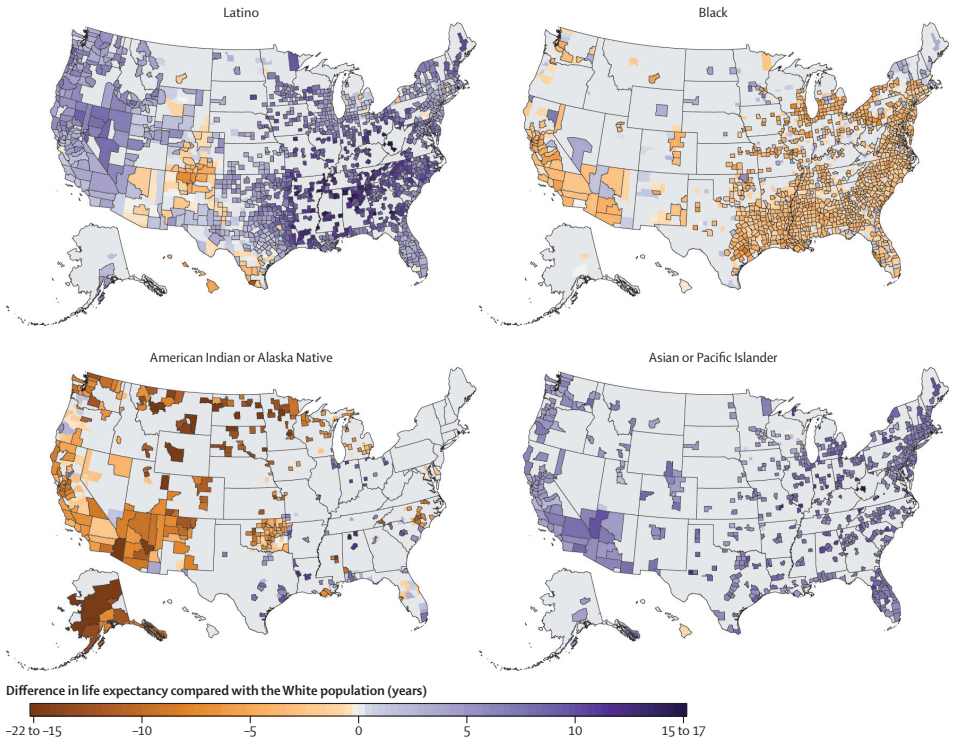
In this paper, we provide an overview of the root causes of Black-White health disparities in the U.S. and provide suggestions for areas of investment that have the potential to reduce the racial health gap. While we provide some detail for other groups as context on the overall state of health disparities in the U.S., this report primarily focuses on and examines health disparities between Black and White Americans. Our intended audiences are impact investors, community development organizations, corporations, financial institutions, and others seeking to understand how to identify key features of a project or strategy that has the potential to effectively address the Black-White health gap.

The Racial Health Gap in the United States

Racial health disparities in the U.S. are evident across an array of health outcomes, which manifest themselves in lower life expectancy and quality of life compared to White Americans. Population and death data from the National Center for Health Statistics shows that Black and American Indian or Alaska Native (AIAN) people have shorter life expectancies, whereas Asian and Latino populations have longer life expectancies, compared with their White counterparts.[4] Nationally, in 2021, life expectancy for Black Americans and AIANs was 5.8 and 11.2 years shorter than White Americans, respectively. Life expectancy for Asians and Latinos was 7.1 and 1.3 years longer than White Americans, respectively.

However, these numbers mask differences at the sub-national level.[5] Magnitudes of these differences in life expectancy across racial–ethnic groups relative to the White population varied substantially between counties. Estimated life expectancy was lower for Black Americans than for White Americans in 86.9 percent of the 1,480 counties where reliable estimates were available, with the difference in estimated life expectancy as large as 15.5 years. For the AIAN population, estimated life expectancy was lower than for the White population in 75 percent of the 418 counties where reliable estimates were available, with the difference in estimated life expectancy as large as 21.7 years.[6]

FIGURE 1: Absolute difference between the White population and members of other racial–ethnic groups in estimated county-level life expectancy at birth, 2019



