THE MILBANK QUARTERLY
A MULTIDISCIPLINARY JOURNAL OF POPULATION HEALTH AND HEALTH POLICY

Perspective

How Health Departments Can Use Inside-Outside Strategies to Build Partnerships With Community Power-Building Organizations to Achieve Structural Change

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Policy Points:

- Changing structures, such as laws, policies, regulations, practices, and norms, in pursuit of health and racial equity is hard for any organization to do alone, including health departments.
- Health departments can advance health and racial equity by partnering with movements for fairer and more just social arrangements that often emanate from civil society through the work of community power-building organizations.
- This requires health departments to adopt an inside-outside strategy, which consists of practices needed internally to effectively participate in movements and practices needed externally to become allied in them.

Context: Disparities in health often arise due to unfair or unjust social arrangements making them inequities. These social arrangements are codified through structures—laws, policies, regulations, practices, and norms. Changing structures is generally considered the work of

The Milbank Quarterly, Vol. 104, No. 1, 2026 (pp. 58-75)

professional entities, such as health departments. However, inequities persist, which suggests new, more focused approaches are needed.

Methods: Health departments are not alone in pursuing fairer and more just social arrangements. There are also movements for social justice, which emanate from community power-building organizations (CPBOs). CPBOs benefit from being in relationship with organizations that know how to change structures, such as health departments.

Findings: For health departments to be in relationship with CBPOs and movements requires them to adopt an inside-outside strategy. Inside refers to the work needed to be done internally to effectively participate in movements. Outside refers to the work needed to be done externally to become allied in them. We describe two such strategies, one from California and one from Illinois.

Conclusions: Our examples illustrate how public health's careful participation in movements can advance health equity. Health departments need to think of themselves as part of an ecosystem of organizations pursuing fairer and more just social arrangements.

Keywords: public health, health equity, social movements, community benefits, minimum wage, earned sick leave.

Disparities in health are inadequately explained by individual factors, such as health behaviors,[1] genetics,[2] or access to care.[3] Many arise due to unfair or unjust social arrangements making them inequities.[4] These social arrangements include differential access to healthy food, safe and affordable housing, early childhood care and education, safe recreational spaces, good quality health care, and job training. They are codified through structures—laws, policies, regulations, practices, and norms.[5] Establishing and changing structures is generally considered the work of professionals, such as politicians, lawyers, policymakers, and leaders of government departments. Leaders of health departments have had notable successes over the years in advocating for fairer and more just social arrangements, but inequities in health still persist, which suggests new, more focused approaches are needed.

Health departments are not alone in pursuing fairer and more just social arrangements. There are also movements for social justice, which emanate from civil society. Movements occur when people come together to advance a political, social, or artistic idea, often through organizations. However, movements are not always for fairer and more just social arrangements; they may, in fact, seek quite the opposite. Either way, the civil society organizations that create movements are often ones that build or direct the power of communities. A broad definition of *power* is the ability to achieve purpose,[6] and community power-building organizations (CPBOs) tend to use two overlapping processes to do this: base building and community organizing.

Base building is a diverse set of strategies and methods that support community members to be in relationship with one another and develop a common identity or purpose shaped by similar experiences and a shared understanding of the root causes of their conditions.[7] Community organizing is the process by which people who have a common identity or purpose unite to build relationships, identify shared issues, collectively analyze those issues to understand structural unfairness or injustice, develop collective goals based on that analysis, and implement strategies and tactics (often called *campaigns*) to reach those goals.[8] Consistent with these processes and building on our previous work,[9] we define *community power* as the ability of people with similar experiences, identity, or purpose to develop, sustain, and grow an organized base of people who implement strategies and tactics through democratic structures to set agendas, shift public discourse, and influence those who make decisions in order to achieve collective goals. Although CPBOs are a type of community-based organization (CBO), their focus on power-building distinguishes them from most CBOs, which, broadly speaking, are focused on supporting communities by providing services or serving as a trusted voice.

