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Health Research Brief

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How State and Local Leaders View Social Determinants of Health and Health Equity

The *What Shapes Health and Well-Being Survey* explores how state and local leaders view, understand, and talk about the factors affecting health and well-being in their communities. Drawing on data from 5,450 state and local leaders throughout the United States, this brief presents the main findings from the survey, which ended in March 2022. It also provides links to toolkits and other resources for state and local leaders who want to work toward a future in which all people have a fair and just opportunity to be healthy. This work was supported by the Robert Wood Johnson Foundation and conducted by Mathematica.

Introduction

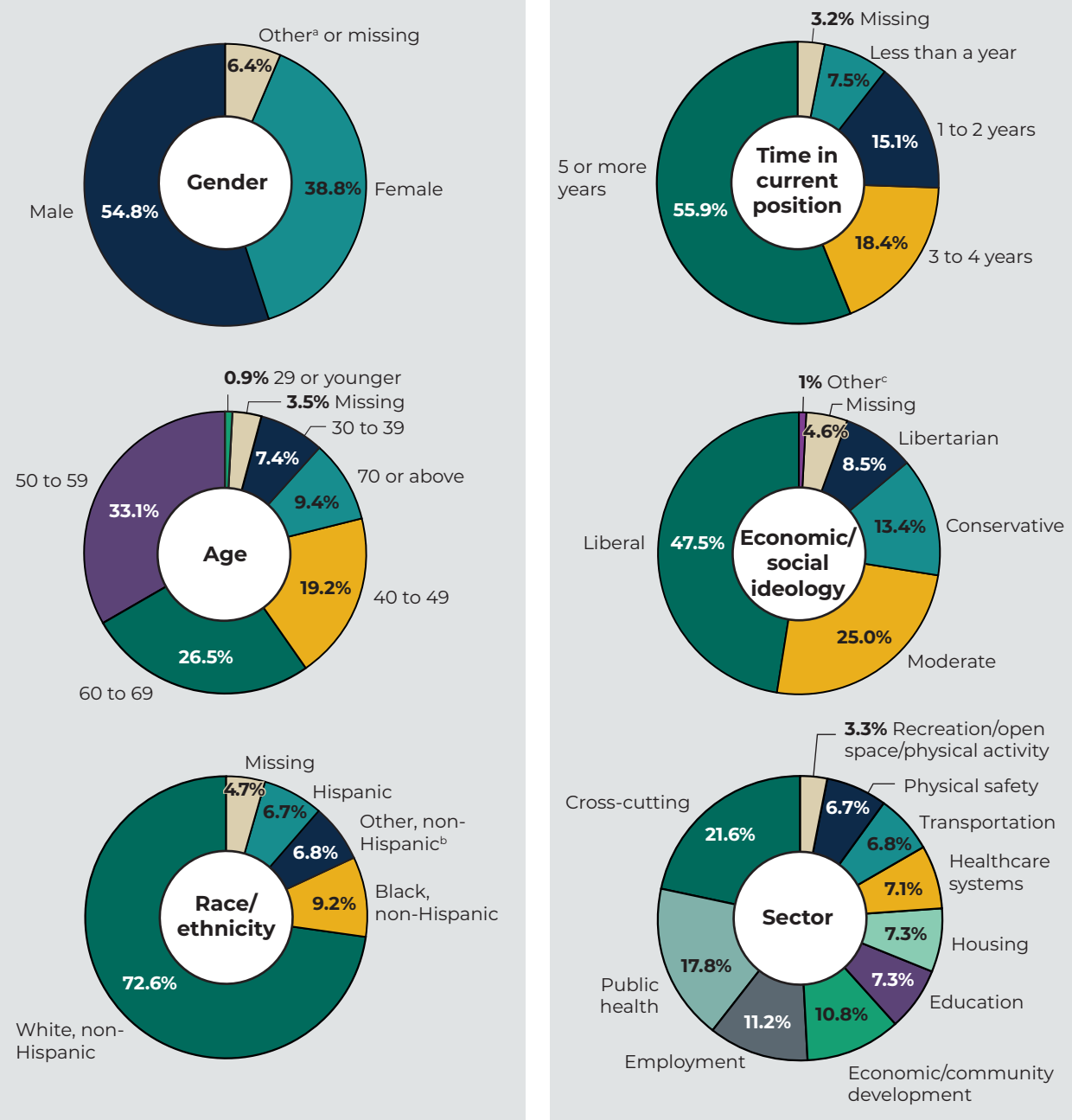
Social determinants of health (SDOHs)—the conditions in which people are born, live, learn, work, play, worship, and age—are vital levers in efforts to advance health equity (Artiga and Hinton 2018; Braveman et al. 2017; Marmot and Allen 2014). Research suggests that SDOHs such as socioeconomic status, education, employment, and social support networks account for 30 to 55 percent of health outcomes (World Health Organization n.d.). Despite a strong evidence base on how SDOHs can increase or limit people's opportunities to be healthy, few studies have explored how state and local leaders (hereafter "leaders") view, understand, and talk about these concepts. Because leaders are in a unique position to advance programs and policies that improve health and well-being for all, understanding their views on what shapes health and well-being is key to improving population health.

