

Health Care Equity Tool Kit for a Winning Policy Strategy

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Introduction

This publication is designed to support organizers, health workers and others to engage in community organizing and policy advocacy to build healthier communities. It provides analytical frameworks, tools, and concepts to support policy advocacy to hold the institutions accountable that affect our health and health care. This handbook started with an internship by Maya Pinto in 2002 whose research and writing provided an initial framework. It was further shaped by discussions with Vernellia Randall at the Institute on Race, Healthcare and the Law and participants in the National Meeting of the Policy Advocacy on Tobacco and Health (PATH) Initiative in September, 2003. The conversation was about how we could help social change activists draw on the lessons and tools that have come out of successful grassroots policy advocacy to more effectively address health issues in ways that shifted the emphasis from individual blaming (behavior change) to institutional accountability (policy change). As a result, this toolkit assembles techniques developed and tested by SCOPE, Community Coalition, and The Environmental & Economic Justice Project, among others.

About The Praxis Project

The Praxis project works from two basic assumptions about the root causes of health problems:

- 1. There is something wrong with the current systems of power relations. They are unjust, unfair and make it challenging to impossible for most people in this world to thrive. This is a problem that's systemic and institutional of which individual action and beliefs play a part.*
- 2. Much of what manifests as social problems (disease, poverty, etc.) are symptoms of these larger issues of injustice. If we are to effectively address social problems we have to develop ways of addressing their root causes.*

Our approach is shaped by a framework that makes community organizing and capacity building central. We are committed to building power in communities that are often marginalized in policymaking. Projects with the potential for building long term infrastructure for change are a priority as addressing root causes is a long term project.

Praxis mission is to support and partner with communities to achieve health justice by leveraging resources and capacity for policy development, advocacy and leadership. Praxis uses innovative participatory approaches that bridge theory, research and action.

How to use this report

The Health Care USA section is a big picture perspective on health care and illustrates the impact of health inequity on people of color. The tool kit section walks you through frameworks and techniques to develop a winning policy campaign. As you

read, work through each tool using the hypothetical United Families Coalition’s campaign effort and learn how to apply the techniques. Use Worksheets as roadmap for investigation. The principles can be applied to all situations; complexity will vary depending on the material conditions, resources and the organization’s capacity. Resources such as websites and publications are listed within the context of the worksheets and at the end of each section.

Consider the following questions as you sift through data:

- Define “Community”: Who is in the demographic picture? (race, class, gender, age)
- What is the rate of poverty, unemployment, incarceration, education and insured/uninsured?
- What are some environmental factors that impact the community’s health? (Look at the public space—air and water quality, violence; living space—lead paint; and occupational space—exposure to toxic substances.)
- Does the community have access to nutritious food, exercise, health prevention programs?
- Are their language and/or literacy barriers?
- What other barriers exist? (Transportation, hours of operation, customer service, overcrowded waiting rooms, etc.)
- What is the morbidity and mortality rate by specific population?
- What are the ten leading causes of death in your state or county?
- Are there chronic illnesses that can be traced to socio-economic conditions? (heart diseases, cancer, chronic lower respiratory diseases, diabetes)
- What is the relationship of these chronic illnesses to health services? Are there preventative and long-term care services available?
- What health services exist? Who do they target? Who uses them?
- How much of the state/county’s budget is allocated for this community’s health?
- How does this compare to the white majority’s access to health services and health outcomes?
- What is the pattern of disparity?
- Are there gaps or unfair policies that you can address through advocacy?

Health Care USA

In brief, the national health care model is structured on market imperatives. In this system, health care is treated as a commodity not a right, and the market is the most efficient arbiter of health care provision and financing. As a primarily “private” model, the government has two main roles: care provider through public health facilities, and insurer through Medicaid and MediCal program. The elderly, children and some low-income residents have access to these government-supported programs. Otherwise, the majority of residents are expected to purchase health insurance on their own or receive health insurance benefits through their employer.

This model is ineffective because all employers do not offer health insurance and insurance costs have become too expensive for many people to purchase, resulting in a significant portion of the public becoming uninsured or underinsured (i.e. limited access to health care).¹ According to *The State of Health Insurance in California: Recent Trends, Future Prospects*, the U.S. spends 11% of its Gross National Product on medical care and has approximately 42 million uninsured, compared to Canada and France, which spends 8% of GNP on medical care but provide universal coverage.

What this looks like in California, is people of color are 13% more likely to be uninsured compared to non-Latino whites; while people between the ages of 19-24 are 38% most likely to be uninsured and 49% least likely to receive health insurance coverage through an employer.²

Over the last few years, an increasing number of for-profit insurers and providers, recognizing the profit potential of health care, entered the managed care industry. In managed care, insurers negotiate fees and services with a selected group of providers. Most subscribers enrolled in managed care receive health care from this selected group of providers or pay additional costs to see providers outside of the system.

Today, the nation faces a health care crisis of monumental proportions. With millions of people without health insurance and fewer public health facilities, health care for people of color and working class is bleak. The federal government has pushed its responsibilities for healthcare provision and financing to cash strapped state and county governments.

Meanwhile, managed care is driven by profit-making as opposed to providing accessible quality care. This trend has increased the denial of care, and contributed greatly to the demise of the public health care safety net. For example, the County public health system is a region's provider-of-last-resort for low-income and uninsured individuals. As of 1994, private hospitals realized it was profitable to compete with public hospitals for Medicaid patients in order to receive Disproportionate Share Hospital (DSH) funds (federal dollars that supplement payments to hospitals for serving indigent patients). Historically, these funds helped large public hospitals that care for a large section of the uninsured and underinsured. Although private hospitals receive these funds they can be selective and serve a few indigent people while the County must serve all indigent patients, but now with less federal funds. Also, public hospitals must transfer funds to the state to meet the federal requirements. Even though private hospitals do not contribute to these funds, they are able to receive the DHS funds. The result is a smaller stream of funding for public hospitals.

