# NARROWING WOMEN'S HEALTH-WEALTH GAP IN LOS ANGELES COUNTY

LOS ANGELES COUNTY
COMMISSION FOR WOMEN
ADVOCATING FOR THE LIVES AND WELL-BEING OF WOMEN

## 2023 Report for Los Angeles County Board of Supervisors

https://laccw.lacounty.gov/

# INTRODUCTION

The Los Angeles County Commission for Women (LACCW) is committed to continue to work toward the following goal:

Empower, influence, and support women to forge ahead to reach gender equity in the workplace.

## LACCW Mission

The Los Angeles County Commission for Women seeks to represent the interest and concerns of women of all races, ethnic and social backgrounds, religious convictions, sexual orientation and social circumstances. The Commission is mandated to:

- Advise the Board of Supervisors, County departments and agencies on needs of women and matters relating to discrimination and prejudice on account of sex, marital status and sexual orientation.
- Recommend programs or legislation to promote and ensure equal rights and opportunities for women.
- Research and Investigate conditions which allegedly discriminate against women and disseminate results of investigations.
- Provide a coordinating function for County departments, community groups and organizations concerned with women's rights.

## LACCW Vision

The Los Angeles County Commission for Women will advocate for the lives and wellbeing of women through building strong collaboration, sharing available resources, and educating and empowering through participation in the legislative process.

# UNDERSTANDING FINANCIAL AND HEALTH DISPARITIES

In an effort to gain a broader understanding of financial and health disparities, the Committee embarked on the following activities:

**1)** Held annual virtual webinars from 2020-2022 on the health-wealth divide. The webinars were hosted in conjunction with the Iris Cantor - UCLA Women's Health Center, Blue Shield of California Promise Health Plan and the Federal Reserve Bank of San Francisco. Each webinar was attended by approximately 90-120 participants. Webinars featured the following topics:

**Women of Color in Los Angeles County**
October 28, 2020

**Moderator:**
- Linda Griego, *MLK Health & Wellness Community Development Corporation*

**Panelists:**
- Maggie Cervantes, *New Economics for Women*
- Nai Kasick, *LA Care Health Plan*
- Bina Shrimali, *Federal Reserve Bank of San Francisco*
- Erika Toriz, *Haven Services*

**Promoting Child Care Equity**
October 7, 2021

**Moderator:**
- Dora Jacildo, *Child Lane*

**Panelists:**
- Ashley Williams, *Center for the Study of Child Care Employment*
- Donna Sneeringer, *Child Care Resource Center*
- Max Arias, *SEIU Local 99*
- Debra Colman, *Office for the Advancement of Early Care & Education, LA County Dept. of Public Health*

**Moving Essential Workers Forward**
November 17, 2022

**Moderators:**
- Lila Guirguis, *Karsh Family Social Service Center*
- Jessica Monge Coria, *Federal Reserve Bank of San Francisco*

**Panelists:**
- Jenna Shadduck-Hernandez, *UCLA Institute for Research on Labor & Employment*
- Kimberly Narain, *UCLA*
- Adine Forman, *Hospitality Training Academy*
- Myong Kim, *Downtown Women's Center*

**2)** The issues raised in the webinars propelled the Committee to collect data that would add greater understanding about the health-wealth disparities among low-to-moderate income (LMI) women in Los Angeles County. The Committee held a series of interviews with:

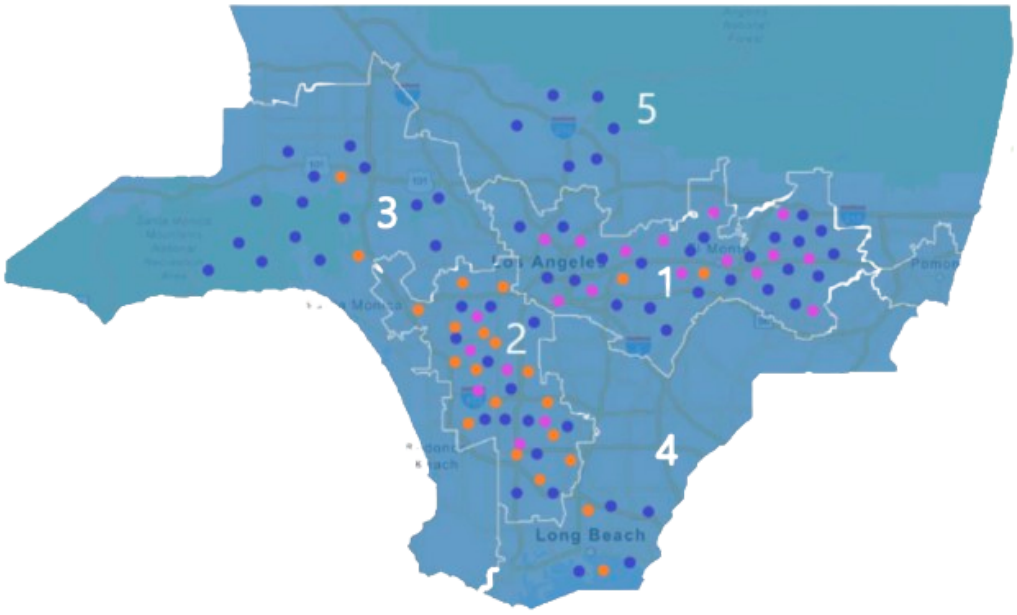
- **24 LMI women** in Los Angeles County to understand both their health and financial challenges and choices.
- **16 stakeholders from organizations in the health and finance sectors** serving LMI women to identify gaps in services, programs, and policies.

# DATA HIGHLIGHTS

This report highlights data gathered from the interviews and provides a snapshot of insights into the health-wealth gap. It reflects the experiences of a limited number of interviews with LMI women and stakeholders. Due to funding and capacity limitations, the Committee did not conduct interviews that were demographically or geographically representative of all of Los Angeles County, Therefore, these findings do not provide a full picture of the health-wealth gap in this region.

For an overview of LMI women and stakeholders interviewed and a full list of organizations featured in the Committee's webinars, see Appendices A and B, respectively. The map below shows the geographic range of LACCW's reach.

## LACCW Community Participation by Zip Codes & Supervisorial Districts




- 2022 "Closing the Women's Health-Wealth Gap" Webinar Attendees
- Locations of Stakeholder Organizations Serving Low to-Moderate-Income (LMI) Women Interviewed for Report
- Residences of LMI Women Interviewed for Report