To better understand the views and knowledge of people in positions of influence in state and local communities, the Robert Wood Johnson Foundation partnered with Mathematica to field a nationally representative survey of leaders in the United States. These leaders represent influential people in local communities, businesses, and state-level organizations whose views and actions can affect the health of the community. We sampled leaders from 50 states, 325 cities, and nine sectors to take part in this study.

Views of state and local leaders

Between October 2020 and March 2022, 5,450 leaders responded to the *What Shapes Health and Well-Being Survey*. (See the methodology appendix for details on how we collected these data.) Most survey respondents identified as male, white and non-Hispanic, and liberal in their economic and social ideology. Most had also been in their current job for five or more years and were ages 50 to 69. Leaders came from nine sectors and worked for city councils, faith and community foundations, city and state departments (in education, health, housing, police, parks and recreation, and transportation), large local employers, universities, economic and community development organizations, and financial institutions, among others (Exhibit 1).

Exhibit 1 . Demographic characteristics of survey respondents (n=5,450)



Source: Mathematica's analysis of the What Shapes Health and Well-Being Survey, October 9, 2020, to March 31, 2022 (N=5,450).

Note: Numbers may not add up to 100 percentage points due to rounding.

[a] Comprises respondents who selected "prefer not to say" (2.8 percent) and "prefer to self-identify" (0.3 percent).

[b] Comprises respondents identifying as American Indian or Alaska Native, Asian, Native Hawaiian or Pacific Islander, other race, more than one race, or missing race.

[c] Comprises respondents identifying as liberal or very liberal on economic ideology, and very conservative, conservative, or moderate on social ideology.

What do leaders think affects people's health and well-being?