For movements and campaigns to increase their chances of changing structures, CPBOs may benefit from being in relationship with organizations that also know how to operate in the arenas in which these structures are formed. The work might involve, for instance, advocacy, policymaking, the law, research, and communications.[10] This network of CPBOs and specialist organizations is often called an *ecosystem*.[11] The ecosystem provides the diverse set of expertise, skills, education, care, and capacity required to bring about and sustain structural change. Often supported by intermediaries, such as foundations, the ecosystem is stronger than any one organization within it.

Health departments should be part of this ecosystem. In fact, public health emanated from social reform ecosystems in the late 19th century. However, it largely ceded its place in reform movements throughout the 20th century by embracing a biomedical, rather than sociopolitical, understanding of health.[12] Since the mid-to-late 2000s, however, some health departments have started to reverse this trend by allying with CPBOs, movements, and campaigns in pursuit of structural changes to enable more people and communities to thrive.[13–15] The approach has been called an inside-outside strategy.

The term *inside-outside* has been used in different ways in public health. For instance, Townsend and colleagues explored how nongovernmental organizations (NGOs) sought to influence the commercial determinants of health.[16] Using a typology from political science, they delineated between direct contact with commercial actors (inside strategies) and acts to generate public attention toward them (outside strategies). Recent work on how health departments can participate in movements and campaigns has described inside strategies as *anything* a health department does to participate, whether it's internally or externally, and outside strategies as the

movement or campaign.[17] By contrast, we build on earlier work that was more focused on what health departments need to do. It describes inside practices as the work needed to be done internally to effectively participate in movements and campaigns, and outside practices as the work needed to be done externally to become allied in them.[18,19]

Building a Field of Practice

Some health departments have contributed to notable successes using inside-outside strategies. For instance, in 2014, advocacy groups and labor unions in Minnesota successfully campaigned for an increase in the state's minimum wage,[20] in our view a significant structural change. For a few years prior, the Minnesota Department of Health had been executing an inside-outside strategy aided by an assistant commissioner with experience of working with CPBOs.[13] One of the outcomes of the strategy was the Healthy Minnesota Partnership, a table at which the health department and community partners gathered to develop a shared understanding of the root causes of health informed by the experiences of those enduring inequities in health. This shared understanding was being used to inform the State Health Improvement Plan.

Some of the community groups involved in the Healthy Minnesota Partnership were also part of the minimum wage campaign, and so they asked the Department of Health to produce a white paper on the relationship between income and health. In 12 data-laden pages, the department showed how the "association of lower income with poorer health suggests policies that contribute to increasing income levels…would be expected to have a positive impact" on health.[21] It added that "any discussion of the relationship between income and health must acknowledge that income is not only strongly associated with health, but also is associated with other factors that create the opportunity to be healthy, such as employment opportunities, transportation options, and quality of housing." Through its inside-outside strategy, the department used its knowledge and influence to help increase the state's minimum wage.

Despite their successes, inside-outside strategies have not been widely embraced. The reasons for this are multiple.[22] CPBOs do not exist in some parts of the country, especially rural places or regions that lack a philanthropic base of support. Where they do exist, many in public health simply do not know about them. Where they are known, health departments may not know how to partner with them or be skeptical as to the efficacy of such partnerships. Some have suggested that part of this skepticism is because public health operates on the basis of probabilities—it does things to make population-level health *more likely*.[23] By contrast, the likelihood that building power will achieve structural change depends on how much power opposing forces have; i.e., it is always *relative*. Overall, building community power is more about possibilities than probabilities.[23] This speaks to the cultural differences between public health

and CPBOs, which is another reason inside-outside strategies have not been widely embraced. Finally, while CPBOs are clear-eyed about the role of power and politics in health, some in public health either have not connected the dots or are reluctant to given unease with advocacy or confusion about how it differs from lobbying.[24] All that said, a number of health departments *are* executing inside-outside strategies but are either not using the term or preferring to keep their work quiet (Julian Drix, email communication, May 2025) given that governmental public health is politically governed and working with movements might be seen as rabble-rousing or partisan.