# This report is divided into the following sections

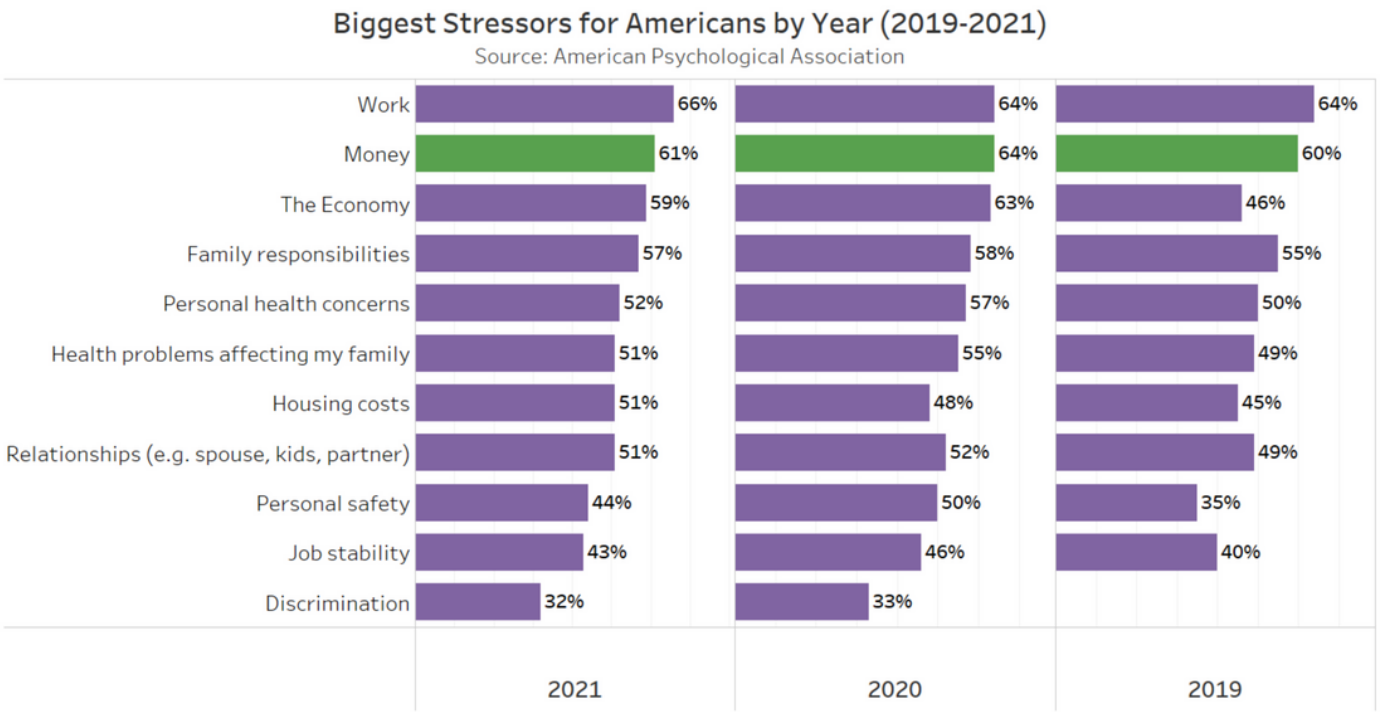
- An overview of the health-wealth gap
- Interview insights of the health-wealth gap
- Health and financial challenges and choices
- Barriers to accessing care and services
- Inventory of service utilization of stakeholder organizations
- LACCW Health Committee recommendations
- Stakeholder section needs

# OVERVIEW OF THE HEALTH-WEALTH GAP

**Social Determinants of Health** are defined as conditions in the environments where people live, work, and congregate, that impact a wide range of health, financial and quality-of-life outcomes and risks (U.S. HHS, n.d.).

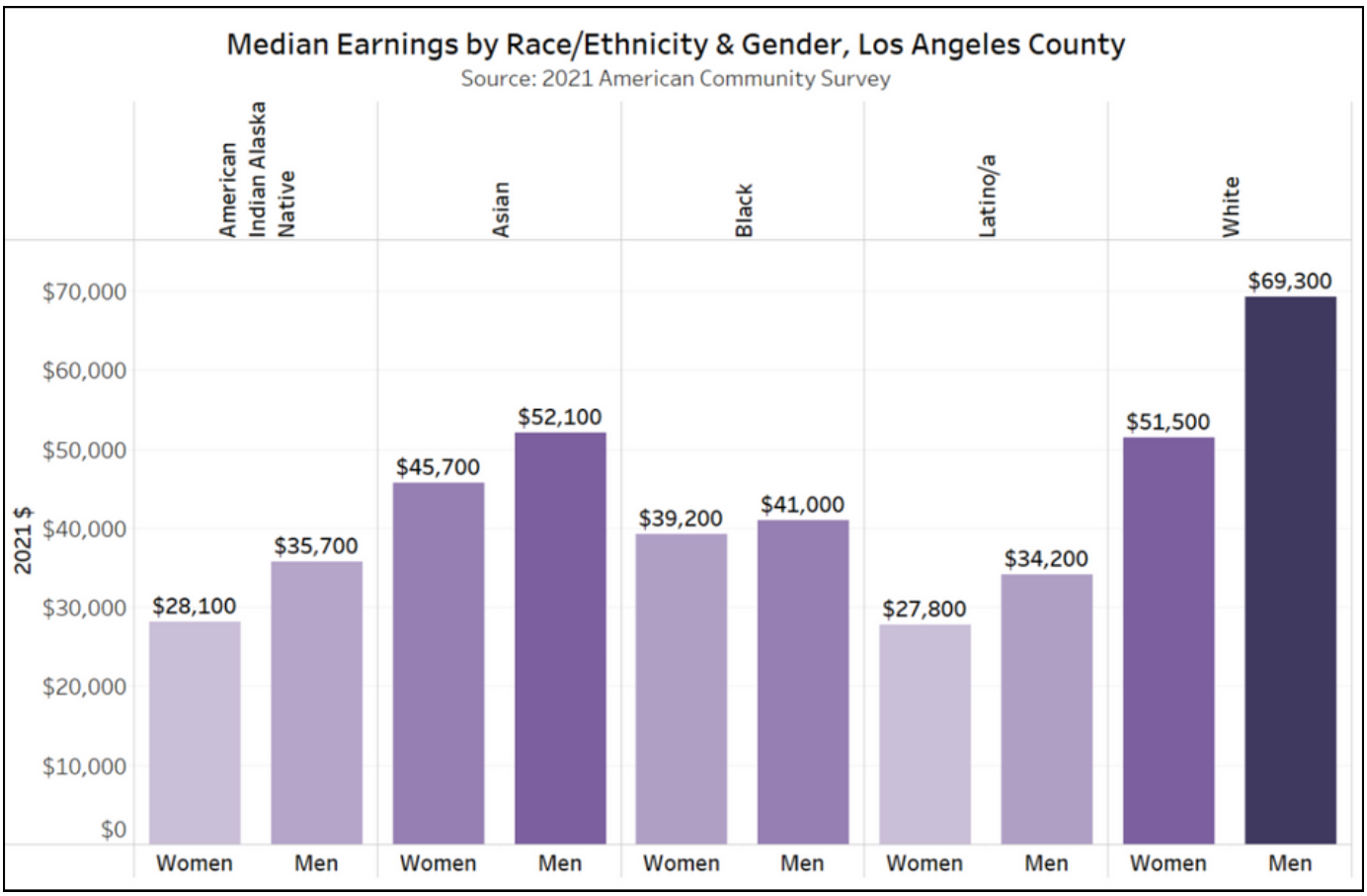
One of the most **significant factors affecting a person's health is their household income and personal finances**. A study of over one billion American tax records found that the highest income Americans can expect to live ten to fifteen years longer than the lowest income Americans and have far lower rates of chronic diseases (Chetty et al., 2016). These disparities in health and financial status define the "**Health-Wealth Gap**."