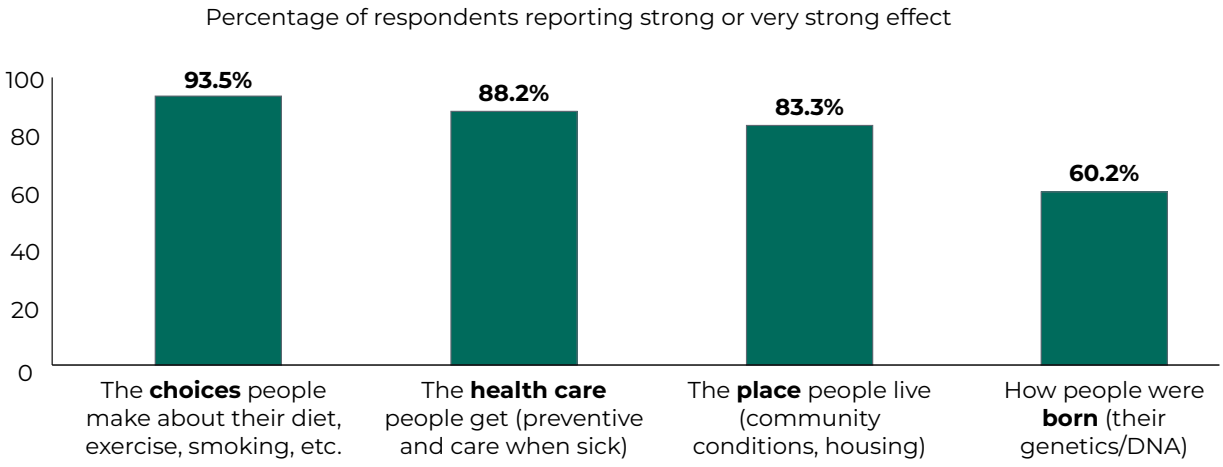
Leaders believe *people's choices about their diet, exercise, and smoking* most affect their health and well-being. Leaders also believe that health care and community conditions such as housing affect health and well-being, followed by genetics/DNA (Exhibit 2). People's choices are constrained by factors such as access to healthy foods, quality health care, and economic and work opportunities that are generally tied to where a person lives and considered to be "upstream" from health outcomes; for that reason, leaders seeking to improve the choices people make might want to invest in upstream improvements (Braveman et al. 2011). For example, living in an area that lacks affordable housing may mean people have to forgo medicines and healthy food to afford their rent; this could create health issues such as prevention and management of diabetes. By offering incentives for developers to build more affordable housing units, or by giving residents housing vouchers so that they use their income for medications and nutritious foods, leaders could make it easier for people to make healthy choices. As one respondent offered, "I feel strongly that an individual can make healthy choices when the barriers are reduced."

What do leaders think about SDOHs?

Leaders feel it is important for residents to have access to positive SDOHs. The factors most commonly rated as very or somewhat important were healthy and affordable food, quality K-12 education, and quality and affordable health care. The factor least commonly rated as very or somewhat important was public transportation (Exhibit 3). In considering SDOHs more broadly, one respondent offered, "Social determinants of health play a critical role in shaping the health and well-being of residents in our community. Resources to assist all residents meet basic needs for housing, food, education, child care, and health care would make a huge difference in improving the health and well-being of residents."