There are two notable initiatives to cultivate inside-outside strategies, Health in Partnership's Power-Building Partnerships for Health (PPH)[25] and the California Endowment's Building Healthy Communities (BHC).[26] PPH began in 2018 and is currently a ten-month program to support health departments and CPBOs deepen their relationships, develop trust, and build structures for collective action toward health and racial equity. It is currently in its fourth cohort, which consists of four health department and CPBO partnerships, and they recently released a report and a toolkit.[17]

BHC began in 2010 and sought to tackle inequities in health by investing in CPBOs in 14 low-income places across California. Its approach was informed by work at the Health Department of Alameda County, California,[15] where the department's leaders had observed how communities disproportionately impacted by environmental hazards had organized to not only protect themselves but also pursue structural changes that would reduce or eliminate the hazards. The department's leaders expanded the definition of *environment* to include social, economic, and political contexts and explored ways of working with CPBOs to pursue health equity. In effect it incorporated the practices of environmental justice activism into public health and prototyped inside-outside strategies. Similar work was being done in Kansas City, Missouri; Cook County, Illinois; and King County, Washington, and the Minnesota Department of Health was soon to follow. The California Endowment's vision for BHC was to accelerate the development of inside-outside strategies.

What follows are two examples of inside-outside strategies, one from Boyle Heights, California, that was part of BHC, and one from Cook County, Illinois. We then draw out some key lessons for public health leaders and practitioners.

Community-Engaged Development in Boyle Heights, California

Boyle Heights is a neighborhood of Los Angeles that has seen numerous waves of immigration. Over the years, it has been home to Jewish, Mexican, Japanese, Yugoslav, Armenian, African American, and Russian populations. Today, it is primarily a Mexican American community. It is dominated by seven freeways, including the East LA

Interchange that, at some points, is 27 lanes wide. As a result, the area around Boyle Heights is one of the most traffic congested in the world with some of the most concentrated pockets of air pollution in America. Despite that, Boyle Heights has for decades been of interest to property developers seeking to create facilities and homes for Los Angeles's growing economy.

In the early 2010s, one organization trying to grow was the University of Southern California (USC). It wanted to support the creation of a "biotech corridor" between its Health Science Campus on the west and the California State University to the east. News of the corridor built on residents' frustrations with being displaced by development and concerns that the new investment would not benefit them. For decades, the residents of Boyle Heights had endured rising rents and evictions, with displaced residents being forced to move outside the City of Los Angeles to find housing. Frustration boiled over into anger when rumors circulated that USC was making a "secret deal" with the County Board of Supervisors to acquire public land in order to expand its Heath Science Campus. Whether true or not, the anger peaked in late 2016 when the *Los Angeles Times* editorial board published an article saying that local supervisor Hilda Solis needed to "finally open formal negotiations."[27] Although the article acknowledged the views of all parties, its conclusion suggested the newspaper had been lobbied by USC and was taking its side. Residents realized they needed to respond.

Boyle Heights has a number of CPBOs. They work on numerous issues, such as education, health, and housing, but all were aware that rising rents and evictions were eroding community life. As part of BHC, the CPBOs came together to share their experiences and discuss how they wanted to respond to USC, a private entity, potentially taking over public land to further its own interests. In parallel, the California Endowment sought the advice of Public Counsel, a nonprofit law firm that serves low-income clients and works in coalition with CPBOs in Los Angeles County. Public Counsel had experience in public land use and, together with the Endowment and the CPBOs, explored frameworks for how a private company might be required to provide "community benefits" if it wants to make use of public land. The CPBOs and residents realized they needed to campaign for a process by which the county had to seek the views of local residents when trying to define what benefits the community might receive. To give their campaign heft, they created a coalition of local CPBOs that represented neighborhood residents as broadly as possible. They called it the Eastside Leadership for Equitable and Accountable Development Strategies (Eastside LEADS).

Although this work was largely independent of the Los Angeles County Department of Public Health, its staff were aware of it due to the department's commitment to solving health challenges through partnerships, whether with other government agencies, local businesses, community organizations, or residents. This "outside" work included a community liaison team whose role was to engage with partners and represent the department in efforts related to community health improvement, disease control, and emergency response. The approach was adopted to ensure public

health strategies reflect local priorities, needs, and lived experiences. As a result of this long-standing commitment to "outside" work, the department had strong relationships with numerous communities across Los Angeles County.