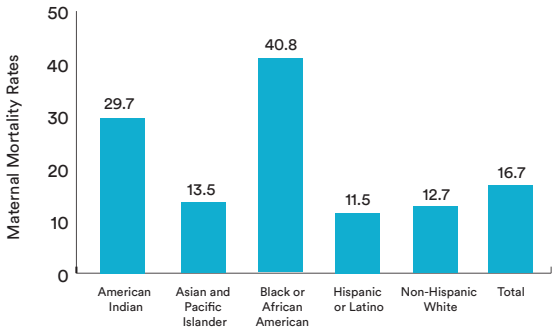
Source: Lancet, 2022

This pattern is also reflected in maternal and infant mortality rates. During the period 2007 – 2016, the maternal mortality rate in the U.S. was 16.7 deaths per 100,000 births. However, for Latina, White, and Asian women, the rates were between 11.5 and 13.5 deaths per 100,000 births, whereas for American Indian and Black Women the rates were 2.3 and 3.2 times higher, respectively.[7] In 2017, the infant mortality rate in the U.S. was 5.8 deaths per 1,000 live births. For American Indian infants, the mortality rate was 8.0 deaths per 1,000 live births, and for Black infants the mortality rate was 10.8 deaths per 1,000 live births.

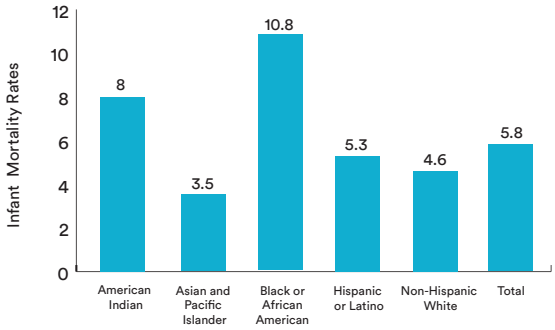
The above statistics highlight the staggering differences in health across race and ethnicity in the U.S. These differences are experienced from birth and persist throughout life. For example, when compared to their White counterparts, Black people experience higher rates of diseases like diabetes (18.8 percent vs 12.0 percent), hypertension (56.9 percent vs 43.5 percent), and obesity (49.9 percent vs 41.4 percent).[8]

Similarly, this pattern is reflected in self-reported health status. Evidence has shown that repeated exposure to socioeconomic adversity, racism, marginalization, and discrimination has detrimental impacts on health. This is known as weathering, where the racism experienced by Black people contributes to accelerated biological aging due to chronic stress that contributes to premature death.[9,10] Additionally, exposure to racism can lead to toxic stress, which is characterized as strong, frequent, or prolonged activation of stress response systems in the body and brain. During childhood, a period of development, toxic or chronic stress can lead to problems in learning, behavior, and both physical and mental health.[11] In 2018, 9 percent of Americans reported their health was generally fair or poor. However, 13.5 percent of Black Americans reported their health was generally fair or poor and 18.6 percent of American Indians reported their health was generally fair or poor.

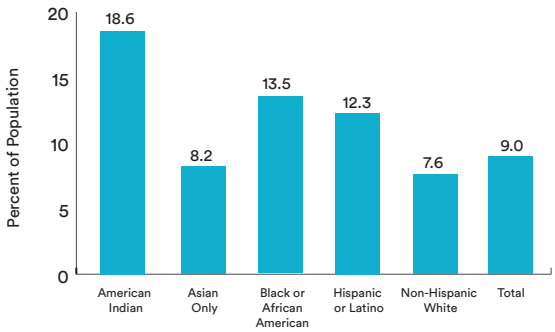
MATERNAL MORTALITY RATES IN THE U.S. BY RACE/ETHNICITY, 2007 -2016*



INFANT MORTALITY RATES IN THE U.S. BY RACE, 2017*



RESPONDENT-ASSESSED FAIR OR POOR HEALTH STATUS IN U.S. BY RACE, 2018*



The next sections investigate the determinants of the Black-White health gap in the U.S. We then propose investment strategies to reduce that gap, identifying how additional capital flows will help solutions and strategies to reach scale. We conclude by encouraging impact investors to take up innovative solutions to addressing the Black-White health gap, urging them to tap into their appetite for risk associated with experimentation in exchange for financial and social returns.

**Sources: CDC. (2019). Morbidity and Mortality Weekly Report. 68(35): 763, Centers for Disease Control and Prevention, National Center for Health Statistics. NCHS, National Health Interview Survey.*

Social Determinants of Health

Centuries of racism in the U.S .have impacted housing, education, wealth, and employment opportunities. These social determinants of health are key drivers of health inequities within Black communities, placing millions of people at greater risk for poor health outcomes. The social determinants of health are a useful framework for understanding structural racism[12] and its impacts on health, as well as the solutions required to address the Black-White health gap.

Black Americans disproportionately experience negative health outcomes related to the social determinants of health because of centuries of structural racism that have contributed to a lower average socioeconomic status for Black Americans. The result is a Black-White health gap, which predicts a higher likelihood of conditions damaging the health and quality of life of Black Americans compared to Whites, culminating in a lower overall life expectancy. The following subsections summarize the social determinants of health.