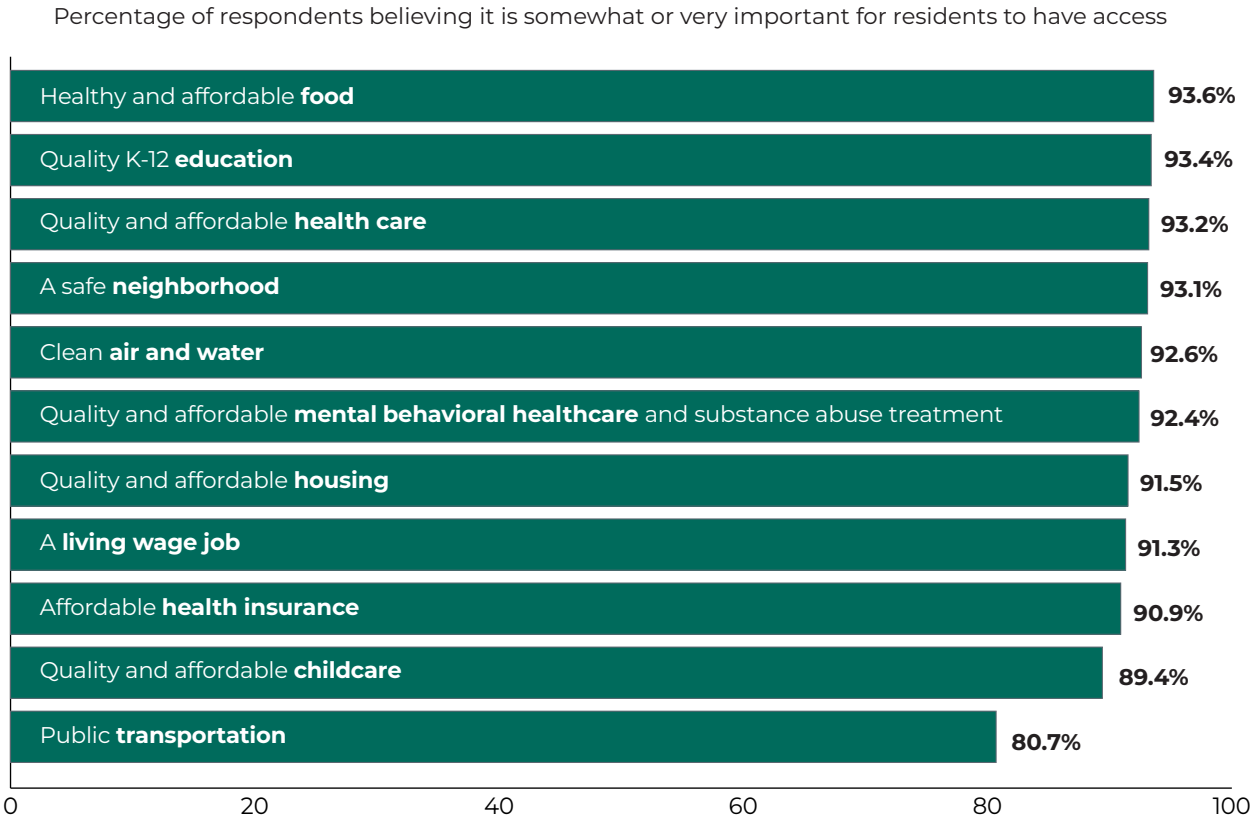
Although leaders believe that transportation is less important to health than other factors, research links public transportation to better diet, greater access to physical and mental health care, and better job opportunities (American Hospital Association 2017; Artiga and Hinton 2018). Increasing leaders' awareness of the connection between transportation and health might help them understand the positive health benefits associated with expanded public transportation, such as reducing air pollution while also increasing physical

Exhibit 2 . Factors that affect people's health and well-being



Source: Mathematica's analysis of the What Shapes Health and Well-Being Survey, October 9, 2020, to March 31, 2022 (N=5,450).

Exhibit 3. Factors that are important for residents to have access to



Source: Mathematica's analysis of the What Shapes Health and Well-Being Survey, October 9, 2020, to March 31, 2022 (N=5,450).

activity and improving access to health and social services (Heaps et al. 2021); community advocates and city planners might be able to educate leaders about the return on transportation investments. Leaders might also want to engage with partners in health and non-health sectors to determine the transportation needs in their community. This might mean focusing on public transportation such as buses and trains, while also considering other aspects of transportation such as walkability and bikeability in the community. As one respondent offered, "I see and value public transit as an economic equalizer and a tool for creating equity in communities. The health benefits of public transit are numerous."

What actions do leaders think will advance equity, and to what extent can their organizations take these actions?

