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Addressing Economic Drivers of Health in the Clinic: The Role and Potential of Medical-Financial Partnerships

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Background

In his 2015 book *The Health Gap*, Michael Marmot cites social policy professor David Gordon's "top tips for health."[1] Rather than offering traditional health advice focusing on behaviors like "eat healthy," Gordon's wry tips emphasize social factors largely out of patients' control that strongly influence health.[2] His first recommendation is blunt: "Don't be poor."

An abundance of evidence identifies economic conditions generally, and poverty and financial insecurity specifically, as major drivers of health outcomes. Marmot and others have shown that lower income is associated with higher mortality rates, domestically and internationally.[3-5] In the United States, the mean difference in life expectancy is 10 years longer for women and 14 years longer for men with the highest incomes compared to those with the lowest incomes.[6] Poverty and financial insecurity also have been linked to significantly higher rates of chronic disease and mental health conditions.[7-9]

Lack of economic security takes a particular toll on the health of children, who have the highest rates of poverty of any US age group. Approximately 1 in 5 American children live in poverty, and about two-fifths live in low-income households making less than 200% the federal poverty line.[10,11] Growing up in poverty has been associated with higher rates of developmental delays, chronic illnesses including diabetes, cancer relapse, and behavioral issues, and poverty in the earliest years of life has an especially large impact on health lifelong.[11-16]

The association between poverty and poor health is clear, but combating poverty has not been a clear priority of the systems and sectors concerned with promoting health, particularly the healthcare system. In recent years, healthcare systems have increasingly recognized the importance of the social drivers of health, which has led to increased screening for social factors such as financial difficulties. However, as health systems' capacity to "diagnose" financial insecurity has grown, their ability to "treat" it has lagged far behind. Meanwhile, millions of patients pass through clinical settings each year who are eligible for billions of dollars worth of tax credits, public benefits, and other financial supports but never access them due to a lack of awareness, assistance, and other barriers.[17-20]

Given the clear need for progress, several professional medical associations--including the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP)--have called on health providers to develop feasible approaches to mitigating the ill health effects of poverty and financial insecurity.[11,21,22] Specifically, AAP has called on

clinics to help families address unmet social and economic needs through community partners and highlighted the important role of the earned-income tax credit and child tax credit in improving children's health.[11]

In this article, we explore one promising clinic-based approach to improving patients' financial security--medical-financial partnerships (MFPs)--which connect patients in clinical settings with financial services to improve their health and economic well-being in concert. We start by defining MFPs and describing the range of services they provide. We then review evidence on the broader effects and the unique health and social welfare benefits of MFP services. We conclude by exploring ways the MFP approach transcends and can potentially transform the limits imposed by the traditional medical model.

The Role of Medical-Financial Partnerships

MFPs have been defined as "collaborations between medical clinics, hospitals, or health systems and financial service organizations designed to improve patients' financial well-being as a health intervention."[23] Like medical-legal partnerships, many MFPs connect patients to services that address health-related social needs, such as safe work and affordable housing. However, rather than providing legal assistance, MFPs provide an array of financial services to address not only poverty-related social needs but also the economic insecurity underlying those needs. These services include financial coaching, employment support, tax preparation, and help with public benefits enrollment.

In the past decade, MFPs have been developed at clinical sites across the US and Canada. The MFPs vary in the scope, intensity, and site of services they provide. Among eight MFPs surveyed by Bell et al[23] and six surveyed by Marcil et al,[24] the most commonly provided services were free tax preparation and financial coaching. Some MFPs also offer job training, support in accessing public benefits, microfinance lending, and/or matched savings programs. Many MFPs offer these services at a clinical site, as StreetCred does in providing tax-filing services to patients as they wait to be seen at medical clinics. Other MFPs provide services in the community after a warm handoff from a healthcare team, as with LISC-ProMedica's job training and financial coaching at its community-based Financial Opportunity Center.[19,23]

MFPs also vary in the populations they serve. Several focus on families with young children, during an early developmental window when financial insecurity can have particularly harmful effects.[24] Other MFPs serve patients of all ages. Whatever the target population, MFPs tend to be

funded primarily by grants from foundations or health systems, or through private donations.[23,24] Some MFPs, like St. Michael's Hospital Income Security Health Promotion program in Toronto, have also received public funding.[23] Table 1 describes four different MFP models in greater detail to show the scope and breadth of MFP services.