EDUCATION

There is an extensive body of research demonstrating a positive correlation between educational attainment and health outcomes.[13] Each additional level of educational attainment is associated with at least an 18 percent lower mortality rate.[14] Additionally, educational attainment affects health across generations. Research has shown that children born to mothers who have not completed high school are twice as likely to die before their first birthday compared to children born to college graduates.[15] While education may impact health outcomes through income and employment opportunities, education also affects health independently through health knowledge and problem-solving skills, which influence health behaviors.

Since the early 1980s, the proportion of Black people 25 and older who obtained a bachelor's degree has persistently been about 10 percentage points below the U.S. national rate. The racial education gap has been attributable to several different factors including access to quality and adequately funded schools, access to math, science, and college preparatory courses, and disproportionate use of disciplinary actions such as being held back a grade, suspended, or expelled.[16]

HOUSING

Housing, as a social determinant of health, refers to the availability of high-quality, safe, and affordable housing for residents at varying income levels. Housing affects health through the physical conditions within homes such as indoor air quality, lead paint, and allergens, through the neighborhood characteristics by providing safe places to play and exercise free from crime and pollution, access to grocery stores and healthy foods, and through housing affordability, which affects financial stability and the overall ability of families to make healthy choices.[17]

Historically, Black Americans were excluded from government efforts to reduce barriers to affordable and safe housing. Instead, Black communities were often destroyed to create public spaces, to construct new highway systems, or to combat urban blight. This has contributed to people of color being unable to obtain and retain their own homes and access safe, affordable housing.[18]

For more than three decades, the federal government refused to insure mortgages in or near African-American neighborhoods, a practice known as redlining, and subsidized subdivisions for Whites while prohibiting the sale of homes to African-Americans.[19] Current neighborhood segregation directly relates to the government's past redlining and discriminatory practices in the housing market.

INCOME AND WEALTH

Low-income American adults have higher rates of heart disease, diabetes, stroke, and other chronic health conditions than wealthier Americans. Additionally, children in poor families are approximately four times as likely to be in poor or fair health as children in families with incomes at or above 400 percent of the Federal Poverty Level. The gap in life expectancy between the richest and poorest 1 percent of individuals was 14.6 years for men and 10.1 years for women.[20] Access to financial resources affects health by buffering individuals against the financial threat of large medical bills while also facilitating access to health-promoting resources such as access to healthy neighborhoods, homes, land uses, and parks.[21]

There is extensive literature on the racial wealth gap.[22] White families have 8 times as much wealth as Black families.[23] Gaps in wealth between Black and White households reveal the effects of accumulated inequality and discrimination, as well as differences in power and opportunity. White families receive much larger inheritances on average than Black families. Economic studies have shown that inheritances and other intergenerational transfers "account for more of the racial wealth gap than any other demographic and socioeconomic indicators." Additionally, because intergenerational transfer of wealth is lightly taxed, historical gaps persist over generations.[24] While White households have been able to build generations of wealth for themselves and their descendants, Black households were often stripped of whatever wealth they could amass either through anti-Black violence or government actions. Examples include the destruction of Black Wall Street in the Greenwood neighborhood of Tulsa, Okla., in 1921 and the possession of Bruce's Beach by eminent domain in Manhattan Beach in Los Angeles County, Calif., in 1924.

Research conducted by Andre Perry and coauthors with the Brookings Institution found that homes of similar quality in neighborhoods with similar amenities are worth 23 percent less in majority Black neighborhoods, compared to those with very few or no Black residents. He estimates that across all majority Black neighborhoods, owner-occupied homes are undervalued by $48,000 per home on average, amounting to $156 billion in cumulative losses.[25] Similarly, they find that only 3 percent of Black households own commercial real estate, compared to 8 percent of White households, with commercial real estate in Black neighborhoods undervalued by 7 percent. This amounts to Black commercial property owners losing $171 billion in aggregate wealth.[26]

EMPLOYMENT OPPORTUNITIES

Employment opportunities influence health through income, providing access to housing, education, and other factors that promote health, but also through the work environment, the nature of the work, and access to health insurance and paid sick leave.