¹ Community Institute for Policy Heuristics Education & Research (CIPHER), "*California Health Care Crisis Briefing Book*," 2002.

² Ibid.

The Uninsured by Race

Source: U.S. Bureau of the Census, Current Population Surveys, March 1999, 2000, 2001

| People Without Health Insurance for the Entire year by Race and Ethnicity (3 year Average): 1998 to 2000 [Numbers in thousands] | | | |
|---|---------|-----------|---------|
| | Total | Uninsured | |
| | | Number | Percent |
| Total | 274,123 | 39,558 | 14.4 |
| White | 224,834 | 29,831 | 13.3 |
| White, Non-Hispanic | 193,634 | 19,531 | 10.1 |
| Black | 35,499 | 6,916 | 19.5 |
| American Indian or Alaska Native | 2,739 | 733 | 26.8 |
| Asian and Pacific Islander | 11,051 | 2,074 | 18.8 |
| Hispanic | 32,785 | 10,737 | 32.7 |

The Problem--Health Inequity

According to Wall Street Journal, "the United States with a \$1.3 trillion health care system is the most expensive and the most inequitable among Western industrial nations."³

What does this mean for communities of color? Their health status is lower, their death rates higher, and life spans shorter than the white majority.⁴

Consider these statistics:

- *The infant mortality rate for African Americans is more than twice as high that of whites.*
- *Asian American/Pacific Islanders have the highest rate of liver cancer among all populations five times that of their white counter parts. Cambodian, Hmong and Laotian men are especially at risk.*
- *African American, Hispanics and Native American have a much higher rate of death and illness from diabetes.*⁵

³ Ron Winslow, "The Outlook," Wall Street Journal, 17 December 2001.

⁴ National Academy of Science's Institute of Medicine, Cause Communications and the California Endowment, *Unequal Treatment, Unequal Health: What Data Tell Us About Health Gaps in California*, 2002.

⁵ *Ibid.*

Some researchers suggest that racial and ethnic disparities in health are linked to health insurance status. It is a fact, people of color are more likely to be uninsured, and a lack of adequate health insurance means patients are less likely to receive adequate, timely care. *Yet, how do we account for the data that shows lower health status indicators persist for people color even among those who have health insurance.*

So why is it that for most causes of death and disability, African Americans, Latinos, and American Indians suffer poorer health outcomes relative to whites with statistically equivalent levels of socioeconomic position?

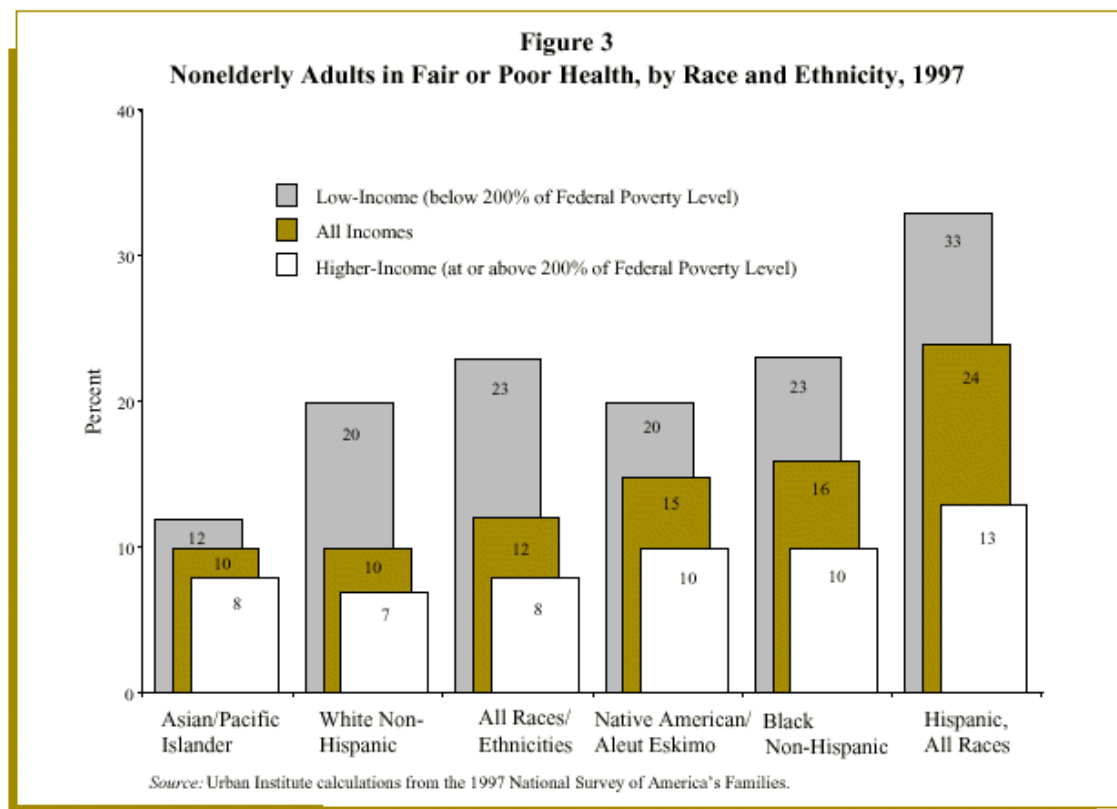
One answer is racism. Racism functions as a power relationship that designates access to resources and opportunities, environmental conditions, and psychosocial factors. As a power relationship; the white category receives privileges at the expense of the Black/non-white group. Therefore, racism is systematic versus an individual prerogative.

According to Vernellia R. Randall JD., University of Dayton School of Law, "institutions can behave in ways that are overtly racist (e.g., specifically excluding people of color from services) or inherently racist (i.e., adapting policies that while not specifically directed at excluding people of color, nevertheless result in exclusion).