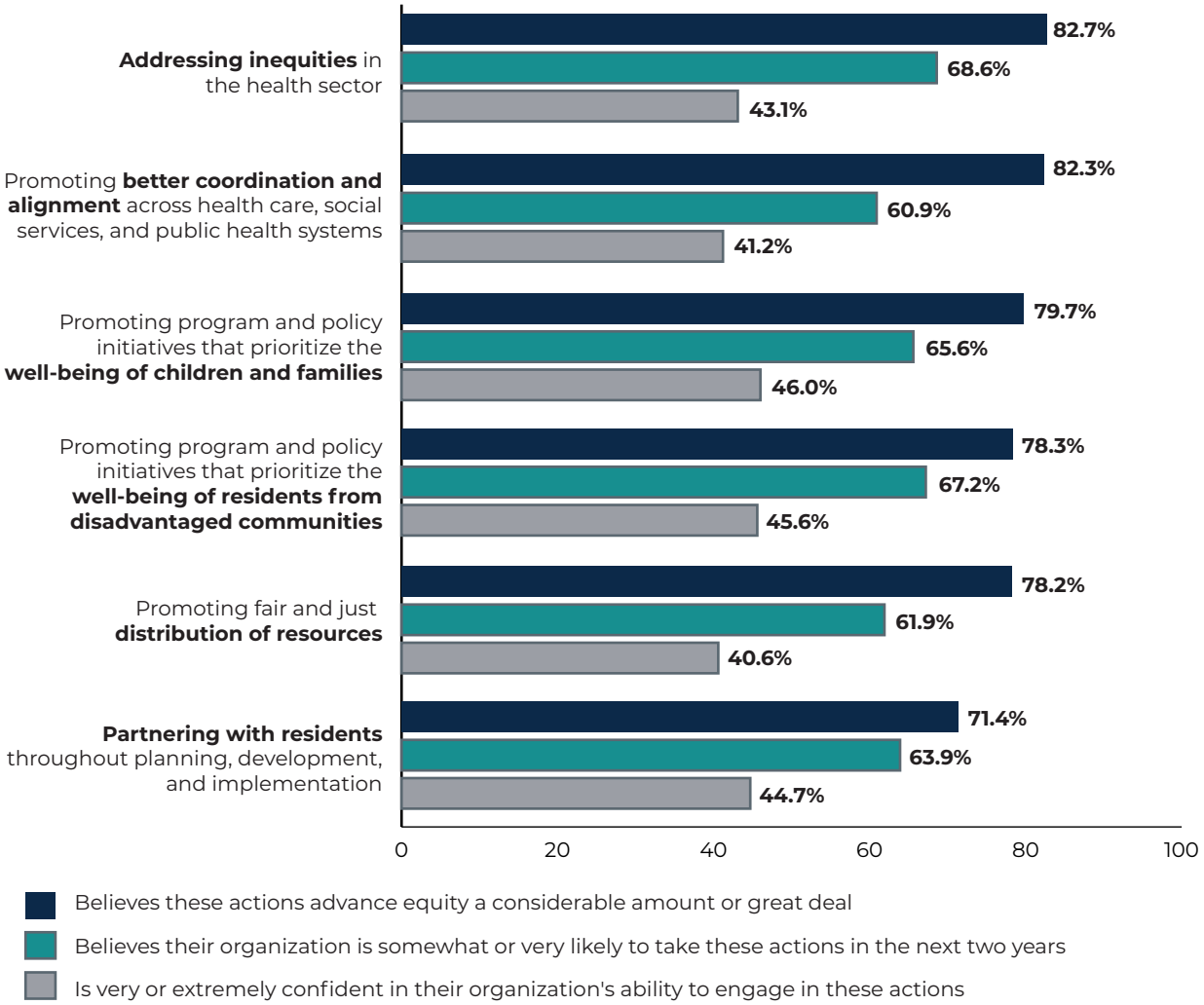
Across the board, leaders believed in the importance of an activity (dark blue bars), but lacked confidence that one's organization can (gray bars) or will do anything about it (teal bars; Exhibit 4). For all items, the likelihood of taking the action in the next two years (teal bars) was higher than one's confidence in their organization's ability to engage in these actions (gray bars). This suggests that leaders are motivated to take action but are not confident in their organization's ability to do so. Because leaders have relatively low levels of confidence, and confidence is a strong predictor of a leader's behavioral intention, funders and governmental entities may need to help boost leaders confidence.

In terms of specific actions, leaders believe that *addressing inequities in the health sector* will do the most to advance residents' opportunities to

be healthy, closely followed by *promoting better coordination and alignment across health care, social services, and public health systems* (Exhibit 4, dark blue bars). As one small aid to addressing these inequities and barriers to coordination and alignment across sectors, we suggest toolkits and other resources to help motivated leaders promote equity. For example, because evidence suggests that cross-sector collaboration is an important first step toward addressing inequities (Towe et al. 2016), leaders seeking to reduce inequities in the health sector might want to explore the Health in All Policies Resource Center to learn how to best establish partnerships in public safety, economic and community development, education, and other sectors. As one respondent said, "I truly feel that cross-sector collaboration is what is required to move the needle on this [inequities] issue."