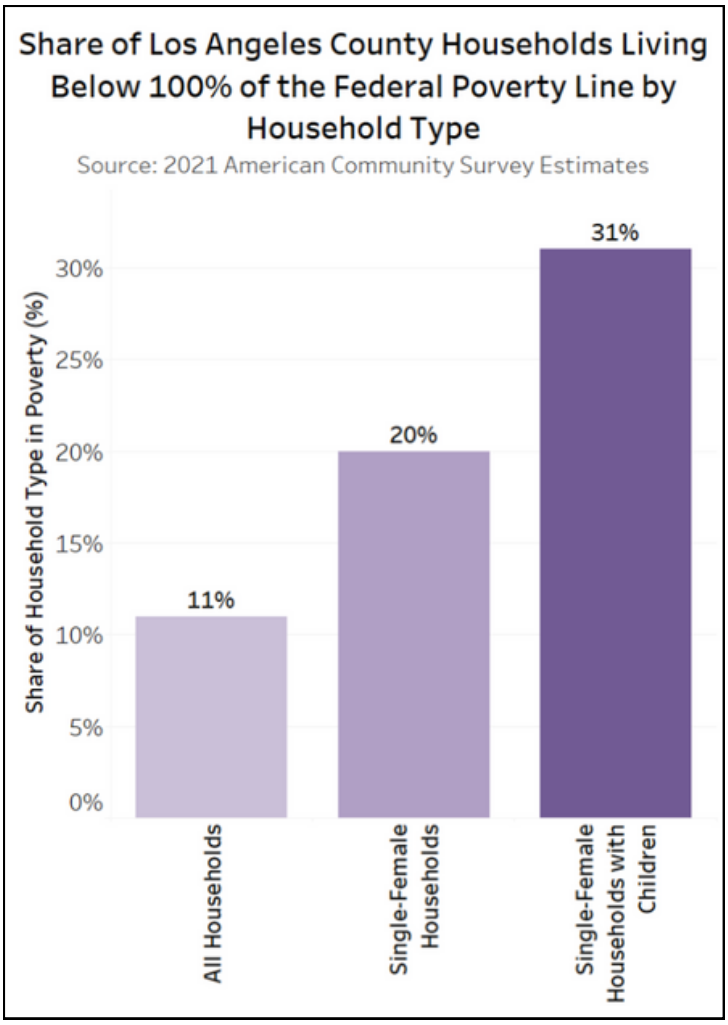
Given these disparities, year over year, money and personal finances consistently ranks as a top stressor for American adults. As shown in the figure to the right, 61% of Americans reported "money" as one of their biggest stressors in 2021, down from 64% during the height of COVID-19 in 2020 (APA, 2021).



# Intersections of Gender & Race/Ethnicity

**Inequities related to race/ethnicity and gender significantly contribute to the health-wealth gap**. In 2021, median earnings for white men in Los Angeles County were just over $69,000 according to American Community Survey 1-year estimates. By contrast, American Indian/Alaska Native and Latina women both had median earnings of approximately $28,000, as shown in the figure below.






Similarly, **single-female headed households in Los Angeles County are significantly more likely to be living in poverty** than the average household. In 2021, approximately 11% of households were living below 100% of the Federal Poverty Line (FPL) compared to 20% of single-female headed households and 31% of single-female headed households with children, according to American Community Survey 1-year estimates.

Nationally, **women report higher rates of stress and anxiety about their finances than men**. According to a 2021 national survey about finance-related stress in post-COVID America, 65% of women reported being anxious about their finances compared to 54% of men.

Latinas reported higher levels of finance-related anxiety than any other group (Hasler et al., 2021). According to a 2015 report by the American Psychological Association, **women who experience financial stress are more likely to engage in sedentary or unhealthy behaviors to manage stress** that include watching television or surfing the internet, eating, drinking alcohol, or smoking than their low-stress counterparts (APA, 2015).

Data shows that **LMI women of color in Los Angeles County are being disproportionately impacted by the Health-Wealth Gap.** Latinas and women living below 100% of FPL in Los Angeles County are more likely to self-report poor health status than other women as well as the general population. Additionally, Black and Latina women are more likely to be diagnosed with obesity and diabetes than other women and the general population across LA County (LA County DPH, 2017).

# HEALTH AND FINANCIAL CHALLENGES AND CHOICES

This section outlines the biggest financial strains, the impact that financial stress has on their health, and practices interviewees use for actively managing their health and finances.

## Sources of Financial Strain

Eighty-two percent of LMI women interviewed reported being forced to spend more money than they have available. Participants cited the **rising costs of food and housing**, and during the pandemic, the increased priority of paying for **home internet service** as their children's education became increasingly digital.

Financial service providers uplifted a range of external factors that pose financial challenges for their female clients, including **high cost of housing and childcare in Los Angeles County** and a **lack of access to living wage jobs**. Many providers also shared that a large portion of their clients are undocumented and face challenges in obtaining employment more broadly.

**Provider Insights**: Providers also shared that many of their female clients tend to be **frequently managing crises or prioritizing meeting basic needs**, and are unable to engage in financial planning as a result. Among LMI women interviewed, other commonly cited financial strains included emergencies and unforeseen circumstances such as car trouble, sudden illnesses, or the passing of a family member. Seventy-nine percent of women interviewed said they would be unable to cover the cost of a medical emergency should one arise, and 83% said they have no savings set aside to pay for medical emergencies.

Providers also uplifted **medical debt as a prevalent financial challenge** among their female clients. A recent analysis by the Los Angeles County Department of Health found that one in ten adults in Los Angeles County is impacted by medical debt, and county residents have over $2.6 billion in outstanding medical debt (LA County DPH, 2023).

Beyond dental coverage, some interviewees discussed the stresses of being uninsured; others incurred unexpected costs related to rising premiums or cited having to take on medical debt despite having health insurance.

**Interviewee Voices**

*"The bills pile up and sometimes I only focus on the phone bill (for example) and then I remember I have the car payment too. And then I realize that I do not have enough to cover both. Like the saying: 'you uncover one to cover another.'"*

Among LMI women interviewed, two thirds reported that they are not currently using a budget. The **majority of providers shared that most of their female clients don't have credit**, either because they don't know what it is, they don't feel confident that they can utilize and build credit, or because obtaining basic necessities is a higher priority. Other providers shared that even when their clients do have credit, they don't know how to utilize or build it.

In addition to external factors like affordable housing and employment, providers also highlighted that most of their female clients have a general lack of financial knowledge. One provider noted that most of their female clients don't have a bank account, for example. Another stated that their female clients have varying levels of reading and writing proficiency, which can make things like budgeting difficult.

## Hesitancy About Financial Institutions

Financial service providers shared challenges related to a lack of trust in financial institutions in under-resourced communities, particularly among many Native American and immigrant communities.

Stakeholders shared that **complex terminology and "jargony" language** present barriers to accessing services. If or when classes or educational materials do exist, most are not created with low-income communities in mind and may not exist in a language other than English.

In addition to complex terminology, providers shared that the women they serve are often unaware that they could be penalized with services like overdraft fees. In this case, the lack of trust can often be a self-reinforcing cycle. If a client does take a leap of trust to open an account, service or overdraft fees can often serve to reinforce the lack of trust they feel in financial institutions.