In the health care landscape institutional racism manifests as: a lack of providers of color in hospitals and clinics; a lack of multilingual staff, and a lack of culturally competent caregivers in communities. According to an Institute of Medicine study racial and ethnic bias within healthcare institutions and among practitioners contributes to disparities such as patterns of unequal diagnosis treatment and a lack of responsiveness by medical training institutions.

Furthermore, the IOM Study concluded that that it does not matter where you live, what age your are, how much money you make or what your insurance covers, inequalities in health status and treatment are found across most racial groups and diseases. "What does this mean for communities of color? Their health status is lower, their death rates higher. In a country founded on the belief that we are all created equal, we have a healthcare system that is not equal or fair for all."⁶

⁶ The Institute of Medicine (IOM), "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, 2002.



STRATEGIC TOOLS FOR HEALTH JUSTICE POLICY CHANGE

Policies determine our quality of life. A policy is a definite course of action such as agreements, the codes that shape every aspect of life. They guide and determine present and future decisions about our lives.

Great brochures and good advice may help change individual behavior but are not enough to achieve health justice. It will take organizing from the ground up: social change that transforms the current systems of neglect, bias, and privilege into a system—policies, practices, institutions—that truly support health for all.

Shaping policies within your community begins with a few action steps: (1) understanding community context; (2) assessing community resources and realities; and, (3) taking stock of your organizational capabilities to bring about change.

Where to Begin

Those who are successful in winning a policy issue share one thing in common: They have an effective **strategy** that is based on a **power analysis**. Strategic thinking begins with looking at the big picture.

The crisis in health inequities for people of color is a broad concern. The first step is to analyze the problem and decide what kind of solution to work toward. We recommend before the group starts to choose an issue, the members or constituents be asked to participate in an issue development process. Think of it as doing social justice detective work, sleuthing for the answers to an unsolved crime.

Familiarize yourself with the health care system in its current context. Ground yourself in how health care is administered, financed and legislated in your state and county. This process will provide you and your constituents a window onto the field where the players (e.g. legislators, unions, consumer interest groups, corporate lobbyists and others) battle it out to shape health care financing and services. Remember to summarize your findings in a briefing paper so that you can share them with your constituents and allies.

The central reason for understanding your community context is to obtain accurate meaningful information about its key determinants of health. It is important to consider multiple sources of information and to pay attention to data on specific population groups that make up your constituency.

The Center for Health Improvement web article, *Health Policy Coach: Identify Opportunities for Change*, does an excellent job at identifying a step by step approach to gathering information, <http://www.healthpolicycoach.org/doc:>

Describing the community— This means defining who you will be working with, where they live and what they do, and the presence of other problems like poverty and unemployment. Some of these data are available at the county level from your state and county health agency.

Developing a plan for identifying local needs—To conserve resources the scope and time frame for assessing local needs should be defined. This means agreeing on the purpose of the assessment, linking with other community assessments if possible, developing or adapting an assessment tool, if necessary and linking the assessment to actions you will take later.

Collecting information about problems—Secondary data (data already existing in the community) like census data, county health information, planning information from area hospitals and findings from special studies may be available. Often these data are not exactly “on point” you should exercise care in determining their purpose and usefulness. Gaps in these data should be identified and filled in by primary data—data directly collected by you. Irrelevant data should not be used; as such data will not assist your cause.

Going deeper to understand “root” causes of problems—Even after you have identified a problem, it is important to determine why the problem exists within a community, if and how it has been addressed before how people feel about. Focus groups and public hearings can provide this type of direct information. The University of Kansas’ Community Tool box provides an example using comparative data to highlight policy issues.

Excerpt from *Identify Opportunities for Change*, a Health Policy Coach article.

Worksheet 1: Issue Development Process will help you to focus your research on the problem situation or trend. The tool can work as a funnel for your research that leads to cutting the problem into a specific piece with a partial solution.

Worksheet 1: Sample Issue Development Process

The Central Families United organization is a “bread and butter” issues coalition located in Rust City, California. The members are African-Americans and Latinos who work as restaurant workers, maids, janitors, other low-wage jobs and social service providers. Rust City is an urban center with high unemployment and uninsured rates. A recent TV news story reported that the area has a high incidence of diabetes, heart disease, cancer, chronic lower respiratory diseases, influenza, pneumonia and asthma. Many of the CFU members have lost family members to strokes, heart attacks, pneumonia and diabetes or ‘high sugar.’ A significant number of the adults and children experience respiratory problems. The group recently led a countywide coalition that halted the demolition of Rust City’s low-income housing.

During the recent campaign, member organizers knocked on doors, made phone calls, and visited community members to elicit their support. The people, however, expressed another concern—their children seem to always have bad colds and breathing problems. Residents complained they must work, do not have health insurance and doctor’s visits are expensive. In addition, there are no childcare services available for sick kids and numerous school absences result in academic problems.

Step 1: Define the Problem--a situation or condition that causes hardship or suffering for a large group of people.

Children are suffering asthma attacks leading to difficulty breathing, tightness in the chest and wheezing. The local health clinic is overcrowded and parents usually end up in the hospital emergency room for care. Parents miss work, lose income, and children are absent from school for extended periods of time, falling behind in class and failing academically.

Step 2: Do Cause Analysis

First, the group defines the community of concern creating a profile (see questions in the sidebar).

Resources:

- Local State and County Health Departments websites, annual health statistical reports on the region.
- City Councilperson, Alderman or County Supervisors office.
- Local University School of Public Health

Second, the UFC members study asthma. At first, they believed “breathing problems were caused by stress and cold in the lungs. During this phase, attitudes and beliefs begin to shift from “blaming the victim” to understanding the disease, role of environmental and socioeconomic factors as key determinants in the incidence and severity of asthma.

Education:

- Disease-specific Advocacy Organizations—Asthma and Allergy Foundation of America.
- PBS Kid’s all about Asthma; Quest for the Code a Game about Managing Asthma for Children; and Disease Detectives. Meet the Disease Detective: Dr. Stephen Redd, a.k.a. Dr. Asthma.