After concerted advocacy by Eastside LEADS and Public Counsel, the County Board of Supervisors in March 2017 directed its chief executive officer to require community participation in major economic development projects. For the biotech corridor, this was to be delivered through a Health Innovation Community Partnership (HICP) whose aim was to create the space and process for community stakeholders, the county, and USC to come up with a shared vision, goals, and metrics to shape the development. Given the importance of the issue to local residents, the Department of Health got involved. Despite being just one entity in the HICP, the department's experience with partnering made it an important facilitator—it had the skills, capacity, and standing to bring all parties together. There was also a feeling that its focus on health equity made it a natural, if informal, guardian of the work to define community benefits.

Over the next two years, the HICP, aided by the Department of Health, helped to shape a community benefits policy that was approved by the Board of Supervisors in June 2019. The policy applied to the whole of the county, not just the corridor. The Community Benefits Policy for County Economic Development Projects, as it's called, establishes the criteria and procedures for public-private economic development projects so that benefits are generated for the businesses and communities surrounding each project. Specifically, the policy stipulates that such developments must incorporate a robust, culturally competent community engagement process; hire 30% of construction workers locally and 10% from groups facing barriers to employment, such as a criminal record, disabilities, limited English, homelessness, or veteran status; have a goal of using local small businesses for 25% of the work and disabled veteran businesses for 3%; square footage reserved for local tenants; and a minimum of 20% of any residential units set aside as affordable housing.

All in all, the CPBOs of Boyle Heights, working with residents and public agencies, have secured policies to further an "investment without displacement" approach that was partly made possible by the Department of Health's willingness to listen to impacted residents as part of their inside-outside approach. Additionally, the CPBOs that participated in the HICP gained greater insight into the workings of county government, greater access to county department staff, and technical information, all of which supported their wider advocacy strategies.

Minimum Wage and Earned Sick Leave in Cook County, Illinois

Cook County is the second most populous county in the United States. It is made up of almost 130 municipalities, the largest of which is Chicago. The Cook County

Department of Public Health (CCDPH) serves about 2.3 million people living in the majority of the suburban areas outside of Chicago. It's an area of approximately 700 square miles, three times the size of Chicago. CCDPH is part of Cook County Health, one of the largest public health care systems in the nation. CCDPH reports to Cook County Health and is overseen by Cook County Government, which is run by a board of elected commissioners headed by a president.

In 2016, the University of Illinois Chicago (UIC) established the Center for Healthy Work (the Center), a research and education center to advance the health and well-being of those employed in precarious jobs—work that is unstable, unpredictable, or otherwise risky for the worker. The Center was a Center of Excellence for *Total Worker Health*® with funds from the National Institute for Occupational Safety and Health, a federal agency. One of the Center's initiatives was the Healthy Work Collaborative (HWC), a multiyear initiative in which public health and health care organizations engaged with labor, government, and worker advocacy organizations to collaborate in advancing policy and systems change to address precarious work within their jurisdictions.[28] Launched in 2017, the HWC created the opportunity for inside-outside work, and CCDPH participated.

As part of the HWC, CCDPH engaged with two entities it already knew: Centro de Trabajadores Unidos (CTU), a worker advocacy organization, and Arise Chicago (Arise), a membership-based worker center and interfaith organizing group. The group project focused on supporting the minimum wage and earned sick leave ordinances recently adopted by Cook County Government as many municipalities were opting out.[29] Specifically, CCDPH, CTU, and Arise collaborated on an education campaign to further existing efforts to encourage municipalities either to not opt out or to opt back in.

At the beginning, the three organizations prioritized building strong relationships and trust with each other and simultaneously developing a shared understanding of each other's strengths and how they could work together effectively—all examples of "outside" work. In doing this, the group realized that CCDPH had valuable expertise that had not yet been fully leveraged by the worker centers, such as its ability to access and analyze data, convene Cook County Government and the worker centers, and plan across suburban Cook County. This led to CCDPH providing government data about how many workers in municipalities affected by the two ordinances were earning minimum wage and had the right to earned sick leave. This, in turn, helped illustrate the scale of the problem and supported the link between minimum wage, earned sick leave, and health outcomes, which was then elevated in educational materials developed by the Center, Arise, and CTU with input from CCDPH. Furthermore, while Arise and CTU mobilized their communities and navigated the political landscape, CCDPH used its positional power—the authority it has by virtue of being part of government—by providing testimony at municipal meetings.