Due to restrictions within the U.S. labor market, Black Americans have long been excluded from employment opportunities promoting upward mobility, stuck instead in low-wage occupations that are less likely to offer health insurance and paid sick leave.[27] For example, in South Carolina, Black Americans were prohibited from engaging in any trade or business other than farming, manual labor or domestic service. Additionally, the Black unemployment rate has consistently been at or above twice the White unemployment rate for the past 50 years.[28]

Clinical Care

Primary care providers have a significant impact on health outcomes. They serve as the first point of contact for patients, and therefore the first line of defense to keep small health issues from becoming large ones and to catch the first warning signs of serious illness, the timing of which can spell the difference between treatable and life-threatening diagnoses. Primary care providers can also coordinate patients' care under multiple specialists and can–if they do their jobs equitably and sensitively–know their patients and their health history and better care for them throughout their life.[29]

"These beliefs that Black Americans experience less pain than White Americans can be traced back to the 19th century when doctors would experiment on slaves."

Race has been shown to play a role in clinical decision making and treatment, despite race being a socio-political construct without a biological basis.[30] There is substantial research showing racial differences in diagnoses, treatment decisions, pain management, and dosing and prescribing of certain drugs.[31] The Institute of Medicine found that for patients of similar insurance status, income, age, and severity of conditions, people of color receive lower-quality health care. They are less likely "to be given appropriate cardiac care, to receive kidney dialysis or transplants, and to receive the best treatments for stroke, cancer, or AIDS." These disparities leave Black individuals more likely to die from illnesses. A 2016 study showed that racial bias in pain perception is associated with racial bias in pain treatment recommendations, specifically that individuals with at least some medical training held and use false beliefs about biological differences between Blacks and Whites to inform medical judgments.[32] These beliefs that Black Americans experience less pain than White Americans can be traced back to the 19th century when doctors would experiment on slaves. For example, advancements in gynecology came about from experiments on slaves without the use of anesthesia because of the belief that Black people did not experience pain the same as White people.

Physicians with high levels of implicit bias have been shown to dominate conversations with Black patients more, and those patients trust them less.[33] Evidence has shown that Black women's greater exposure to risk factors around the time of pregnancy does not fully account for the racial gap in maternal mortality.[34] Specifically, many instances where women experienced complications or died during pregnancy or birth include aspects where medical professionals had not been fully attentive to Black women's concerns or medical needs. This treatment is irrespective of education or class. Infants of college-educated Black women experience 3.1 more deaths per 1,000 live births than infants of White women with a high school degree or less.[35] A recent study found that in California, infant and maternal health in Black families at the top of the income distribution were worse than that of White families at the bottom of the income distribution.[36]

Health Care Access and Affordability

The U.S. has one of the highest costs of health care in the world, despite having the lowest life expectancy and highest chronic disease burden compared to other high-income countries.[37] Hospitals and doctors charge more, the same procedures and medicine cost more, and administrative costs are higher in the U.S. compared to other high-income countries.[38] A lack of government regulation also allows prices to skyrocket as companies and hospital systems merge.[39]

Not only does the U.S. spend more on health care per person than do other countries, but more of these costs shift to the patient in the U.S than do costs elsewhere. Despite Americans, on average, spending less time in hospitals and making fewer visits to doctors,[40] they pay premiums and co-pays on top of additional large bills for tests and treatments not covered by insurance. High-deductible health plans–which cover nearly one-third of people with employer-sponsored health insurance and are becoming more common–leave even insured individuals responsible for burdensome medical costs.[41]

In the face of these costs, nearly a quarter of Americans have reported they skip medical care because of the cost, and 18 percent reported having to borrow money to pay medical bills, with 9 percent taking on substantial debt.[42] Individuals without insurance are less likely to receive preventative care and treatment for chronic conditions that affect development and quality of life.[43]

The lack of equitable access to high-quality health care is closely related to structural racism in U.S. health care policy. Early U.S. health care policies created disparities in health care and health insurance. For example, the Hospital Survey and Construction Act of 1946 allowed states to construct racially separate and unequal facilities. The National Labor Relations Act of 1935 resulted in higher wages and benefits such as health insurance for individuals represented by unions; however, it excluded service, domestic, and agricultural industries–sectors that disproportionately employed people of color due to labor market discrimination.[44]

Modern U.S. health care policy continues to limit equitable access to high-quality care. While the Affordable Care Act (ACA) expanded health insurance coverage and reduced inequities,[45] the Supreme Court's decision in National Federation of Independent Business v. Sebelius made Medicaid expansion optional for the states. To date, 11 states, primarily in the South with large numbers of Black and Latino populations, have not adopted the expansion.