The UFC asthma study group searches the internet for advocacy groups. The members learn that they should find out if their neighborhoods are sites of toxic waste disposal and under-regulated industrial plants. They learn that indoors, breathing is compromised by inadequate ventilation, dust mites, animal dander, cockroaches, mold and mildew. Furthermore, they find

financial barriers may prevent consistent use of prescribed medications and increase the severity of asthma attacks.

Disease specific sites:

- Center for Disease Control—<http://www.cdc.gov/nceh/airpollution/links.htm>.
- Grant-Making Foundations--e.g. Robert Wood Johnson—<http://www.rwjf.org/>, Annie Casey—<http://www.aecf.org/> and The California Endowment--<http://www.calendow.org> offer publications, data and other links.

Who is responsible? How or why?

The group interviews the County Health Department and School District officials to explore who is responsible for resources and policies regarding asthma. Members secure a public health care organizational chart, County asthma statistical data, and local county health department contacts.

- Health department officials refer the group to the County Supervisor's and City Council health policy deputies for an update on policies and resources for asthma. (Please note: Although each state and county is structured differently elected officials are decision makers that develop policy and allocate resources. Organizational charts are available from your Governor and County Supervisor's office. NHeLP provides a manual on State and Local Responsibility for Indigent Health Care. (See resources)

Who loses/suffers?

According to the data they found:

- African-American children were four times more likely to be hospitalized and seven times more likely to die from asthma than white children.
- Latino children are hospitalized for asthma in California at a rate that is 50% greater than for white children, in four counties—Imperial, Kings, Fresno and San Francisco. The Valley is located in Kings County.
- Children in low-income communities are more exposed to environmental hazards in homes, schools and outdoors than children in higher-income neighborhoods. They also have less access to consistent, high-quality health care.

Employers lose worker productivity due to employee's absences and parents lose wages. The UFC group surveys the residents in the target area to: 1) create public awareness about asthma; 2) determine who is affected—identify their constituent base; 3) identify and test out their hypothesis that asthma is an important issue for their target area.

The organization convenes a community forum to present the survey findings to the neighborhoods most impacted by asthma. This is an organizing opportunity to recruit new members and identify a data base of concerned residents for later campaign events.

Who gains? How?

The UFC group follows the money—pay-per-visit clinics probably gain because acute patients are frequent visitors for urgent care.

What have been solutions? Which solutions have worked? Why or Why Not?

The UFC contacts key advocacy organizations for updates on what have they done on the issue, review the current state and county legislative proposals listed on government websites, and foundation grant making strategies on the issue.

Review of the materials, phone calls to various departments on the public health care organizational chart finally reveals:

- Over the last two years, California has an Asthma Coordinator within the Department of Health that is has been developing a statewide strategic plan to meet the growing needs of children with asthma. However, there is no specific target date for adoption of the plan, steps for approval are unclear and implementation dates are uncertain.

Another possible solution:

- A public, private and non-profit consortium sponsored model for Asthma among School Aged program to improve the quality of life designed to provide clinical diagnosis, treatment and management of asthma.

Step 3. Define Issues or a partial solution to problem. There are many issues for any particular problem.

In this case the UFC group considered the following:

Children are suffering asthma attacks; there is poor access to medical services. As a result, children frequently are hospitalized for severe episodes. UFC’s organizational goal is to build an organization that is known for eradicating racial health inequities and delivering services and resources to their constituency.

This is how UFC cut the issue: The big problem is the disease burden of asthma is greatest in lower-income and nonwhite populations. This problem is too huge to address but they carve out manageable parcels and define solutions.

Step 4: Issue Evaluation

Is it deeply felt? Why? By Whom?

UFC tested out the issue with their constituency at a public hearing, and focus groups. These tactics engaged members, constituents into strategy planning and outreach actions.

UFC decided issue #2 is the best organizational fit: comprehensive initiative to improve clinical diagnosis, treatment and management of asthma for school-aged children with asthma would satisfy the organization’s goal to improve health outcomes.

The major determinants included:

1. There is a strategic fit with the organization’s mission
2. The issue will bring about an improvement in the quality of their lives?
3. Does the organization have the capacity to win? (The Power Analysis will answer this)

Is there a clear handle(s)? (Legal, moral, or political leverage point)

A handle is a legal, moral, political, or economic fact that stands in contradiction to the position taken by the target/opposition. Usually information that exposes a weakness of the opposition, data or documentation that can embarrass the target or shows that your position is fair, just, and legal. The handle in this issue is political—the newly-elected county supervisor, wants to be appointed Surgeon General, and needs an opportunity to be a “hero.”

Is there a clear target? Who holds power to give you what you want? (BOD, stockholders, state bureau of insurance, CEO) In UFC’s case, the Director for the County Health Department is the decision-maker.

Is it winnable? (Do a power analysis to answer this)—see sample Power Analysis and worksheet 3 to fill out the power analysis

What types/amount of power do we need to move them?
Analysis/profiles on primary constituency and allies

Analysis/Profiles on opposition

Is there a clear timeline? Yes, based on the power analysis it will take 12 months to move all the players to goal.