Additionally, some financial providers discussed the barriers to making changes to existing financial products so that they would better serve low income women. They uplifted that the majority of **people with the power to make an impact in the financial industry don't understand the experiences or needs of low-income people** - most especially women of color. Relatedly, some providers felt that the profit motive in the financial industry often gets in the way of acting in the best interest of low-income clients.

In addition to challenges with the financial products and services themselves, many providers highlighted that there simply **aren't enough traditional banks and credit unions in low-income and immigrant communities**. This forces residents to turn to payday loans, check-cashing services, auto title loans, and other non-traditional forms of credit that charge high-interest rates and expensive fees, trapping them in dangerous cycles of debt.

According to analysis of data from the Neighborhood Data for Social Change platform, in areas containing a high cost lender, the median household is an average of $20,000 less than in areas that contain a traditional bank or credit union. Providers shared that **low-income women in particular tend to lack knowledge about which financial service providers are predatory and which are not**. Further, high cost and lenders tend to target their advertising towards undocumented workers, leaving them particularly vulnerable to predatory financial services.

## Prioritizing Healthcare Spending

### Interviewee Voices

*"Not because of the cost, but sometimes I'd rather go to work than go to a medical appointment. This way I don't miss out on the work day to get money. Then I hope to go to another appointment soon."*

Women were asked how they prioritized spending money on their health compared to other basic necessities. Some noted that they prioritized medical expenses such as doctor visits and prescriptions over other basic necessities. This answer was most common amongst women who had pre-existing conditions or who had recent hospitalizations or surgeries.

The majority of women shared forgoing healthcare spending to prioritize other basic necessities like food and housing.

- Sixty-five percent of interviewees reported missing a medical appointment or skipping prescriptions because of the cost. Factors like lack of childcare, transportation or ability to take time off of work played a larger role than cost.
- Some participants reported experiencing stress from feeling uncertain about their health, developing chronic conditions, hospitalization due to the worsening of a condition, medication withdrawal, and living through pain without medication. One participant also discussed that missing an appointment meant that her children were unable to get vaccinated.
- While **health insurance was cited by many participants as important, it was also noted as a point of stress**.
- One of the most commonly cited financial burdens and/or unexpected expenses was dental care - typically for an interviewee's children. Many women complained that their **health insurance did not cover any sort of dental care.**

## Interviewees by the Numbers

**82%** reported being forced to spend more money than they had available.

**67%** reported that they are not currently using a budget.

**79%** said that they would be unable to cover the cost of a medical emergency should one arise.

**83%** said they have no savings set aside to pay for medical emergencies.

**Health providers:** Pre-existing conditions such as diabetes, heart disease/hypertension, obesity, thrombosis, hepatitis C, HPV, cervical or uterine cancer, long COVID and dental health were highlighted as recurring diagnoses amongst the women they serve.

# Finances and Wellbeing

Ninety-one percent of women interviewed reported **experiencing stress related to their financial situation**. This included: worsening of pre-existing conditions, developing high blood pressure, insomnia, hair loss, anxiety/depression, panic attacks, headaches, and hospitalization.

Health providers noted **mental health/stress as the second most prevalent health condition they saw in female clients** (after diabetes).

In addition to high stress levels, ninety-one percent of women in listening sessions reported that their financial situation was impacting their general wellbeing. Participants lamented not having time for fun, bonding with their families, or being severely restricted in the places they could go. Some interviewees also discussed concerns that their personal finances were limiting the opportunities available to their children.

Some participants also discussed making **financial compromises that impact their wellbeing** such as living in overcrowded housing and most commonly, eating poorly. Health providers also highlighted **food insecurity as a major contributing factor to health disparities amongst women.**

**Provider Insights:** Providers talked about the **failings of the built environment in many neighborhoods**, where women have to rely on convenience stores or corner markets that lack healthy options for grocery shopping, as well as the lack of curriculum around nutrition in K-12 education (particularly for high school students). Providers also discussed the negative impacts of food insecurity among their patients associated with decreased motivation, poor mental health, and higher risk of chronic health conditions.

## Interviewees by the Numbers

**91%** reported experiencing stress related to their financial situation.

**91%** reported that their financial situation was impacting their general wellbeing.

**78%** reported that they are actively managing their health.

**61%** reported that they are actively managing their finances.

## Health and Employment

Some women reported having to take on additional shifts at work or multiple jobs in order to make ends meet. However, 60% of interviewees also **reported that their job had been negatively impacted by their health status**. Some participants discussed missing work during or following hospitalizations, being unable to work due to chronic conditions, and many cited instances where **stress-induced symptoms kept them from their jobs**.

Some women also discussed **negative health impacts due to the types of available employment options**. One woman talked about spiraling into depression due to factors at work. Another woman talked about the extensive psychological, emotional, and physical trauma she experienced after being violently attacked while working as a street vendor.

## Practices for Actively Managing Health & Finances

Women were also asked about the ways that they are actively managing both their health and their finances. Seventy-eight percent reported that they were actively managing their health in some way. This included:

- Most commonly by **attending doctor's appointments, eating healthy foods at regular intervals, and walking or exercising**.
- Other less common answers included **resting, having leisure time or time with family, attending church, and seeking mental health counseling**.

Compared to managing health, a smaller share of participants reported actively managing their finances (61%). Common tactics included **setting aside savings, budgeting for necessities, using coupons and paying bills on time.**

# BARRIERS TO ACCESSING CARE & SERVICES

LMI women interviewed shared insights about financial and logistical constraints to accessing healthcare. This section discusses the barriers to facilitating service access for LMI women that both healthcare providers shared during their interviews.

## Healthcare Access

A lack of **access to preventative care**, leading to conditions being diagnosed at advanced stages, was a critical issue uplifted among providers. Additionally, they also cited **limited access to specialty services such as mammograms, colonoscopies, and physical therapy.** Providers noted that **long delays for appointments** were common across all of these areas due to a **provider shortage**. These insights were validated by some of the LMI women interviewed, who valued free community clinics but noted that they were limited in use by the months-long delays in getting appointments.

Providers shared that the **COVID-19 pandemic exacerbated delays in accessing care** for a number of reasons, including a worsening provider shortage, **fears among patients** about contracting COVID-19 at a medical office, and the strain of not having the **technology access** or skills needed for virtual appointments. Additionally, one provider mentioned that as Medi-Cal eligibility expands to populations not formerly covered, provider shortages will likely continue to get worse. One solution advocated was increasing provider reimbursement rates for both physical and mental health providers.

## Bureaucratic Hurdles

In addition to provider shortages, the stakeholders also highlighted the challenges of bureaucracy, including **complicated processes for navigating access to care and insurance reimbursements.** Many noted that their clients were commonly **unaware of the services and locations available** to them. Further, providers shared that even when their clients are able to identify services and schedule appointments, they often face external barriers such as **lack of transportation, no childcare, or an inability to get time off work.** This further underlines the prevalence of these logistical challenges discussed by interviewees in the previous section. Finally, providers stated that **unhoused women are a particularly vulnerable group.**

## Hesitancy and Fears Among Patients

In addition to shortages and bureaucracy within the healthcare system, stakeholders interviewed also discussed challenges related to either hesitancy or fears around accessing care among patients. Providers noted that their clients often consider their own health and healthcare needs behind the needs of their children and other family members. This was also a common insight from interviewees, several of whom discussed prioritizing paying for their child's braces above other healthcare spending, for example. Providers also shared that some patients may have cultural norms about only accessing care when they are sick rather than for wellness or in preventative situations.