Data on MFP Effectiveness

Substantial evidence demonstrates financial and health benefits of services commonly provided by MFPs. One common MFP service is free assistance and tax preparation for patients in applying for the federal Earned Income Tax Credit (EITC) and Child Tax Credit (CTC).The EITC, a tax credit for low- and moderate-income households, provided $64 billion to 31 million workers in 2021, making it by some measures the largest US antipoverty program.[25,26] The EITC has also been associated with improvements in birthweights and maternal mental health, and reductions in child behavioral problems.[25,27-29] The CTC typically provides up to $2000 per qualifying child annually. When the 2021 expansion of the credit offered up to $3600 per child, it lifted an estimated 4 million children out of poverty and reduced child poverty by nearly half before being discontinued.[30,31] The CTC has also been associated with decreased rates of food insufficiency.[30] Nevertheless, like many public antipoverty programs, the EITC and CTC often don't reach many of those eligible. For example, 20% of EITC-eligible families receive no EITC benefits, due in part to a lack of knowledge about eligibility, high costs charged by many tax services providers, and other factors.[19,32]

MFPs also provide non-tax-related services that have been shown to reduce financial strain and improve health. Financial coaching has been associated with significant increases in savings and credit scores and with reductions in debt and financial strain.[33-35] One evaluation of two financial coaching interventions found that, compared to the control group, coaching participants were significantly more likely to set aside emergency funds (48% vs 31%) and were significantly more satisfied with their financial situation (score of 3.8 vs 3.42 on a scale of 1-7 with 7 reflecting highest satisfaction).[33] Financial coaching takes the approach of tailoring financial supports to the specific needs, strengths, priorities, and goals of coaching clients in an effort to make the financial and social services as relevant as possible to individuals' lives, often through techniques like motivational interviewing. Coaching recognizes that taking steps that ultimately improve financial well-being often requires a foundation of trust built through individual relationships, as well as the space to reflect on one's priorities and options in support of financial self-efficacy.

Several MFPs also provide assistance with applying for public benefits programs such as the Supplemental Nutrition Assistance Program (SNAP), which has been positively associated with caregivers' and children's health status, and the Low Income Home Energy Assistance Program (LIHEAP), which has been associated with reduced hospitalization rates.[36,37] Additionally, enrollment in college savings accounts for children, with which some MFPs assist, has been linked to improved socioemotional development for children and reduced incidence of maternal depression.[38-40]

In addition to the substantial evidence of the health and financial benefits of the services MFPs provide, there is also an emerging evidence base that assesses MFPs themselves as particularly beneficial sites for providing those services. Several studies of the desirability of healthcare-hosted financial services found that a significant majority of patients want those services.[41,42] In one survey of 221 caregivers at a pediatrics clinic, 68% of respondents said the clinic should provide financial services.[43]

In addition, internal analyses of MFP programs have documented increases in financial literacy and capability, reduced financial stress, significant increases in yearly income for program participants, and millions of dollars in health-enhancing tax credits.[23] Over the course of 2 years, Boston Medical Center's MFP StreetCred helped 750 EITC-eligible households secure $1.6 million in tax refunds, including over $400,000 in EITC benefits.[23] Some 21% were first-time EITC recipients, and even those who had regularly filed returns were able to avoid the fees charged by for-profit tax preparers.[19,24]

Recent studies have begun to use more rigorous clinical evaluation methods with control groups to assess MFPs. For example, in a study comparing StreetCred participants and nonparticipants, the participants received an average of $730 more in CTC benefits and $495 more in EITC benefits.[44] An NIH-funded community-based randomized study of the Harbor-UCLA Medical-Financial Partnership is currently underway; initial results suggest that the MFP is associated with improved clinic attendance and vaccination rates.[45] As the MFP model grows and effective evaluation methods evolve, assessing which aspects of MFPs are most beneficial for which populations will become easier.

Strengths of the MFP Model

By connecting clinic patients with financial services and public benefits programs that help their families make ends meet, the MFP model has unique health, healthcare, and social service coordination implications. In

healthcare settings, MFPs expand the scope of clinical care by directly addressing financial insecurity, a major contributor to health problems. MFPs represent only one part of a larger strategy to address economic security, but they offer evidence-based interventions that clinics can quickly deploy.