The COVID-19 pandemic highlighted the structural racism in the U.S. health care system. Black Americans were three times as likely – and Hispanic and Latino Americans were twice as likely – as Whites to report the loss of health insurance during the pandemic.[46] Workers of color were also more likely than White workers to have jobs that lacked employer-subsidized health insurance and paid sick leave, and that exposed them to COVID-19 in "essential" positions.[47,48,49]

The most commonly cited barrier to getting mammography by Black women, an important screening for signs of cancer, is the cost of health care or a lack of insurance.[50] A study on the impacts of high-deductible insurance plans showed that Black cancer survivors were almost three times as likely to skip medication to save money than White survivors on the same plan. High-deductible plans–as with other financial barriers to health care–"compound the many structural inequities that Black cancer survivors are already facing" and contribute to a widening Black-White health gap.[51]

Research and Development

Research and development allow for the development of new technologies, drugs, vaccines, and diagnostic tools to combat and treat health challenges. Additionally, more diverse clinical trial representation is critical to help ensure the immunology of a disease is accurately reflected in the drugs we develop.

The National Institute of Mental Health, the lead federal agency for research on mental health, found that Black people who apply for research funding with the institute are less likely to receive funding compared to White people, even when controlling for factors such as educational background, publications, citations, research awards, and seniority.[52] There has been evidence to suggest that research on diseases and conditions that primarily affect people of African descent are underfunded and under researched. For example, Sickle cell disease, a recessive inherited disorder, which primarily affects people of African descent and affects millions globally, has had few breakthroughs in treatments. In comparison, another recessive genetic disease, cystic fibrosis, which affects primarily people of Caucasian descent, receives 7 to 11 times the research funding per patient even though cystic fibrosis affects far fewer Americans (30,000 compared to 100,000 Americans with sickle cell disease). Similarly, more FDA-approved therapies are currently available on the market for cystic fibrosis.[53]

"There has been evidence to suggest that research on diseases and conditions that primarily affect people of African descent are underfunded and under researched."

Many clinical trials do not accurately represent patient populations. In 2016, only 7 percent of people who participated in clinical trials were African American. In 2021, African American participation rates of inclusion in trails for the treatment of cancers ranged from a high of 12 percent to as low as 1 percent, despite their 14 percent greater risk of dying from cancers.[54]

Investment Opportunities

This section provides suggestions for investment strategies that have the potential to narrow the Black-White health gap. The first subsections provide evidence-based interventions funded by the private sector that have documented health improvements in people of color. When available, we provide strategies that have addressed each of the root causes of the Black-White health gap. The proposed strategies are not meant to be exhaustive, but rather should be considered as an initial menu of proven options for investors interested in advancing racial health equity. The final subsection argues for investments in innovative solutions that prioritize the health and wellbeing of people of color. Erika Seth Davies, CEO of Rhia Ventures and Founder of the Racial Equity Asset Lab, argues that "color-blind solutions have not worked" and investments need to be intentional in their focus to improve the health outcomes of people of color.

SOCIAL NEEDS AND SOCIAL DETERMINANTS OF HEALTH

Investing in the social determinants of health improves community conditions and can be accomplished through investments in holistic community well-being strategies, infrastructure (such as housing, early childhood centers, small businesses, transportation), and systems approaches to change the ways housing, education, and economic systems impact the health of communities. The private sector can play an important role in narrowing the Black-White health gap by either investing in interventions that address the social needs of marginalized communities and people of color, i.e., the immediate individual needs that are the consequences of the social determinants of health, or by partnering with the public sector to address the "upstream" social determinants of health (i.e., the social and economic conditions in which people live that drive disparities in income, health, and opportunity).

We argue that investing in the social needs of people of color and/or the social determinants of health will not only narrow the Black-White health gap but also can generate financial returns to investors. For example, Montefiore Health System in the Bronx started the Housing at Risk Program to identify and assist homeless and housing insecure patients. The program reduced the number of emergency room visits and unnecessary hospitalizations and resulted in an annual 300 percent return on investment for the Montefiore Health System.[55]

Co-location partnerships between health and social service organizations

Impact investors can finance real estate development projects that utilize co-location models (two organizations operating at one location) or single-service provider models that promote primary care access and improve health by addressing social needs such as affordable housing and healthy food. Community members have identified non-clinical services–such as housing assistance, job training, and food banks–as having greater benefits to their health than medical care.[56] The co-location of health and social services offers a convenient and efficient way to serve community members.[57]

REACH (Racial and Ethnic Approaches to Community Health) 2010 is a federal initiative, established in 1999, funded by the U.S. Centers for Disease Control and Prevention to eliminate health disparities among racial and ethnic communities and serves as evidence of the impact of an integrated approach. The local Charlotte REACH 2010 program was implemented over a seven-year period to reduce health disparities in cardiovascular disease and diabetes in a North Carolina community of 20,000 African Americans by creating changes in individual behaviors, community capacity and systemic policies. The program featured community health workers, targeted individual interventions (e.g., exercise, nutrition, smoking cessation, primary care), and environmental and systemic interventions (e.g., launching a culturally specific mass media campaign to raise awareness and target specific health behaviors, starting and maintaining a local farmer's market, expanding physical activity programs, and promoting healthy food labeling in area schools and restaurants). An evaluation of the program found statistically significant improvements in physical activity, smoking cessation, and healthy eating for those who participated in the program.[58]