## Seeking Mental Health Services

Mental health providers shared that **stigma around accessing counseling** or therapy are common. Many of their female clients may not deem the stressors in their lives as "enough of a reason" to seek out therapy. Further, clients often fear that seeking mental health care services will **result in their children being taken from them**. Across both physical and mental healthcare, providers uplifted that **undocumented women are particularly vulnerable to self-selecting out of care** because they fear that it will result in them being deemed as a "public charge."

**Interviewee Voices**

*"Well, I try to take care of my health, there is no other way. I have family, friends, many people to take care of."*

## Cultural Humility

According to stakeholders, patient fears about accessing care, many of which are related to cultural norms or immigration status, are often exacerbated by **a lack of cultural humility among providers**. The implicit attitudes and behaviors of clinicians can cause disparities in both access and quality of care as well as health outcomes among people of color. For example, a national survey conducted in 2017 found that 22% of Black Americans have avoided seeking care for themselves or family members out of fear of discriminatory treatment from healthcare professionals (Bleich et al., 2019). Black women are three to four times more likely than white or Latina women to die while pregnant or within one year of childbirth, and research has found that poor patient-patient provider communication plays at least a partial role (Chinn et al., 2021).

**Provider Voices**

*"There is a misconception that as women we are codependent. There is a social perspective that women don't have power because they choose to 'depend.'"*

Stakeholders shared that Black, Native American, and Latina women are often not fully heard by their providers or that their symptoms are dismissed or not taken seriously. A **lack of linguistic diversity** among providers also contributes to poor experiences for non-English speaking patients. One provider who frequently works with Native American women shared that many of their patients are reluctant to receive care from non-Native American providers, who they frequently feel misunderstood by.

Further, stakeholders shared that female patients of color, particularly Black women, are often incorrectly perceived as being "hostile" or "aggressive" when they do try to advocate for themselves. Many providers noted the **trauma associated with cases of misdiagnosis** among female patients of color. When women of color receive substandard care, it is often difficult for them to make complaints or change providers due to a combination of the complex bureaucracy and not feeling empowered to do so.

**Cultural Influences:** Providers shared that many of their female clients feel torn between wanting to remain tied and embedded in their cultures and wanting to achieve some measure of financial agency in their household. Providers also discussed the psychological impact of these cultural norms on the women they serve, noting that many have fears around managing money or don't believe in their ability to do so effectively. This psychological and social dependence on male partners is particularly troubling for women who are experiencing domestic or intimate partner violence. They frequently become trapped in their relationships due to financial dependency on their abusive partner.

## Linguistic Diversity

Given the lack of cultural humility and linguistic diversity across both industries, practitioners highlighted the need to build trust by **providing culturally relevant services in a larger range of languages**. This could include hiring healthcare and financial professionals with more diverse linguistic skill sets and translating resources into more languages.

Perhaps more importantly, however, providers uplifted the need to **hire people from the communities they are serving, such as community health promoters, to provide services and help women navigate the larger service system.** Trusted community liaisons who have a genuine understanding of the needs and fears of their neighbors can inform culturally resonant educational curricula on both health and finance topics.

Additionally, one of the most critical assets of community liaisons are the pre-existing trust and relationships that they have with their neighbors, who will be more likely to trust them as advisors when faced with a bureaucratic hurdle or difficult choice. Finally, hiring community liaisons at living wages provides jobs and begins to build a network of expertise on both health and finance topics in high need communities.

## Psychological & Social Barriers

Providers shared that their female clients often face a series of social and psychological barriers that prevent them from accessing services. The most commonly shared barrier is **financial dependency on a male partner.** Stakeholders shared that particularly in many immigrant communities, male partners do not share knowledge about their household financial situation with their female partners, and **women are not given agency to make financial decisions.**

Additionally, many providers shared the **psychological impact of experiencing poverty and institutional racism**. Clients face challenges with making financial decisions from a place of mental, emotional, or physical instability. Providers also uplifted the impact of multi-generational poverty, sharing that some of their clients struggle with hoping or believing that they will ever get out of the cycle of poverty.

## Location of Services

In addition to culturally relevant services, providers also mentioned the need for **services with physical locations closer to where women live and work.** Both providers and LMI women shared that transportation or inability to take off work is a frequent barrier to attending healthcare appointments. In response, providers shared the need for **mobile vans, walk-in appointments, home visits, and co-location of services** as important factors to facilitate access to care among low-income women. On the finance side, providers shared the need for **more ethical alternatives to predatory lenders in high need communities.**

## Accessing Available Services

Providers across both industries shared that **many of their clients simply aren't aware of the range of services available to them**. Stakeholders discussed the need to leverage communication channels such as word of mouth, social media, churches and faith-based organizations, childcare centers, and Public Service Announcements.

# SERVICES ACCESSED AT STAKEHOLDER ORGANIZATIONS

Both the healthcare and financial service providers were asked to share the services they provide that are most commonly utilized among female clients. Given the intersectionality of health and personal finance among women, there was overlap in services both within and across the two groups of providers. This section provides an overview of the types of commonly utilized services.

### Education

- Health Education Classes
- Employment Training
- Financial Coaching
- Consumer Education

### Food Access

- Enrollment in CalFresh, Special Supplemental Nutrition Program for Women Infants and Children (WIC)
- Direct food distribution

### Services for New & Expectant Mothers

- Perinatal and postnatal education and outreach
- Home visiting programs for pregnant and postpartum women
- Diaper and other baby good distribution
- Breastfeeding support
- Early childhood education

### Primary & Mental Health Care

- Primary/preventative care
- Substance use disorder treatment
- Mental health services

### Case Management & Service Navigation

- Medical program enrollment
- Troubleshooting health coverage
- Bank account enrollment
- Placements into housing

### Small Business & Entrepreneurship

- Educational services on small business and entrepreneurship
- Access to capital
- Resource and mentorship programs for new entrepreneurs

### Services for Special Groups

- Basic needs and access centers for unhoused women
- Family reunification for immigrants
- Non-predatory auto-lending for people with Individual Taxpayer Identification Numbers (ITIN)

# NEEDS OF STAKEHOLDER ORGANIZATIONS

In addition to the factors that facilitate access to care, health and finance providers were also asked about the types of support that their organizations need to achieve their mission and vision (beyond the need for additional funding). This section provides an overview of the themes shared.

## Staffing and Professional Development

Across both industries, providers noted **issues with finding or attracting qualified candidates.** Health providers discussed the **need for higher salaries** as a way to both address burnout and attract the right candidates. Health providers also uplifted the **need for continuing education** on topics such as healthcare access and technology, workshops for employees on self-care, support groups for employees, and trauma-informed care training among all levels of staff from security guards to doctors. Additionally, stakeholders are seeking more support and mentorship to encourage youth to enter the health professions (most especially among Native American youth).