For clinics already providing social supports to patients, MFPs can complement and enhance those services. For example, for clinics with existing medical-legal partnerships (MLPs), the MLP can promote housing security in the short-term by helping to overturn unlawful evictions while the MFP can promote longer-term housing security by connecting participants to tax credits, public benefits, and/or financial coaching that can help them build a financial cushion so they can pay rent even in the event of unforeseen expenses. In addition, many clinics rely on social workers to assist patients with navigating resources or applying for public benefits. MFPs can provide those services and/or create tools to make it easier for patients to help themselves, freeing up social workers to support patients with issues they are uniquely trained to address.

MFPs also have important implications for delivery of public benefits and social services. Benefits like the EITC, CTC, SNAP, and LIHEAP often do not reach potential beneficiaries, as many are unaware that they qualify for public benefits or don't know how to enroll. In addition, community organizations offering low-cost or free financial services have limited touchpoints with potential clients, a challenge worsened by the COVID-19 pandemic.

In this context, clinics with MFPs become effective and welcome access points for connecting individuals with benefits and services. Particularly for young children and others with frequent medical visits, the clinic can serve as a primary point of contact for engaging families, given that patients facing financial hardships have consistently expressed interest in accessing clinic-based financial support services.[41-43]

Finally, another important strength of the MFP model is its potential to attract long-term investments from healthcare and public benefit providers, which could allow it to overcome the exclusive reliance on short-term grants that threatens the sustainability of many clinic-based social needs interventions. To the extent MFPs can help clinics achieve their healthcare goals--such as increasing participant vaccination rates and attendance at recommended visits or decreasing anxiety and depression related to financial strain--health systems and insurers may have incentives to invest in MFPs. While the amount, scope, and provider of the potential investments depends on several factors--such as the time horizon of health effects, the return on investment (ROI) of particular financial services, and

the reimbursement model (fee-for-service vs. value-based)--healthcare investments could represent a means of greater financial sustainability for MFPs.

Given the unique access to financial social supports that MFPs offer, they can also be an attractive investment for providers of those supports, whether local social service organizations or public agencies that provide benefits or tax credits. The size, scope, and providers of the investments depend on various factors such as the range of MFP services offered, the target population, and the availability of alternative access points. Nevertheless, investments in MFPs from social service providers and public agencies seeking to increase access to their services and benefits could play an important role in sustaining MFPs. These strengths of MFPs, and the potential investments they can attract, are important considerations in the further development and expansion of the MFP model.

Transcending and Transforming the Medical Model

MFPs do not simply provide additional services. They also represent a different model of healthcare that can transcend several of the limitations of the traditional medical model. These limitations include the medical model's reliance on problem-based, individual-level, and downstream approaches, as opposed to strengths-based, community-level, and upstream health promotion and prevention approaches. To the extent the MFP model is expanded and integrated into the provision of healthcare services, it may even contribute to transforming the medical model itself.

Bringing Strengths-Based Approaches to a Problem-Based Model

The traditional medical model is organized around diagnoses of medical problems and conditions, which risks reducing patients' health status to problem lists and flattening the fullness of patients to their medical pathologies (eg, "a diabetic", "a hypertensive", etc).[46] While a systematic understanding of a patient's medical problems is an important component of providing quality care, patients' medical problems can draw the medical gaze away from developing capacities patients have to promote their health and well-being. Strengths-based approaches that identify and engage these positive capacities are needed for healthcare providers to more effectively counsel and treat patients.

Fortunately, a strength-based approach is an integral part of many MFP models. Financial coaching--a core aspect of many MFPs--recognizes and engages participants as change agents in their own lives, while also

taking seriously the burdens imposed by financial stressors. Coaching involves individualized goal-setting that requires participants to identify and develop their own goals and unique capacities, building on areas of strength in the process of addressing financial challenges. Some MFPs, like the Harbor-UCLA Medical-Financial Partnership, have explicitly adopted strength-based frameworks like motivational interviewing and trauma-informed care. To the extent MFPs emphasize and expand these strengths-based approaches, they can overcome limitations of the primarily problem-oriented structure of the medical model.

In addition, MFPs can play an important role alongside other strengths-based approaches within clinical settings to transform the problem-focused structure of the medical model itself. Strengths-based approaches emphasizing patient-centeredness, trauma-informed care, and motivational interviewing are gaining increasing momentum within clinical spaces.[47-49] MFPs can contribute to these efforts in several ways. In collaborating with healthcare providers, MFPs' financial coaches provide helpful context regarding the participants' strengths and capabilities that can change the provider's view of patients and even inform the medical plan. To facilitate this strengths-based sharing, MFPs could experiment with models like "My Life, My Story" that include patient narratives in the electronic medical record and have been shown to positively impact the way providers relate to patients.[50] Clinics could also potentially leverage the expertise of financial coaches and other MFP staff in strengths-based approaches like motivational interviewing to train and support clinical providers in implementing these approaches. In these ways, strengths-based MFP models have the potential to transcend and help transform the primarily problem-based medical model.