Overall, the campaign was significant for protecting thousands of workers in precarious jobs through the county ordinances, raising awareness about workers' rights

as a public health issue, and engaging residents in their communities. It also deepened the partnership between Arise, CTU, CCDPH, the Center, and other groups involved in the campaign.

During the pandemic, it became clear that workers in precarious jobs were some of the most at-risk individuals and came from higher risk communities. As a result of the relationships established through the HWC, there were discussions between CCDPH, worker centers, and the Center about how CCDPH could use its authority and resources in ways that protected workers who were most vulnerable. Together, CCDPH and several workers' centers created the Worker Protection Program (WPP) to ensure people in precarious jobs received information about the virus, how to stay safe, and how to get vaccinated. The program was coordinated by Raise the Floor Alliance, a coalition of worker centers that were best placed to ensure the information reached as many people as possible. As a result of that reach, CCDPH benefited by gaining richer insights into what workers were experiencing and how best to support them.[30]

After the pandemic, CCDPH made a commitment to continue investing in inside-outside strategies to make them a core component of its approach. For instance, it hired a former labor and community organizer as a regional health officer partly to support inside work. Specifically on precarious work and worker health, it has formed a countywide council, with representation from Cook County Government, that has overseen a countywide assessment of precarious work and developed a strategic agenda for worker rights, health, and safety. Over time, CCDPH aims to lead and participate in developing the collective power of partners and workers to drive structural change across suburban Cook County to advance improvements in work and worker health.

A "New" Frontier

While inside-outside strategies are not new, they remain a niche innovation in public health. Our aim in describing the approach and outlining the practices that have been documented within it (see Table 1) is to aid in their wider adoption. BHC, PPH, and the structural successes achieved in Minnesota, Boyle Heights, and Cook County all illustrate how public health's careful participation in movements and campaigns for fairer and more just social arrangements can advance health equity and help more people and communities thrive.

We are aware that the two examples in this article have arisen from two very large urban health departments. The Los Angeles County Department of Public Health is one of the largest in the nation, with an annual budget of almost $900 million. And while leaders within the CCDPH already had a desire to work with impacted communities, the university-anchored HWC provided an opportunity to explore inside-outside work that few other health departments will have. We do not, however, think

Table 1. The Practices That Have Been Documented Within Inside-Outside Strategies[15,17,22,35–41]

Inside Practices: The work needed to be done internally to effectively participate in movements and campaigns
Understanding history
The social reform roots of public health
How historical racism has created inequities in health
How public health has harmed communities nationally and locally
Deepening understanding of key concepts
What are power and privilege, and how do they influence population health
What are power analyses, and how are they done
What are narratives, how they have power, and how they influence health
The link between structures, conditions, and equities
The different forms of racism, with an emphasis on structural
How different forms of exclusion reinforce each other (intersectionality)
Practices to understand and/or explore
What base building and community organizing are
How cultural competency and humility can enhance partnership work
How to blend the knowledge from empirical research with lived experience
How to work with people and organizations of different political persuasions
What are the different forms of participation (informing, consulting, involving, collaborating, and deferring to), and when are each appropriate
Where the line between advocacy and lobbying is in your public health context
Research and exploration
Surface and question the narratives that underpin current public health interventions (i.e., are they based on "deservingness" or "personal responsibility"?)
Produce analyses of local social inequities and map them to local health disparities (consider factors such as place, poverty, income inequality, racism, foreclosures, and displacement)
Explore how the concerns of CPBOs can be added to community health improvement plans (or their equivalents)
Define criteria for when to work on issues that are not traditionally within the purview of public health, such as criminal justice or worker exploitation

Continued

Table 1. (Continued)