In addition, relative to other actions, leaders believe their organization is unlikely to promote better coordination and alignment across health care, social services, and public health systems (Exhibit 4, teal bars). One leader offered this is because

Exhibit 4. Leaders' beliefs, confidence, and likelihood of taking actions to improve opportunities to be healthy



Source: Mathematica's analysis of the What Shapes Health and Well-Being Survey, October 9, 2020, to March 31, 2022 (N=5,450).

it is "Very labor intensive. It takes so much work to coordinate services. We're all frustrated by the lack of political will, lack of funds, lack of coordination, and the hugeness of the issues." Leaders like this seeking to launch cross-sector initiatives could start by consulting several publicly available resources. These include the Health in All Policies Resource Center, a report describing six strategies for building trust for cross-sector data collaboration, and an article on partnering outside the formal health care system.

Finally, on the whole, leaders lack confidence in their organization's ability to improve residents' opportunities to be healthy (Exhibit 4, gray bars). Leaders seeking to increase their confidence in promoting programs and policies focused on children and families (Row three) might want to consult resources such as the Child Opportunity Index, which provides information on the health needs of children in various communities. Leaders who want more information about the health and social needs of residents from disadvantaged communities (Row four) might want to explore The Congressional District Health Dashboard. If leaders want to feel more confident engaging with residents (Row six), they could use various toolkits for community engagement, such as those from the Assessing Meaningful Community Engagement project. Although these resources will not completely transform an organization's ability increase equity, they can help leaders gather more data about the health needs in their communities.

What are the perceived barriers to increasing residents' opportunities to be healthy?