## Collaborations Across Sectors

Across the health and financial sector industries, providers discussed the need for more collaboration within their industry and across sectors. Health providers discussed a need for more tracking and follow up mechanisms across organizations to ensure successful referrals. Both health and finance providers shared a **desire to provide a set of holistic services and/or more seamlessly connect their clients with referrals to other types of services they need,** such as housing, food distribution, mental healthcare, and childcare. One financial service provider also discussed the need for requirements for financial wellness curricula in the K-12 education system.

Given the prevalence of predatory lenders in low-income communities, finance providers discussed the need for **support from government partners to showcase banks and organizations who are engaging in ethical practices.** Additionally, finance providers shared a desire to collaborate with the public sector to find strategies for making profits ethically and sustainably and incentives/regulations for more financial institutions to engage in ethical practices.

## Reducing Bureaucracy

Many health providers emphasized the need for **less bureaucracy to streamline access to healthcare and other services, particularly County services.** Other bureaucratic pain points include billing processes for medical providers, who are concerned that patients are receiving lower quality care because staff are spending so much time navigating systems and bureaucracy. Providers repeatedly uplifted the need for **more navigators across all points in the system.**

## Simplifying Grantmaking

A number of health providers also offered solutions to improve funding distribution across organizations, including:

- **More Opportunities for Collaboration:** Collaborative funding opportunities that allow organizations to jointly apply for grants rather than competing for them, support for collective purchasing of computers and other equipment to reduce costs, more opportunities for small organizations to subcontract with larger organizations
- **Less Administrative Requirements:** Less stringent requirements about administrative capacities and staff training from funders or lead agencies, less cumbersome applications and contracts
- **Flexible Timelines:** Opportunities for smaller organizations to access grant funds more quickly, more multi-year contracts

## Service Expansion

Finally, both health and finance providers talked about the need for expanding highly utilized services across their industries:

- **Health Access for:** High risk abortions, birth control and contraceptive education; expansion of the Comprehensive Perinatal Services Program (CPSP) from 60 days to a full year; expansion of breastfeeding support services; expansion of mental health, preventative and specialty care services and providers; additional transportation and in-home support services
- **Finance:** Additional services for women impacted by domestic violence, skill building for higher paying jobs, expansion of auto-lending services, support for entrepreneurs and small business owners

# LACCW HEALTH COMMITTEE RECOMMENDATIONS

Based upon the analysis of the interview data, and issues addressed in past LACCW "Health-Wealth Gap" webinars, the Committee proposes the following recommendations for the LA County Board of Supervisors to consider:

1) Expand investments in guaranteed income programs such as LA County Poverty Alleviation Initiative to provide women with more financial stability to address economic hardship.

2) Explore embedding financial coaching and health education programs into life skills training in LA County funded job training programs by working with the Department of Business and Consumer Affairs, Public Health, Public Services, workforce center and other entities.

3) Partner with diverse stakeholders and LMI women across all supervisorial districts and engage the Department of Health Services to gather comprehensive data on health and financial challenges and choices faced by LMI women.

4) Review initiatives in and outside LA County that integrate financial literacy/coaching, health education, training, patient and service navigation, to identify replicable and scalable models for expansion to determine opportunities for collaboration with LACCW.

5) Collaborate with LA County departments such as: Health Services, Business and Consumer Affairs, and Public Health to continue researching the prevalence of medical debt amongst women in LA County with the aim of identifying and addressing the contributing factors and pathways out.

The systemic issues creating the health – wealth gap require a social justice approach where cross sector partners collaborate. The Health Committee can serve as a resource for the Board of Supervisors in advocating for policies, programs, initiatives, and training to advance women's health equity and financial stability.

# ACKNOWLEDGEMENTS


## Funder

California Commission for the Status of Women and Girls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# Los Angeles County Land Acknowledgement

The County of Los Angeles recognizes that we occupy land originally and still inhabited and cared for by the Tongva, Tataviam, Serrano, Kizh, and Chumash Peoples. We honor and pay respect to their elders and descendants — past, present, and emerging — as they continue their stewardship of these lands and waters. We acknowledge that settler colonization resulted in land seizure, disease, subjugation, slavery, relocation, broken promises, genocide, and multigenerational trauma.

This acknowledgment demonstrates our responsibility and commitment to truth, healing, and reconciliation and to elevating the stories, culture, and community of the original inhabitants of Los Angeles County. We are grateful to have the opportunity to live and work on these ancestral lands. We are dedicated to growing and sustaining relationships with Native American and local tribal governments, including (in no particular order) the

Fernandeño Tataviam Band of Mission Indians

Gabrielino Tongva Indians of California Tribal Council

Gabrieleno/Tongva San Gabriel Band of Mission Indians

Gabrieleño Band of Mission Indians – Kizh Nation

San Manuel Band of Mission Indians

San Fernando Band of Mission Indians

To learn more about the First Peoples of Los Angeles County, please visit the Los Angeles City/County Native American Indian Commission website at lanaic.lacounty.gov.

# APPENDIX A: HEALTH & FINANCE ORGANIZATIONS

## Organizations Interviewed

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**Health African American Families**

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**Maternal and Child Health Access**

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Chief Program Officer
**Downtown Women's Center (DWC)**

Cameron Lewis
Project Administrator
**Shield for Families**

Patricia Lopez
Nurse Practitioner
**United American Indian Involvement**

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Deputy Director, RAISE Equity Inclusion Advisor
**LIFT**

Luis Pardo
Executive Director
**Worksite Wellness Los Angeles**

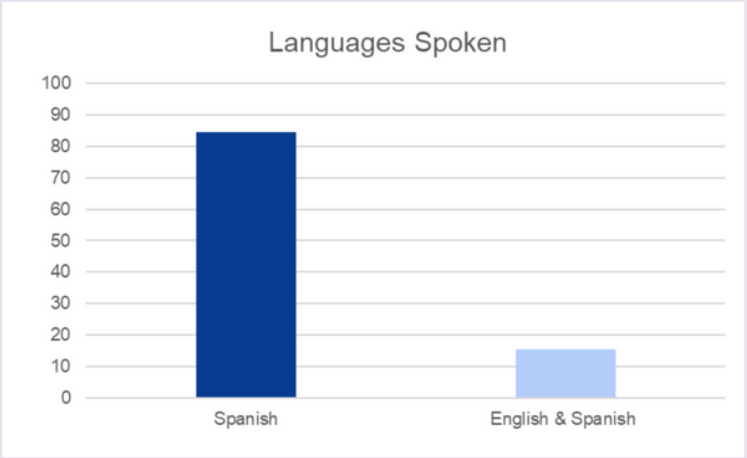
Kathleen Sanchez
Founder/Owner
**Health Disparities Research Group**