The National Center for Medical-Legal Partnership leads efforts to help every health organization in the U.S. leverage legal services as a standard part of the way they respond to social needs. They integrate the expertise of lawyers into health care settings to help clinicians, case managers, and social workers address the root causes of health inequities.[59] Over 400 medical-legal partnerships, where health care providers refer patients to on-site legal services, are currently in place in 48 states and engage in clinic- and policy-level projects designed to improve health and health equity for communities. Having lawyers embedded in the health care team can help patients resolve housing, employment, and other legal issues before they reach crisis levels. Reported benefits include improved health and fewer hospital admissions among people with chronic illnesses, reduced stress and improvements in mental health, and greater medication adherence.[60,61,62,63]

Health information technology combined with community resources and services

Invest in companies that develop innovations in health information technology. Health information technology (IT) is the processing, storage, and exchange of health information in an electronic environment. Investments in health IT have the potential to improve the quality of health care, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.[64] Additionally, combining health information with high-quality data on community resources provides opportunities for health care providers and patients to address basic, wellness, and disease management needs.

CommunityRx, launched in 2012, is a health innovation that uses aggregate electronic health records and community resources data to provide patient-centered e-prescriptions and resources for community health and social services. An independent evaluation of the innovation in Chicago's south and west sides found that CommunityRx increased primary care use and lowered hospital admissions for Medicare patients and lowered emergency department admissions for Medicaid patients.[65]

Investments in high quality early childhood initiatives

Invest in high quality early childhood initiatives. Inequities in health begin early in life, and effectively reducing them calls for investments in early childhood interventions. Black children are less likely to access high-quality early care and education, and are twice as likely as Hispanic and White children to be in child care centers rated as "low quality".[66] Research shows that ensuring

access to high-quality, affordable early childhood education programs for children of color who have not had equal access results in long-term benefits such as higher test scores, improved graduation rates, better chances of gainful employment and decreases in incarceration and substance abuse.[67] The Perry Preschool Program, carried out from 1962 to 1967, provided high-quality preschool education to three- and four-year-old African American children living in poverty in Michigan. In adulthood, the recipients of the program had higher educational attainment and income, lower rates of criminal activity, better overall health, and engaged in fewer risky behaviors compared to non-recipients of the program.

CLINICAL CARE

Community-based birthing centers that employ community-based doulas and midwives

Finance the development and expansion of Black-owned or led birthing centers. Birth centers are stand-alone facilities that provide pre- and post-natal care. Care is provided in a nurturing place that emphasizes relationship-building between providers and pregnant people. Studies have found that women giving birth in birth centers had lower rates of cesarean sections, were more likely to carry to term, and had lower rates of low birth weight compared with women delivering in hospitals.[68,69,70] Black-owned, culturally sensitive birth centers have the potential to reduce racial disparities in maternal mortality.[71] Research has shown lower rates of infant mortality for Black infants when newborns share the race with their physician.[72] However, only about 3 percent of all U.S. birth centers are owned or led by people of color.[73]

Doulas are trained professionals who provide continuous psychosocial, emotional, and informational support before, during and after childbirth. Evidence has shown that Medicaid beneficiaries and women of color receiving doula support had lower rates of cesarean sections and preterm births.[74,75]

HEALTH CARE ACCESS

Community Health Centers

A key strategy to improving access to health services is to finance the development, expansion, and upgrades of health centers serving people of color in medically underserved areas, i.e., those lacking sufficient capacity of physicians and health services. Across the U.S., more than 1,400 community health centers provide primary care services to underserved communities that might not otherwise have access to care. Quality of care in these centers is similar to care provided in other settings and observed racial/ethnic disparities in care are smaller, though disparities still remain. Impact investors can support the expansion of providers' capacity to effectively serve patients by opening a new location, consolidating multiple locations, supporting new or continued mobile care delivery, relocating a facility to a more accessible location, or upgrading technology to increase efficiency and reach (for example, through investing in telehealth or administration technology or in additional staff that will allow doctors to see more patients).