Bringing Community-Level Approaches to an Individual-Based Model

In a similar way, MFPs can transcend and transform the individual focus of the medical model with more community-level approaches. The traditional medical model approaches health primarily at the individual level, focusing on encounters between an individual patient and healthcare provider. While these individual encounters are an important component of effective healthcare, both sides of the patient-provider relationship can benefit from a more community-level orientation. This means (1) situating healthcare providers less as isolated medical actors and more as collaborators within a broader network of health-promoting community resources, including social services, and (2) seeing the object of care not just as the individual patient but also the broader community.

The MFP models help to achieve the first aim by acting as a bridge to non-medical community resource providers. In some cases, they are even able to transform the clinic into a community resource hub, providing tools for community organization referrals and public benefit access, not just to MFP members but to everyone in the clinic waiting room. While similar community-bridging functions may also be served by other clinic social needs resources (eg, social workers, community health workers, etc) the MFP approach uniquely expands the community network to include financially oriented resources (eg. no-cost tax preparers, economic development organizations, matched savings programs, etc) often overlooked as health-promoting community partners.

In several cases, MFPs are also contributing to the second aim--serving not just individual patients but the entire community--by complementing their individual wealth-building approaches of financial coaching and resource navigation with community wealth-building approaches that build assets at the community level. In these cases, MFP financial services are combined with "anchor institution approaches" in which the health system uses its hiring, procurement, and investment assets to build wealth in the local community. [51] For example, in addition to co-developing the Financial Opportunity Center MFP with Local Initiatives Support Corporation (LISC), ProMedica in Toledo, Ohio, has used its investment capital to develop a community grocery store that provides local jobs and affordable access to healthy food.[23,52] Similarly, through the Financial Futures to Families MFP, Johns Hopkins provides employment support to patients' families and uses its hiring capacity to provide jobs to participants.[23]

Linkages between MFPs and anchor strategies could be expanded, so that health systems hire MFP participants, purchase from their small businesses, and invest in credit unions, grocery stores, and affordable housing in participants' neighborhoods to directly strengthen the economic resilience of communities. In these ways, MFPs can bring community resources to the clinic and health system resources to the broader community, transcending and transforming the individual-orientation of the medical model.

Bringing Upstream Interventions to a Downstream-Oriented Model

The traditional medical model addresses the proximate biochemical and physiologic causes of illness. However, medical therapeutic targets like blood pressure and blood sugar are often the downstream results of more upstream health-related social needs (eg, food and housing insecurity) and

the systems that generate those needs, what Marmot calls the "causes of the causes" of poor health.[53] These causes of causes are, in many cases, related to finances and the distribution of economic power.

As detailed above, the services MFPs provide improve health by addressing more upstream social needs like food, employment, housing, and economic security, and are distinguished from other social needs interventions by their primary focus on income, wealth, and access to financial supports. Integrating these services into the clinic allows the healthcare model to move beyond its largely downstream focus and move toward upstream care.

MFPs have also demonstrated a capacity to contribute to even further upstream approaches, impacting the systems that generate economic insecurity for households through advocacy. A sample of potential advocacy targets for MFPs is included in Table 2. Medical debt is one key advocacy area in which MFPs are already engaging and are well-positioned to make a unique contribution. One study found that nearly 1 in 5 US households have medical debt, averaging $21,687, and that acquiring medical debt was associated with inability to pay for food, housing, and utilities.[54] Furthermore, medical debt is a major cause of bankruptcy in the US.[55] MFPs like “Dollar For,” a nonprofit that has eliminated over $19 million of medical debt by helping patients fill out, file, and follow-up on debt-relief applications to hospitals, have successfully advocated for individual participants to have their medical debt reduced or forgiven.[56] Because of their intimate knowledge of the harms of medical debt on participants and of institutional policies regarding medical debt, MFPs are uniquely positioned to contribute to broader advocacy efforts to reduce and ultimately eliminate the harms of medical indebtedness at the institutional and public policy level. These may include immediate efforts to increase screening and eligibility for financial supports as well as longer-term efforts to guarantee affordable, universal, and comprehensive health insurance to prevent medical debt.[57,58]