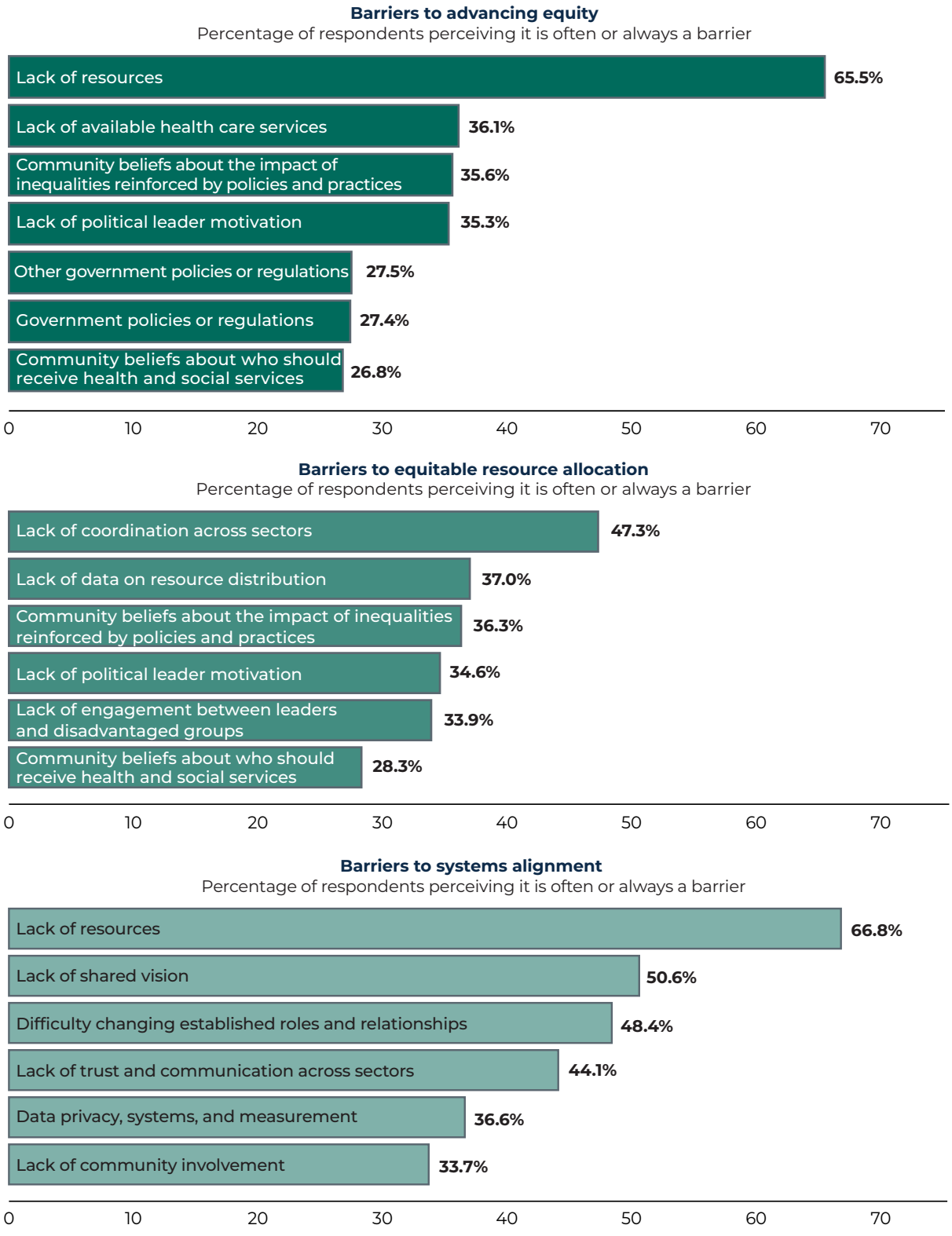
Leaders believe the biggest barrier to advancing equity and systems alignment is *a lack of resources*, including limited funding, staffing, and services (Exhibit 5). Leaders who need help obtaining funding and other resources might want to consult Beyond the Grant: A Sustainable Financing Workbook, which offers tools for helping leaders explore new financing options, or the Local Wellness Fund, which provides organizations with funds to address the well-being of community. The Georgia Health Policy Center's funding navigator guide could also help leaders shift the allocation of their current resources, staffing, or services or work with leaders outside their organization to build a wider network of resources. These resources may help what one respondent identified as a key challenge to their work: "The problem is grant funding. You receive a grant, do good work, then the money runs out. There needs to be more permanent sources of funding."

Leaders believe the biggest barrier to equitable resource allocation is the lack of coordination across sectors (Exhibit 5). One respondent reinforced this barrier by saying, "Our agency focuses on a narrow aspect of public health, and attempts to coordinate with others – some are resistant, some cooperative. We are pushing for enhanced collaboration to ensure the most efficient use of resources and to make a concerted effort to ensure needed resources are available." Leaders like this who want to address challenges related to cross-sector collaboration can access resources through All In: Data for Community Health. This learning network is made up of over 150 community collaborations that focus on multisector partnerships to improve community health. Leaders can attend webinars on cross-sector data sharing, receive technical assistance from leaders in the field, and interact with other leaders facing similar challenges in working across sectors. Aligning Systems for Health also provides resources to help leaders foster alignment across health care, public health, and social services.

How do the attitudes of leaders differ across sectors?

Leaders who were less likely to endorse attitudes promoting population health were mostly from physical safety and employment sectors, and sometimes from economic and community development sectors (results not shown). When leaders in health or health-adjacent fields want to work with partners in these sectors, they might need to clearly show how SDOHs affect community well-being or how restrictive policies affect intergenerational health. To do this, leaders could use issue briefs to help them discuss and

Exhibit 5. Barriers to advancing equity, resource allocation, and systems alignment



Source: Mathematica's analysis of the What Shapes Health and Well-Being Survey, October 9, 2020, to March 31, 2022 (N=5,450).

write about health disparities. There has also been research on how policy narratives help with communicating challenging concepts to community members, so leaders could access tips for engaging the public for more information on choosing the right messaging. As one respondent said, "A person's background, demographics, etc. must be taken into consideration when communicating with them and serving them."