Evidence suggests that community health centers are successful in reducing health access disparities. Using comprehensive site-level data, patient surveys, and medical record reviews, an evaluation of health centers found that the community health center network has reduced racial/ethnic, income, and insurance status disparities in access to primary care and important preventive screening procedures. In addition, the network reduced low birth weight disparities for African American infants.[76]

INNOVATIVE SOLUTIONS

Addressing the Black-White health gap will require innovative solutions, i.e., new delivery models, technologies, and medical insights that prioritize and benefit people of color. Investment opportunities exist in early-stage high-impact companies that are driving innovation, access, and

equity in the health sector. Venture funds like RH Capital, a Rhia Ventures fund, seek both financial and social returns by investing in innovations that aim to improve the health of women in the U.S. with a commitment to gender and racial equity. The fund is increasingly leveraging the work from The Racial Equity Asset Lab as part of its due diligence process to assess potential investments' ability and likelihood to address health equity, providing technical assistance and venture support as needed.

Innovations in health care can have relatively high returns as well as social benefits. Hospitals do not like uninsured patients, patients who cannot be discharged (taking up valuable bed space), patients who are readmitted too soon (Medicare will not pay for readmissions within 30 days for a wide range of diseases), and emergency rooms overwhelmed by conditions that would be better treated in an urgent care community clinic. These all represent low-hanging fruit for innovative solutions. Innovations that allow for home visiting, home monitoring, telehealth, provision of food, utilities, other services can help keep patients home following discharge.

Cityblock Health, a health technology start-up, is an example of a successful startup focused on marginalized and lower-income people across the U.S. Cityblock combines primary care, behavioral health, and chronic disease management services. Cityblock has claimed a 15 percent reduction in emergency room visits, a 20 percent reduction in in-patient hospital stays, and three times year-over-year revenue growth.

Hospitals working in impoverished and housing-unstable neighborhoods can be innovative in how they view their communities and treat local residents. For instance, health care providers caring for individual children from these affected neighborhoods encounter challenges to service delivery, including extreme residential mobility and school changes, that undermine interventions. In response, Nationwide Children's Hospital in Columbus, Ohio, employed a novel approach to addressing the negative impacts that impoverished neighborhoods can have on health and wellbeing by viewing the neighborhood as the "patient" to address the social determinants of health. It considered the needs of the Southern Orchards neighborhood, which was racially segregated from historic housing discrimination and deeply impacted by the construction of major urban highways in the mid-20th century, which physically separated the neighborhood from downtown Columbus. The result is a neighborhood where 50 percent of children live in poverty (half being African American). Nationwide Children's implemented the Healthy Neighborhoods Healthy Families (HNHF) initiative in 2008 to revitalize housing in nearby neighborhoods like Southern Orchards. The outcomes of the HNHF initiative to date are still being assessed, but there is some early evidence suggesting positive impacts. For example, youth who participated in the area's various youth development programs showed progress in emotional health and academic performance. Similarly, the local high school graduation rate increased from 64 percent in 2013 to 79 percent in 2017.[77]

Investing in Black-led organizations and recruiting Black community members to join the investment panels that make final investment decisions can help identify relevant and sustainable community change solutions. Listening to and treating Black community members as experts in defining their own challenges and crafting solutions centers the community voice in developing health interventions that address key needs as defined by residents. This presents opportunities to invest in community-defined evidence practices (CDEPs). CDEPs are a set of solutions/interventions that communities have used to address challenges faced within their communities and have reached

"White-led CDFIs hold six times the assets as Black-led CDFIs, and while assets have been growing over time for White-led CDFIs, they have been stagnant for Black-led CDFIs."

a level of acceptance by the community.[78] The same can be said about investing directly in Black-led organizations that lack access to resources needed to tackle the root causes that alleviate poverty and advance racial equity. For instance, community development financial institutions (CDFIs) provide access to financial products and services for residents and businesses in low-income communities. However, White-led CDFIs hold six times the assets as Black-led CDFIs, and while assets have been growing over time for White-led CDFIs, they have been stagnant.[79]

There are also opportunities to offer innovative financial instruments or financing strategies to build evidence on what works and what does not work in advancing racial health equity. Financial instruments like recoverable grants (RG) offer growth capital for nonprofit organizations and their programs. They operate like a loan in that there is an expectation of repayment, but only if organizations meet particular objectives for impact or financial performance. RGs can be used to test not only the financial viability of an innovation, but also generate evidence of effectiveness. Tiered evidence financing is a financing strategy that incorporates evidence of effectiveness into the financing decision. Under this approach, investment firms establish tiers of financing based on the level of evidence the investee provides on their proposed solution. Smaller amounts of financing are used to test new and innovative approaches, while larger amounts of financing are used to scale approaches with strong evidence. Impact-linked financing is another financial strategy that provides financial incentives for the achievement of social outcomes. Financial incentives may include partial debt forgiveness or lower interest rates.