Another key advocacy target for MFPs is social welfare policy. Sustained economic security requires affordable access to basic needs like food, healthcare, and housing, and social welfare policy plays a key role in ensuring that. Approaches that increase access to quality affordable housing, such as expanding public investment in affordable housing subsidies and construction and eliminating exclusionary zoning policies, are increasingly needed as housing costs continue to rise and strain patient finances.[59,60] Advocacy to expand income supports, such as those provided through the child tax credit, earned income tax credit, and guaranteed income programs, is also crucial for ensuring access to basic

needs.[25,30,61,62] MFPs have already demonstrated their potential to have impact in this area. For example, StreetCred participated in a consortium that successfully advocated for the expansion of Massachusetts' EITC.[19]

A third important advocacy target for MFPs is broader economic policy--including regulations governing employment, wages, and investment--which significantly shapes the social needs to which social welfare policy responds. Broader economic policy advocacy could include efforts to overcome exploitation of workers (eg, through stronger democratic unions, minimum-wage increases, and worker ownership of businesses), the devaluation of care work (eg, through greater investment in long-term care sectors and workforces), and racial wealth inequities (eg, through equity-focused policies in sectors like housing, education, and finance), upstream factors that have been associated with poor health.[63-67]

Given the many demands on their finite resources, MFPs' capacity for advocacy is limited, but it is also important. As with StreetCred's EITC advocacy, MFP advocacy efforts will likely be most effective within broader advocacy coalitions and in response to often-transient policy change opportunity windows. MFPs can play a unique role within these coalitions by highlighting patient stories and health impacts of economic policies (and vice versa). They can also educate clinic staff on the patient impacts of particular economic and social policies. They can even connect participants interested in advocacy with local advocacy organizations through their networks of community partners. In these ways, MFPs can broaden a clinic's health-promoting efforts to include more upstream interventions.

Overall, MFPs bring strengths-based, community-level, and upstream-oriented approaches that transcend the traditional medical model. As MFPs become more commonplace and their scope evolves, they can grow these approaches to help transform the way health systems care for patients.

Conclusion

Medical-financial partnerships represent powerful models for clinics to directly address patients' financial insecurity and the economic drivers of poor health. Evidence on the outcomes of the services they provide suggests they are already significantly influencing patients' physical and financial well-being, and future studies on MFPs themselves can assess how to most effectively design and target their services. By bringing financial resources to clinical settings, MFPs simultaneously expand health systems' ability to address patients' health-related social needs while expanding the reach of social services and benefits to people who may not

otherwise receive them. MFPs also provide strengths-based, community-level, and upstream approaches that not only transcend the limitations of the traditional medical model but can play an important role in transforming the medical model itself.

For Michael Marmot, the health tip “don’t be poor” is a reminder to healthcare providers that two of the major “causes of the causes” of poor health are poverty and financial insecurity. MFPs, particularly when embedded in a larger mission of improving economic security for individuals and whole communities, represent one important way of responding to that pressing challenge.