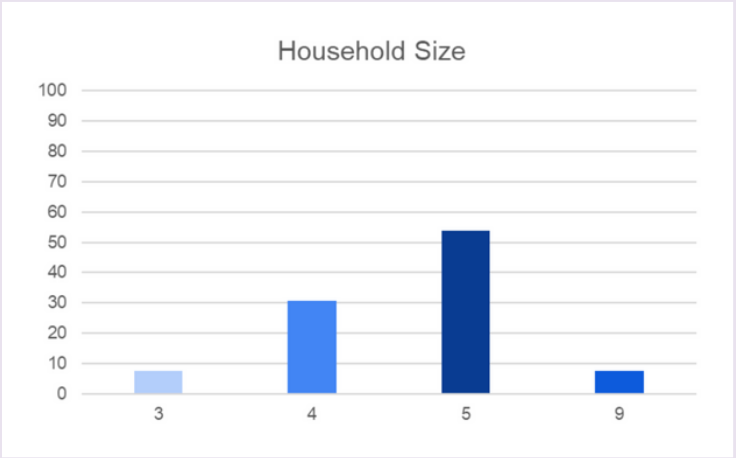
Ruben Sanchez
Branch Manager
**Beneficial State Bank**

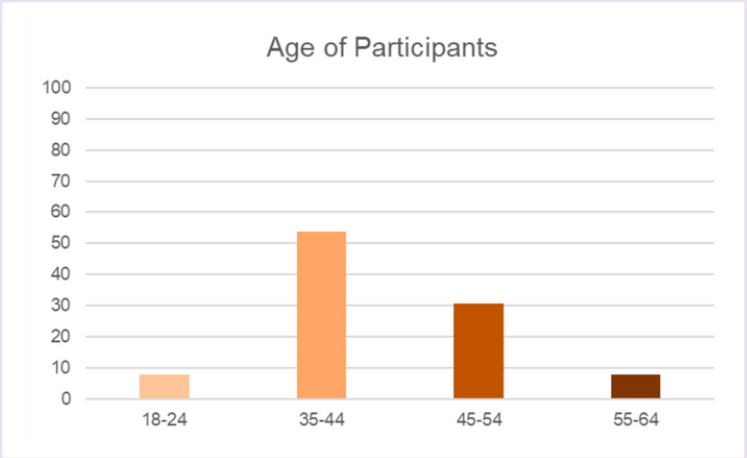
Monic Uriarte
Director of Health Programs
**Esperanza Community Housing Corporation**

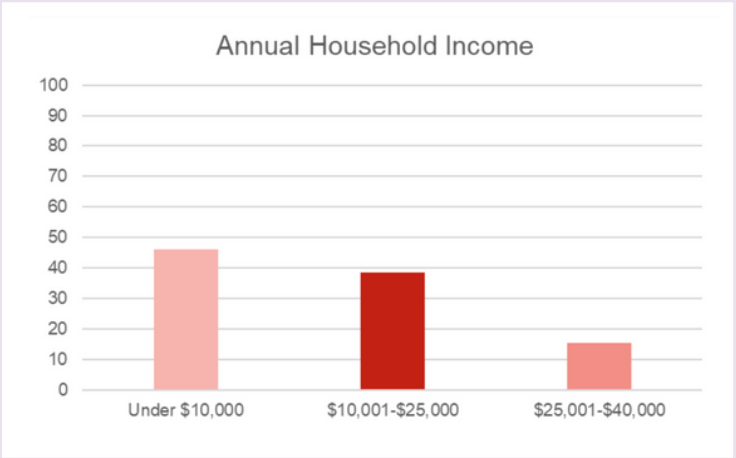
Debra Winski
Health Education Coordinator & Advocate for CalWORKS
**Maternal and Child Health Access**

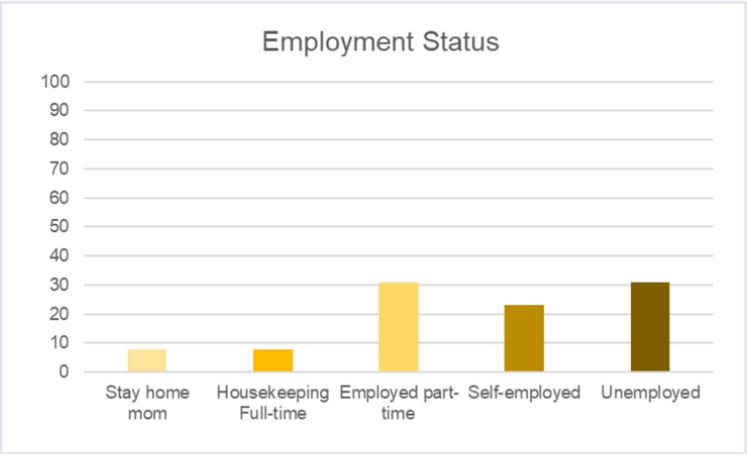
# APPENDIX B: DEMOGRAPHICS OF INTERVIEWEES