Form courtesy of SCOPE

Asthma Inequity Issues

| Problem: Poor non-white children | Solution | Target policy change |
|---|--|---|
| 1) Are more likely to be exposed to asthma triggers at home and in their environment school, child care center, neighborhoods. | Ensure healthy environments by expanding air quality monitoring programs, strengthening and enforcing air quality stands and the rights of low-income tenants. | State legislation |
| 2) Do not have access to quality health care or preventative care therefore they suffer severe asthmatic episodes and convert to asthmatic. | Comprehensive initiative designed to implement a model program to improve clinical diagnosis, treatment and management of - asthma for school-aged children with asthma. | Department of Health Services Health Foundations |
| 3) Are less likely to receive preventative health care services or education. | Require training for all professionals in child-related fields (such as childcare workers, teachers, and coaches In identifying asthma, making referrals and maintaining asthma-free environments. And/or Train health care professionals should reflect the diversity of the community and be trained to diagnose and treat childhood asthma in a culturally competent manner. | Local and state public agencies |
| 4) Are more likely to be excluded from services because policies do not specifically factor in their needs. | Require the appointment of an Asthma Coordinator within the State's Department of Health to coordinate with asthma and culturally sensitive health care advocates to design a comprehensive strategies to outreach people of color, leverage resources and promote effective asthma-related policies and actions. | State legislation Governors cabinet |

RESOURCES

The web links below provide resources that will guide in identifying health policy issues and potential sources of information for your state and/or county.

- The Henry J. Kaiser Family Foundation State Health Facts <http://www.statehealthfacts.kff.org/--> This resource contains the largest state—level data on demographics, health, and health policy, including health

coverage, access, financing and state legislation. You may compare data for all the states by choosing topic e.g. health coverage and insured, minority health. Information will be displayed as bar graphs, tables, or color-coded maps.

- NHeLP State and Regional Issues and Resources
<http://www.healthlaw.org/state.shtml>-- This resource contains links to government health data, legal information, department of public health and advocates websites. In addition, NHeLP provides a manual on state and local responsibility for low-income people's health care. As a service to health advocates, they have posted analyses for each state.
- Health Access <http://www.healthaccess.org/Links>--This link offers research tools and contacts to national advocates and government health data websites.

Power Analysis Process

What is your proposal to change this inequity?

After information gathering and testing out the proposal with key advocacy groups, elected officials, University and foundation contacts, UFC's final proposal: Win Asthma Among the School Aged program by joining together Department of Health Services, University of Rust City, and "We Care" foundation to fund the program as a pilot.

What system has the power to adopt your proposal?

Analyze the target system the various forces exercising influence over the decision-maker, and ways in which the campaign can build the power to win. The target system is defined by the power holders, i.e., anyone with authority to make decisions. The issue determines the target. An individual target helps to structure decision making by identifying who must be influenced, who must be held accountable, and who the organization is "up against." It is often easier to apply direct pressure to an individual than an institution.

Who Makes Policy

In the hypothetical case of Rust City UFC will investigate the County Department of Health internal decision-making/power structure and the County Board of Supervisors, government regulation body who can hold the target accountable. (See appendix 2—Health Care Arena)

Worksheet 2: Develop a profile of the Target/Decision-maker

1. What power does the decision-maker have to meet your goal/demands?

By what authority? Director of the County Department Health Services (Director). The Board of Supervisors gives the Director the authority over the County's health policy and resources.

2. What is the decision-maker's background and history?

The Director is a leader who believes in running government like a business. He is known as a coalition builder—works with unions, corporate and public sectors leaders. He is a pediatrician, and health legislative expert.

3. What is the decision-maker’s position on your issue/goal? Why?

The Director supports employee productivity—it’s good for business but believes that the County can not afford to pay for new health care programs. He agrees with the goal to provide people of color with asthma quality care and prevention because it would decrease the demand on public hospital emergency rooms. However, he does not want to spend any money or allocate any resources to support UFC position.

4. What is the decision-maker’s self-interest?

The Director is ambitious and wants to be the Surgeon General in 2004. He needs a “hero” opportunity. The Director needs to stay in the press as coalition leader. As a child he was an asthmatic who became an all-star athlete.

5. What is the decision-maker’s history on the issue?

He presented a budget to the County Board of Supervisor’s that corrected a shortfall by closing several public health facilities. He’s been exploring private/public partnerships to fund community clinics.

6. Who is the decision-maker’s boss?

The County Board of Supervisors (BoS) oversees the region’s budget and policies. There are 7 board members. The BoS directs the County Department of Health Director to develop the health department’s policies and budgets.

7. What/Who is the decision-maker’s base and support?

His support comes from Association of Hospitals and Health systems, California Medical Association, Association of Health plans, Association of HMO’s and top 6 insurance companies and hospital corporations. Labor did not support the BoS’ decision to hire him.

8. Who are the decision-maker’s allies?

The Director has 3 allies on the board, Supervisors’ Red, White and Blue. UFC will need to investigate each member to assess their positions on the issue. The group will set up meetings with their health policy staff; contact other health policy advocacy groups for information on these members.

9. Who are the decision-maker’s opponents/enemies?

The Director has major opponents-- the President of the Board of Supervisor’s Brown and Supervisor Pink. Other opponents include labor and the non-profit sector. UFC will conduct interviews with health policy advocacy groups to ascertain their track record and grievances with the Supervisor.

10. What other social forces influences the decision-maker?

The Catholic Church and charitable foundations have successfully pressured the Director to change his position on health care issues for the poor. UFC will meet with key individuals in those institutions for their assessment of the Director and tips on what they did to move him in their favor.

Sample Power Analysis Chart

Power Analysis is an organizing tool that helps build a strategy plan to win.

Imagine a football game--the coach aids the team to determine the opposing team's power as defined by its strengths and weaknesses. What kind of power and which players will it take to move the ball across the field to the goal line and victory? The coach is conducting a power analysis that will inform his design of a winning strategy.

The power analysis is a process to determine what kind of power (quality) and how much power (quantity) is needed to move a target, the individual who can give you what you want, to accept the organization's policy or proposal for resolving an issue.

The process includes a systematic series of questions, investigative steps, information collection and refined knowledge of the players with power to deliver you closer to your goal. All with the purpose of moving the people with power to give you what you want or win your proposal.