Table 1. Examples of Medical-Financial Partnerships

Medical-financial partnership	Background and financial services	Notable features
Harbor-UCLA Medical-Financial Partnership – *Los Angeles, California*	The Harbor-UCLA MFP was developed in a Los Angeles County Department of Health Services primary care pediatrics clinic in 2017 and has since grown to include a second pediatrics clinic, a prenatal clinic, and a family medicine clinic, all within the same municipal safety net health system. Its services include: • One-on-one financial resilience coaching • Public benefits program navigation tools • Bundled family financial and social needs supports • Clinic-wide provider training and capacity building • Community-based partner network referral platform	***Rigorous analysis:*** The MFP is currently conducting an NIH-funded community-partnered randomized study to assess the financial and health-related impacts of the MFP on program participants. ***Public benefits tool:*** Harbor-UCLA MFP has developed the "Benefits Explorer Tool", a web-based portal that helps clinic families learn about and apply for a host of public benefits programs they are automatically eligible for by virtue of their children's Medicaid enrollment. ***Community resource hub and referral network of care:*** Harbor-UCLA MFP helped develop and improve the Los Angeles County Department of Health Service's network and informatics platform for closed-loop referrals linking clinicians and community partner service organizations to make community resource referrals more accessible to MFP participants and clinic patients across the health system.
StreetCred – *Boston, Massachusetts*	Boston Medical Center's MFP StreetCred was launched in 2016 and focused on tax preparation. StreetCred scaled to nine clinics and hospitals in five states, before developing an open-source toolkit and network of 24 health and financial services providers that are replicating its model. Since 2016, StreetCred has expanded its services portfolio, which now includes: • Free tax preparation (virtual and in-person) • Financial coaching • Enrollment in 529 college savings accounts	***Clinical integration:*** The physician writes prescriptions for financial services. Then StreetCred helps families file taxes, claim refunds, find jobs, save money, and build budgets, credit, and wealth. ***Tax credit impact:*** By partnering with nonprofits, businesses, and the IRS to recruit, train, and deploy staff in medical settings, StreetCred has returned over $14 million to 6000+ families, free of charge. ***National replication:*** StreetCred also uses a support network and toolkit to help other health systems replicate its efforts. Nationally, 24 organizations use its learnings.
Early Bird – *Austin, Texas*	Launched by The Impact Factory, Austin's hub for social entrepreneurship and community service, Early Bird is a medical clinic-integrated scholarship fund and educational program that helps low-income families save and plan for higher education. As caregivers achieve healthy milestones—such as attending their children's doctor or dentist appointments, meeting with a financial coach, or signing up their kids for pre-kindergarten—Early Bird puts money into college savings accounts for the children. Its services include:	***Partner buy-in:*** Providers and staff at participating clinics are trained on program operations and potential impact, then work alongside Early Bird's staff to implement and tweak the model. Nonprofit partners refer patients and offer financial coach trainings, and state government partners manage savings accounts. ***Talent pipeline:*** Early Bird engages local universities and community colleges and gives paid and volunteer opportunities to students who advertise the program in-person at participating clinics and local nonprofits, call participating families to remind them of upcoming opportunities to earn more scholarship dollars, and collect data for a

	• Enrollment in and seeding 529 college savings accounts • Financial coaching • Counseling on planning for higher education	randomized controlled trial evaluating Early Bird's impact.
Local Initiatives Support Corporation (LISC) – ProMedica Financial Opportunity Center (FOC) – *Toledo, Ohio*	ProMedica has partnered with LISC to operate a Financial Opportunity Center (FOC). The FOC is located at the Ebeid Center, a nonclinical site that serves the broader community and receives referrals from patients who have screened positive for financial risk at ProMedica's clinics. The services they provide include: • Free tax preparation • Job training (including nursing assistant training) • Financial coaching (group and individual) • Employment counseling • Public benefits navigation	***Bundled services:*** The MFP has found that participants who do combined services (eg, employment counseling and financial coaching) are more likely to get a high-paying job and retain their job than participants who do just one program. ***Co-located community resources***: The FOC is co-located with Market on the Green, a community grocery store funded through a ProMedica investment that provides healthy food, cooking classes, and job training opportunities. ***Broader neighborhood investments***: The FOC is embedded within ProMedica's broader neighborhood investment strategy including a loan fund, educational scholarships, and affordable housing.

Table 2. Potential Advocacy Areas for Medical-Financial Partnerships to Promote Greater Economic Security

Advocacy area	Advocacy goal	Potential strategies
Medical debt	Reduce and ultimately eliminate significant medical indebtedness and its harmful effects on patients	• Require screening of all uninsured and underinsured patients for public insurance coverage and other assistance and expand eligibility for financial assistance programs • Prohibit aggressive collections practices that can impoverish patients • Build on current efforts to remove medical debt from credit reports and other measures of creditworthiness • Guarantee affordable, universal, comprehensive health insurance to prevent medical debt in the first place

Social welfare policy	Ensure affordable access to basic needs like food, healthcare, and housing	• Expand income supports proven to improve health and well-being, through the expansion of existing programs like the child tax credit and earned income tax credit and ultimately through more comprehensive approaches like guaranteed income programs • Increase access to quality affordable housing by expanding public investment in affordable housing subsidies and construction and eliminating exclusionary zoning policies that promote housing segregation and scarcity • Streamline processes for eligible participants to apply for and receive public benefits
Economic policy	Transform the drivers of economic inequality and promote shared prosperity	• Pass pro-worker policies that increase the minimum wage, expand democratic unions, and support worker-ownership of businesses • Invest in underpaid sectors of the US care infrastructure, such as the long-term care workforce • Pursue reparative policies in housing, finance, and education to eliminate the racial wealth gap

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