Which attitudes are linked to leaders' intention to increase residents' opportunities to be healthy?

Two attitudes predicted leaders' intention to promote population health: (1) their confidence in their organization's ability to take action and (2) their belief in how much certain groups in their community (such as residents, businesses, and grassroots organizations) want their organization to take action (results not shown). In comparing relative levels of confidence across sectors, we found that leaders from public health and social services, housing, and recreation/open space/physical activity sectors had the highest levels of confidence, and leaders from the employment and economic/community development sectors had the lowest. In comparing relative levels of social norms across sectors, we found that leaders from the public health and social services sector most strongly believed that certain groups wanted their organization to take action, and leaders from the employment sector believed the least.

Leaders who seek to increase the self-efficacy of their organization might want to draw on practical templates like The Assessment for Advancing Community Transformation Tool, which helps organizations understand where they are in their journey toward health transformation and how they can strengthen their efforts toward promoting equity, collaborating across sectors, and engaging meaningfully with community members. Leaders might also want to collect and share data with others on how their initiatives focused on equity, cross-sector collaboration, and meaningful community engagement affected residents' opportunities to be healthy, perhaps by using the City Health Dashboard, Life Expectancy Calculator, What Works for Health tool at County Health Rankings & Roadmaps, and COVID-19 U.S. State Policy database.

Conclusion

The *What Shapes Health and Well-Being Survey* provided initial evidence that state and local leaders understand the important effects of SDOHs on people's health and well-being. The findings also show that, despite perceived barriers, leaders want to advance health equity, enable meaningful collaboration with residents, facilitate cross-sector collaboration, and promote equitable allocation of resources. By sharing these survey results and a curated selection of resources, we hope to help leaders strengthen their effects to improve population health and embrace health as a shared value. As we continue with this study, we look forward to capturing leaders' views on these important topics and working toward a future in which everyone in America has a fair and just opportunity to be healthy.

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Methods Appendix: How we conducted the survey

The survey instrument and sample plan were guided by a conceptual framework. The framework includes eight constructs grounded in behavioral theory (beliefs regarding root causes of health, beliefs about behavioral outcomes, evaluation of the advantages and disadvantages of the outcome, beliefs about how important people will approve or disapprove of the behavior, motivation to comply with important people, beliefs about what facilitates or hinders enacting the behavior, perceived ability to enact the behavior, and intention to enact the behavior). It also contains five topics pertinent to understanding health attitudes (social determinants of health, equity, community engagement, systems alignment, and allocation of resources). Finally, it contains nine sectors upon which we based the sample parameters (health care systems, public health and social services, housing, transportation, recreation/open space, physical safety, employment, education, and economic/community development).

The survey instrument was developed by identifying survey questions through a literature review, creating new questions (formatted as a grid, with response options from 1 to 5 on a Likert scale), and combining similar questions to reduce the cognitive burden. We conducted a pre-test of the draft survey instrument with 18 people and made changes based on their feedback.

The survey focused on organizational leaders in city and state government and leaders of for-profit and non-profit organizations. We chose two mutually exclusive samples of leaders; one sample came from state-level organizations and agencies in all 50 states, and the other came from city-level organizations and agencies in 325 cities across the United States.

Finally, we fielded the survey from October 9, 2020, to March 31, 2022. The survey had two phases: Phase 1 from October 9, 2020, to May 31, 2021 (sample of 13,193 leaders), and Phase 2 from September 28, 2021, to March 31, 2022 (sample of 5,174 leaders). We administered both survey phases via the web, mail, and computer-assisted telephone interviewing over a 22-week period. We received responses from 5,450 leaders—a response rate of 32 percent. ◢

Topline reports for the city sample and state sample are available at: https://mathematica.org/publications/what-shapes-health-and-well-being-survey-city-and-state-topline-report.

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