Conclusion

Our interviews with health experts and investors of color illuminate the shared belief that the decision makers in health care, research organizations, and investment firms determine who is valued, who and what gets funded, and what conditions and diseases are worthy of their resources. There is consensus that addressing the Black-White health gap will require diversifying the pool of decision makers. Within the financial services industry, only 2 percent of asset managers are Black, Indigenous, or People of Color and only 1.4 percent of total U.S.-based assets under management are managed by diverse-owned firms.[80]

Ashley Valentine, co-founder and president of Sick Cells, stated "representation matters. Investors who do not look like or have not lived like the populations they are trying to help, often struggle to prioritize the same issues that we face in our communities. That's because being a historically disenfranchised community means that we have had to navigate the health care system in a way that gives us a different vantage point than those who have been fortunate enough to not face the same barriers."

There is also consensus that the old way of addressing the Black-White health gap in the U.S. is not working and requires a new approach. These new strategies should use existing evidence to scale proven solutions that disproportionately benefit Black people and/or address the root causes of the Black-White health gap. They should identify and invest in innovations that are explicitly focused on racial equity, which will also generate more evidence to determine which solutions are working and should be funded and which ones are falling short of their intended purpose.

The objective of this paper is to help impact investors, community development organizations, corporations, and financial institutions better understand the factors contributing to the Black-White health gap and propose investment strategies that can effectively improve health outcomes of people of color. The Black-White health gap in the U.S. is the result of centuries of racist practices, beliefs, and policies that are still reflected in our institutions, neighborhoods, and funding decisions. Community development organizations and non-profits have been at the forefront of addressing the inequities that Black Americans face. However, more needs to be done to narrow and ultimately close the Black-White health gap. While the government plays an important role in redesigning institutions and shaping policies that equally benefit all Americans regardless of race, the private sector can also play an active role in identifying solutions that reduce inequities. The public sector tends to be risk-averse with taxpayer dollars, given the political consequences if proposed solutions fail. However, the private sector is incentivized to take on risk in order to generate financial and social returns.

It is clear that traditional means of addressing the Black-White health gap have failed and require rethinking how we pursue health equity. The private sector can spearhead these efforts, and we suggest the following strategies to help clarify how solutions are identified and funded.

» **Diversify** the pool of decision makers and asset managers who determine what and who gets funded. This includes diversifying the governance and ownership of investments and decisions. Center the expertise of Black community members to create inclusive solutions that relate to the specific challenges and context of their communities. Allow them to define their own challenges and propose solutions that address key needs as defined by them. Fund those solutions.

» **Fund and scale** interventions that have demonstrated evidence of effectiveness. This includes expanding our definition of "evidence" to encompass community-defined evidence practices. Financial resources are scarce, so it is important that effective interventions are scaled to reach and benefit more people.

» **Invest in innovative solutions** that prioritize and benefit Black people. Solutions that disrupt existing approaches to health care and the root causes of the Black-White health gap offer substantial benefits. While the private sector may be limited in its ability to address the structural racism in health care policy, persistent racist medical practices and beliefs contribute to a Black-White health gap. Interventions that only target the economically disadvantage will be limited in their ability to narrow the Black-White health gap. Identifying solutions that can prevent the racial biases held by medical practitioners from impacting medical decisions can significantly improve health outcomes of all Black patients.

» **Generate evidence of effectiveness** in order to know which interventions work, understanding that the metrics to prove success will take time to generate. While in the short term there may not be any financial benefits of impact evaluations, these metrics can help free up financial resources from ineffective solutions and redirect them to effective efforts that deliver social and financial benefits.

ABOUT THE AUTHOR

Nzinga H. Broussard

Nzinga H. Broussard, Senior Manager, leads the research on NMSC's impact focus areas and evaluations of NMSC's projects. In this role she provides thought leadership and generates learnings from NMSC's investments. Prior to joining NMSC, Nzinga served as a Senior Director of Impact at the Global Innovation Fund (GIF), a non-profit organization that invests in the development, rigorous testing, and scaling of innovations targeted at improving the lives of the world's poorest people. At GIF she quantified the social and economic benefits of potential investments to inform GIF's investment decisions and monitored the social impact performance of GIF's investments and investment portfolio. Prior to GIF, Nzinga was an economist at the Millennium Challenge Corporation. Nzinga has over 14 years of research and applied experience as an economist and impact measurement professional. Dr. Broussard has a joint doctoral degree in Economics & Public Policy from the University of Michigan and a B.A. in Economics and Mathematics from Oberlin College.

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