Sample Power Analysis chart--insert excel chart here

Worksheet 3 Power Analysis Exercise

Create a power analysis chart and place your players on the grid based on your responses to the following:

Remember--Power is not about feeling powerful or positive thinking. As you move each player on the field ask yourselves these questions:

1. How much experience and political clout do you think your organization has in the arena?
 - Enough for a slam-dunk—winning the issue without compromise?
 - Enough to take a small first step—a concession toward your goal?
2. How much experience and clout do the administration officials or targets have over your issue?
 - Enough to stop you cold?
 - Enough to help you win?
 - Enough to help you take the first step—move a step toward your goal?
3. How much experience and clout do your legislative supporters have?
 - Enough to help you ram the whole thing through?
 - Enough to help you make an incremental step first step?
4. How much experience and clout do your legislative opponents have?
 - Enough to stop you cold?
 - Enough to force you to accept a small first step?
5. How much power does your problem and proposed solution have among the public?
 - Does anybody besides you know or care about this problem?
 - Does the affected constituency know about this problem?

- Does the press know about this problem?
 - Do politicians know about this problem?
6. How much power can you borrow from allies?
 7. What compromises to your solution will you have to make to persuade them to join your coalition?

Adapted from Healthpolicy Coach Template

A SNAPSHOT OF STRATEGY PHASES

Opening Game: What will it take to get on the radar screen?

1. Meetings with health care policy advocates, elected officials, Director’s staff to gather information and test out proposal
2. Refine the proposal based on the intelligence you gathered—New goal
Win a private/public partnership to fund a comprehensive Asthma initiative
3. UFC found out “We Care Foundation” is interested in funding a pilot program; the private/public initiative is a good fit for them

Middle Game: What will it take to be a major influence?

1. UFC’s proposal becomes a factor in the County Board of Supervisors arena
2. The decision-makers are asking for your input and responding to your issues
3. Launch Media campaign and allies’ pressure campaign

End Game: What will it take to declare victory?

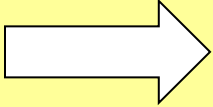
1. The target and his organization agree to proposal in writing
2. The target organization votes for implementation and timeline

Sample Strategy Chart

Derived from game theory—a strategy is the most effective course of action for each player depends upon the actions of other players and the players’ anticipation and assessment of those moves. As such the term emphasizes the interdependence of allies and adversaries’ decisions and their various expectations about each others’ behavior.

Reviewed side by side the strategy chart and power analysis should be updated frequently assessing your actions, and their impact and your adversary’s reactions. You are concerned with moving forward to win your proposal so along the way you may need to take a step back to take two steps forward. Remember it is like football or chess, you’ve got your moves but they do too.

| | Organizing Strategy | Strategy for policy change |
|---------------------------|---|---|
| Goals | Utilize campaign to consolidate leaders and expand base | Win a comprehensive initiative to improve clinical diagnosis, treatment and management of asthma for school-aged children. |
| Strategic fit | Build UFC's leaders, organization and constituency in Rusty City | UFC's African American and Latino residents and workers will develop a community based initiative model to eliminate health inequities. |
| Decision-makers | UFC Board of Directors, staff, and leaders | County Board of Supervisors, Director of Department of Health |
| Campaign Strategy | Involve new leaders in leadership training/activities to consolidate UFC | Involve Rust City leaders/constituents in a campaign to win asthma initiative |
| Objectives/Tactics | <p>Develop 6-8 trained ILI leaders (function as decision-makers, planning and implementation)</p> <ol style="list-style-type: none"> 1. Craft a leadership plan 2. Involve leaders in investigation tasks 2. Host Comm Org'zing, Media Advocacy Trainings <p>Develop base</p> <ol style="list-style-type: none"> 1. Build membership data base 2. Convene Community Forums, house meetings 3. Mobilize base to attend public hearings to educate decision makers and gain support for the proposal <p>Develop a plan to win cooperation/support from Allies (the power analysis will ID the allies you need)</p> <ol style="list-style-type: none"> 1. Identify allies such as Black Health Care Alliance, Latino Alliance, and Jobs with Justice etc. to support campaign Conduct issue orientation 2. Conduct power analysis session 3. Confirm commitments to leverage <p>Mobilize Allies to pressure Decision Maker</p> | <p>Under the radar screen</p> <p>Complete Social Investigation</p> <ol style="list-style-type: none"> 1. Interview Health advocacy groups, Elected Officials Health Deputies 2. Interview Foundation/Professional Health organizations representatives <p>Conduct power analysis</p> <p>Define a campaign committee—scope/members</p> <ol style="list-style-type: none"> 1. ID the composition of an external campaign committee. Some thoughts about this: (this body is the public face of the campaign/demonstrating its power) <p>Refine Proposal based on feedback--Initiative should be a private/public venture</p> <ol style="list-style-type: none"> 1. Seek out private/public partners for commitments to fund program 2. Meet with "Big Bucks" foundation <p>Get on the radar Screen--Produce campaign outreach/education plan to build support</p> <ol style="list-style-type: none"> 1. Identify AA/Latino media outlets and other avenues 2. Mobilize base and Conduct an educational forum with the target decision makers |

| | | |
|--|---|---|
| |  | <p>3. Launch your media blitz</p> <p>Declare Victory Pressure Decision Maker to accept the proposal</p> <ol style="list-style-type: none"> 1. Leverage foundation and private funds 2. Conduct a Private/Public partner meeting to Secure the Director's approval behind the scene 3. Move your allies to positively pressure Director—phone calls, letters, personal visits 5. Host a "hero opportunity" event |
| | Organizing Strategy | Strategy for Policy change |

Courtesy of Community Coalition

Other resources for policy change:

- Center for Health Improvement—this resource provides health policy tips and tools on policy change such as, how to use data to state your case, understanding the policy process and the Health Policy Coach series.
<http://www.healthpolicycoach.org/doc>.
- The University of Kansas' Community Tool box—this resource contains information about how to assess community needs and resources for organizing effective advocacy and community research tools.
http://ctb.lsi.ukans.edu/tool/EN/tools_toc.htm
- Meredith JC and Dunham CM: *Real Clout: A How-to Manual for Community Activists Trying to Expand Healthcare Access by Changing Public Policy*. 2000. The Access Project: Boston, MA.
- Data Center Impact Research for Social Justice—<http://www.datacenter.org/> provides access to strategic information, analysis, and research skills for more effective campaigns. Links to money and politics and government information.
- The Praxis Project www.thepraxisproject.org on-line tools for advocates including: *Policy Options Beyond Legislation*, *Building Diverse Community-Based Coalitions*, *Developing a Policy Initiative*, *Getting Ready for Media Advocacy* and others.
- Right-to-Know Databases <http://www.rtk.net> provides free access to government information on toxic releases, toxic spills, and environmental hazards by company or geographic area.
- Freedom of Information Act Advocates
<http://www.FOIAAdvocates.com/records.html>
- StateNet (<http://www.statenet.com>) monitors 100% of all pending bills and regulations in the 50 states and Congress as well as campaign contributions for state level offices.

Summary of Power Analysis Steps and Strategy Process

- ✓ **Develop understanding of the Big Picture**
- ✓ **Identify and develop an issue**
- ✓ **Research and develop profile on target**
- ✓ **Research and develop power profiles of key opponents**
- ✓ **Research and develop power profiles of "Our Side"**
- ✓ **Chart power relationships**
- ✓ **Explore ways to change power equation**
- ✓ **Update Campaign Plan**
 - sometimes process will lead to a change in Target
 - exploration and update should lead to changes in the power relationship in "our" favor

APPENDICES

APPENDIX 1

Glossary of Terms

Campaign: a set of collective activities planned and executed over a defined period of time whose purpose is to mobilize the support and resources necessary to win a victory for the organization.

Campaign Goal: the decision and/or action which will result in the desired change.

Tactics: if strategy is the "game plan," then tactics are the actions or events that execute the plan.

Action: a specific activity, usually among a set of activities, which moves the organization towards the direction of its strategy.

Constituency: a grouping of people whose self-interest would be served if they supported your organization or campaign.

Handle: a legal, moral, political, or economic fact that stands in contradiction to the position taken by the target/opposition. It shows that your position is fair, just, and legal.

Issue: description of a problem which suggests its solution.
Problem: something that people want to see changed.

Power Analysis: a process to determine what kind of power (quality) and how much power (quantity) is needed to move a target--the individual who can give you what you want, to accept the organization's policy or proposal for resolving an issue.

Strategy: an overall plan to destabilize the position of the target that gives direction and focus to other elements of the campaign.

Target/Decision-Maker: An individual with the power to grant the organization its demands. The person and/or body who have the power to make the decision and/or take the action your organization has determined as the policy outcome.

Specific Objectives or Demands: Specific measurable incremental victories/steps leading to winning the campaign.

Timeframe: The time period from the beginning of the campaign to the end.

Alliance: a short-term relationship of two or more organizations around a single issue or single common interest.

Coalition: a long-term relationship of two or more organizations built upon a shared vision, politics, and action around a common set of issues.

Definitions Courtesy of the Environmental & Economic Justice Project

APPENDIX 2 HEALTH CARE ARENA

What sectors participate in health care policy?

PUBLIC SECTOR

Government

Public policy makers are people who work at local, state and federal levels of government. They establish the rights and standards for entire groups of people. The U.S. government consists of three branches: the [executive branch](#), the [legislative branch](#) and the judicial branch. Each branch has a different set of responsibilities which "counterbalance" the power of the other two branches. This is known as the system of checks and balances.

The Executive/Administrative Branch

The executive branch implements the laws enacted by the legislature. At the national level, the head of the executive branch is the president. His role is similar to that of the elected [governor](#), who serves as the [chief executive officer](#) of the [state government](#) level. Mayors or city managers perform a similar CEO role at the city level. County [commissioners](#) either select one commissioner to act as a CEO or they hire a professional manager who reports to the county commission or board. The executive branch is usually organized into a [cabinet](#) or series of departments administered by people appointed by and accountable to the governor, head commissioner, manager or mayor.

The Legislative Branch

The [legislative branch](#) is responsible for enacting laws. This branch is made up of individuals elected to represent a certain geographic district. Forty-nine states have a [bicameral](#) (two house) legislature like the U.S. Congress; a large House of Representatives and a smaller Senate. Nebraska is the only state with a [unicameral](#) legislature -- a single body of elected senators. County commissions and city councils are unicameral legislative bodies.

The Judicial Branch

The [judicial branch](#) is responsible for ruling on disputes regarding the interpretation of law. Each state's judicial branch is split into civil and criminal court systems. These are further divided into district courts by county. Cases move up on appeal to the state's highest court.

Federal Department of Health and Human Services--see chart

(Check your location for the State, County and Municipal health organization chart)

- Funding and assistance benefits: Medicaid, Medicare, Social Security, CHIP, WIC, Categorical funding programs (elderly, disabled), subsidies to health related corporations and universities/training centers,
- Public health Maintenance and regulate health, research e.g. CDC

State and County government regulate and fund

- Primary health care services
- Public hospitals, clinics
- Prevention programs
- Quality regulation and monitoring

Public Universities, Community Colleges

- Provide professional development (physician, paramedic, nursing and allied professions education programs)