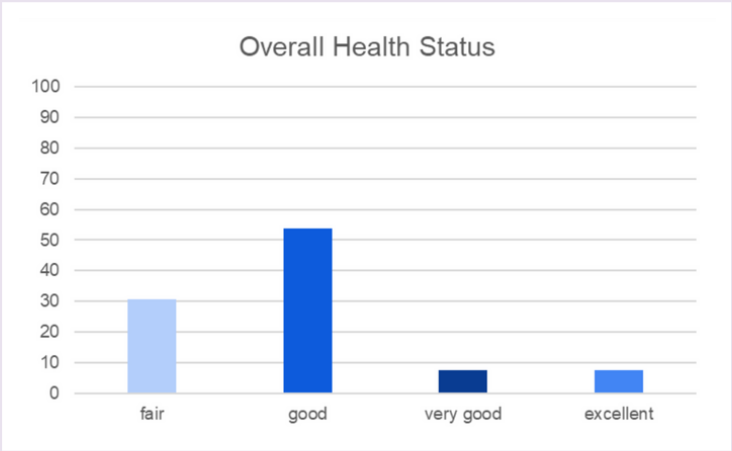


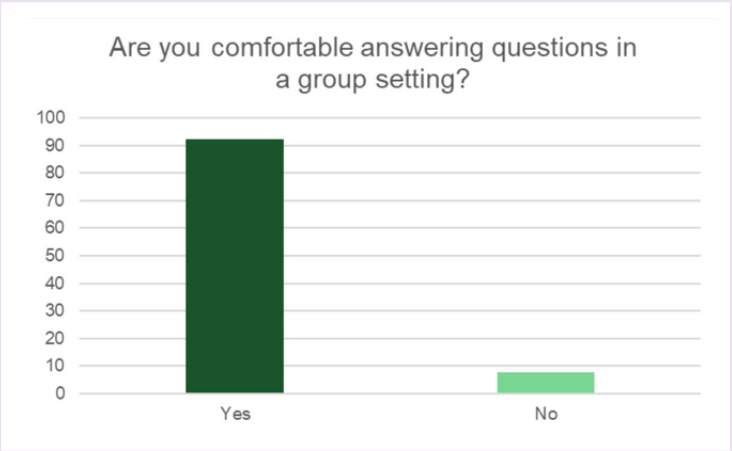



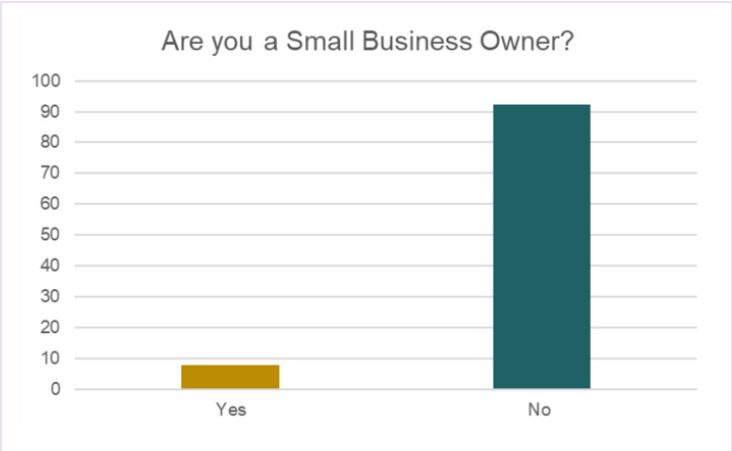



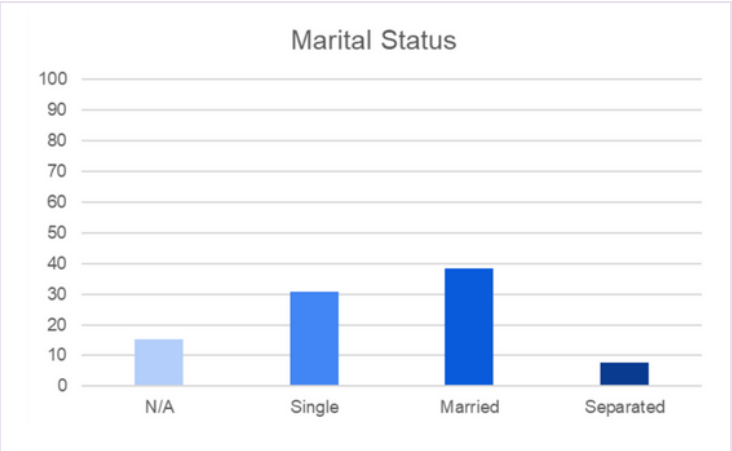



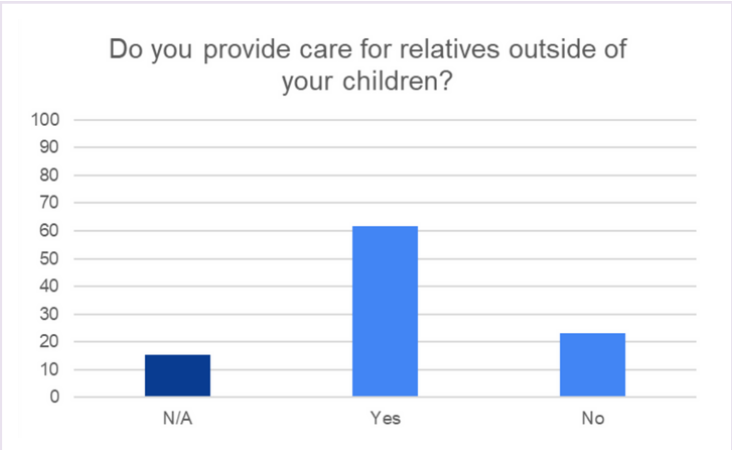



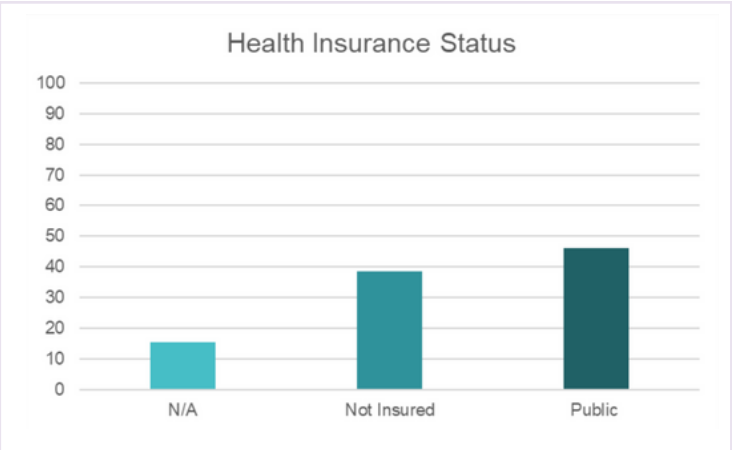


Overall Health Status
100
90
80
70
60
50
40
30
20
10
0
fair
good
very good
excellent

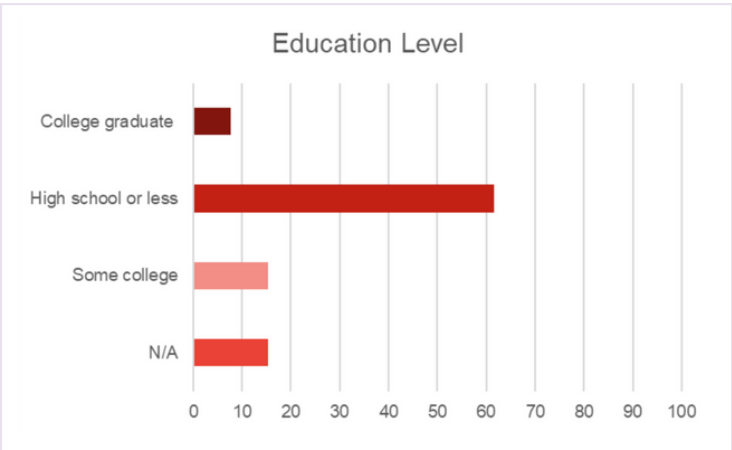

Are you comfortable answering questions in a group setting?
100
90
80
70
60
50
40
30
20
10
0
Yes
No

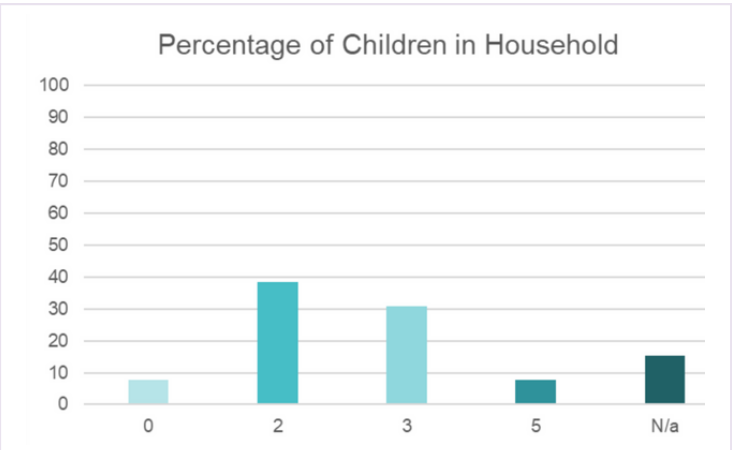

Are you a Small Business Owner?
100
90
80
70
60
50
40
30
20
10
0
Yes
No


Marital Status
100
90
80
70
60
50
40
30
20
10
0
N/A
Single
Married
Separated


Do you provide care for relatives outside of your children?
100
90
80
70
60
50
40
30
20
10
0
N/A
Yes
No


Health Insurance Status
100
90
80
70
60
50
40
30
20
10
0
N/A
Not Insured
Public


Education Level
College graduate
High school or less
Some college
N/A
0
10
20
30
40
50
60
70
80
90
100


Percentage of Children in Household
100
90
80
70
60
50
40
30
20
10
0
0
2
3
5
N/a

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