PRIVATE SECTOR

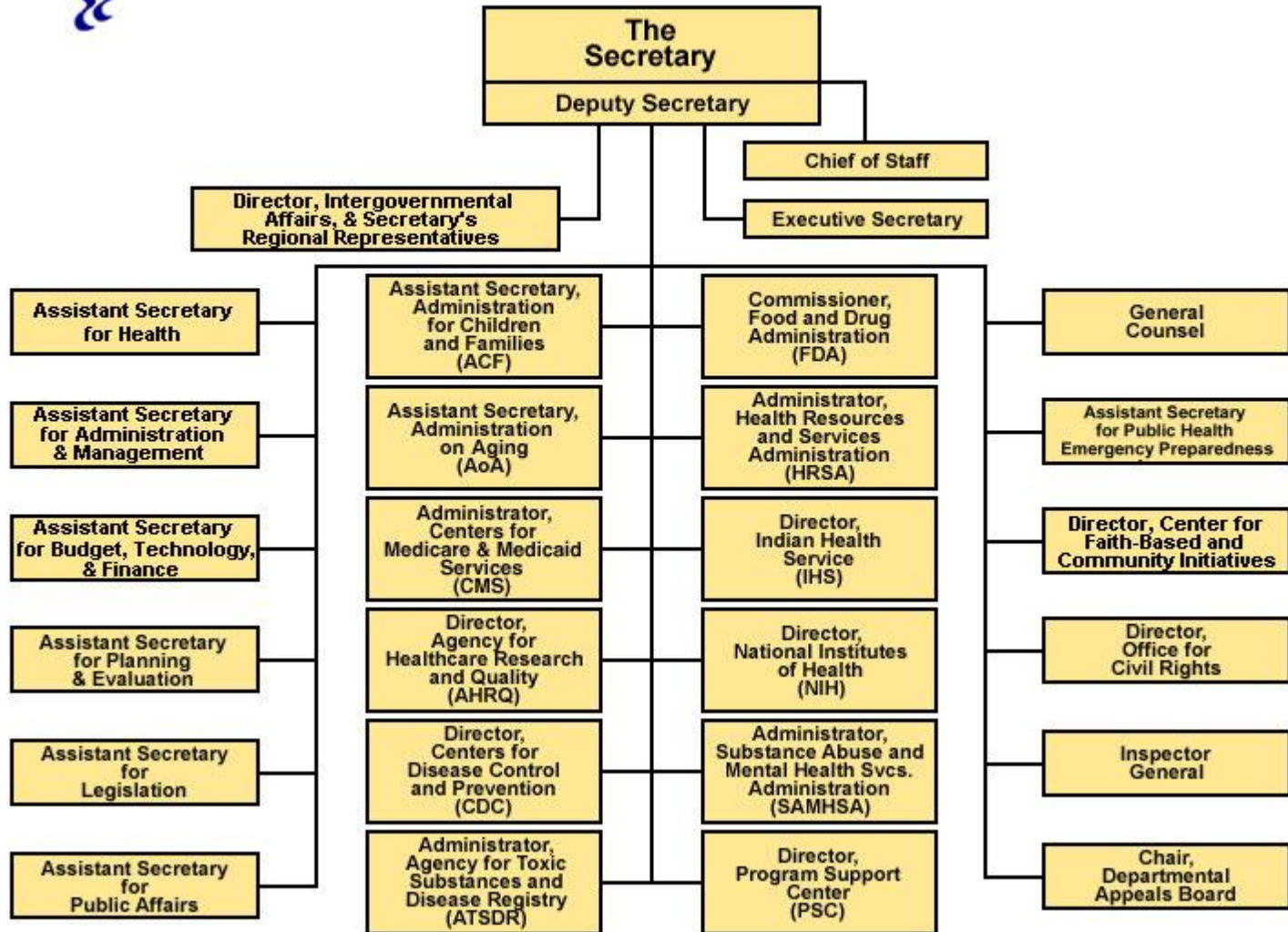
Corporate/Business or The new medical-industrial complex: Health Insurance corporations, Proprietary/Private hospitals, For-profit Health Management Organizations, pharmaceutical corporations, medical technology firms, private health care service providers e.g. nursing homes and medical group providers.

INDEPENDENT SECTOR

Also, known as the “third sector” includes non-profit/non-governmental organizations such as World Health Organization, philanthropic foundations, “civil society” associations—neighborhood block clubs, affinity groups, etc. and community based organizations.

Department of Health & Human Services Organizational Chart

ORGANIZATIONAL CHART



Last revised: November 10, 2003

APPENDIX 3

| Goals | In one sentence how will this issue build our organization?? And/or organizational component. | In one sentence what are we trying to accomplish? What specific and concrete change do we want to see take? |
|----------------------------|--|---|
| Strategic fit | How this issue builds the organization's vision | How this issue will have significance and actually make a difference—why this issue is even important |
| Decision Maker | Who decides organizationally this issue should be taken up? | Who has the power to make the decision concerning the campaign goal—who is the person/decision making body that can give us what we want? |
| Campaign Strategy | What is the organizational strategy to win the goal—how is this issue a vehicle to build the component | What is the primary plan or method to be used to win the campaign and accomplish the goal? |
| Constituency | Who is the target population we plan to organize | Who is the target population we need to organize to move the decision maker? |
| Specific Objectives | <ol style="list-style-type: none"> 1. What are the steps we need to accomplish the strategy that will move us toward our organizational goal? 2. The steps should be numerical and therefore measurable—so we will concretely know if our steps are moving us toward our strategy—which will move us toward our goal. | <ol style="list-style-type: none"> 1. Objective section should be connected to power analysis of the decision maker—what numerically measurable steps do we need to take to influence or force the person in power to give us what we want. 2. What are the specific steps we need to take to move the strategy forward and move us toward accomplishing our goal? 3. The numerical measures are so we can examine and then know if we are moving forward. |
| Activities Tactics | <ol style="list-style-type: none"> 1. In the objective's section we listed numbers—the activities/tactics should be connected and directly affect each objective. 2. In most instances there will need to be more than one activity or tactic that will be needed in order to accomplish the objective. 3. Activities and tactics in this section should concern how we build our organization e.g. recruitment, leadership development, etc. | <ol style="list-style-type: none"> 1. Activities and tactics should be directly connected to a power analysis that dissects the decision and identifies what we need to do to make them do what we want. 2. In the objectives section we listed numbers—the activities/tactics should be connected and directly affect each objective. 3. In most instances there will need to be more than one activity or tactic that will be needed in order to accomplish the objective. |

Courtesy of Community Coalition