Inside Practices: The work needed to be done internally to effectively participate in movements and campaigns
Define criteria for when to work with CPBOs
Explore how your work is directly accountable to local communities, and, if it's not, consider how it could be
Preparing for outside work
Develop relationships with other government entities that have influence over the structural and social determinants of health
Identify community power-building organizations to approach
Look for short-term funding that can enable "proof of concept" work, while considering how the work might be funded medium-to-long term
Hire staff from the communities that are building their power or have experience of working with such communities
Create the conditions for staff to meet people from CPBOs and the communities they serve to build relationships and explore how to work together
Understand what skills and capacity will be required across the four arenas of structural change (electoral, legislature, judiciary, and administration)
Set clear, measurable goals for the department and its staff to ensure that inside-outside strategies become baked into how the agency operates
Outside Practices: The work needed to be done externally to become allied in movements and campaigns
Engaging and building relationships with CPBOs
Meet with CPBOs to explain what public health is from the field's perspective and find out what it is from their and their community's perspectives
Talk openly about how public health has harmed marginalized communities (nationally and locally) and describe how it has changed
Show up to community meetings, especially when invited, and participate with a learner mindset, not as an "expert"
Develop a shared understanding of unfairness and injustice, including appreciating that different fields use different terms
Learn about each other's frameworks, analyses, and approaches
Be clear about what public health is able to support, what work it may grow into, and what is off the table
Finding issues to work on together
Provide data on the issues that CPBOs are working on or offer to partner with them in collecting the data they need

Continued

Table 1. (Continued)

Outside Practices: The work needed to be done externally to become allied in movements and campaigns
Participate in collaborative analyses of power and social inequities
Be open to participating in campaigns that are not within the traditional purview of health but have an impact on the structural and social determinants of health
Create opportunities for CPBOs to participate in community health assessments (or their equivalents)
Participate in movements and campaigns
Develop and share narratives about how health is more a consequence of structures, especially policies, than of health behaviors, genetics, or access to care
Start with small, concrete collaborations to explore what it means in practice to work with CPBOs
Provide analyses, such as through reports, letters, testimony, and engaging with the media, to support the aims of movements and campaigns
Co-identify strengths and weaknesses in the partnership to find areas for growth
Help to build capacity within CPBOs
Pay CPBOs and community members for their time and expertise, as would happen with anyone else with valuable expertise (as well as compensation, consider the costs of transportation and childcare)
Change contracting procedures to prioritize smaller, community-rooted organizations with experience of base building and community organizing
Establish participatory processes for some elements of the department's work, partly to improve decision-making and partly to build familiarity with such processes (and be clear on both aims to aid buy-in and participation)
Establish workshops for residents, especially youth, to connect health, conditions, structures, participation, and power
Partner with CPBOs on grant applications to help them receive the money (but participate as a junior partner to ensure that the CPBOs drive the work)
Help to build capacity within the ecosystem
Find opportunities to bring different CPBOs into the work to help them build relationships with each other and with other agencies or organizations
Engage other government agencies to explain why the health department has engaged in an inside-outside strategy, and the experience of it

Continued

Table 1. (Continued)

Outside Practices: The work needed to be done externally to become allied in movements and campaigns
Engage leaders of local professional associations, such as chambers of commerce, on how health is more a consequence of structures, especially policies, than health behaviors, genetics, or access to care
Engage elected officials to share how health is more a consequence of structures, especially policies, than health behaviors, genetics, or access to care
Understand what infrastructure the ecosystem needs—such as forums, coalitions, alliances, and communications channels—and explore how the department's activities might support it, whether directly or indirectly

that makes the work irrelevant to other health departments in smaller or less urban places, although the precise shape of the strategy will always depend on local circumstances.

Leaders of health departments are rightly concerned with the political risk of allying with movements and campaigns. It is important to remember, however, that residents, communities, and CPBOs also incur risk. While starting or getting involved in movements can enhance a sense of belonging and well-being, either through the work itself or the social cohesion that comes from it, a study of a major "community power" initiative in the United Kingdom found that these effects were less pronounced in women and those of lower socioeconomic status.[31] And, given the conflicts, tensions, stress, and frustrations inherent to the work, these benefits may not last.[32] Furthermore, it is important to understand the "capacity" of communities. Those with more capacity tend to benefit from being in movements, while those with less may actually be harmed by the demands of them.[33,34] Overall, leaders of health departments need to be cognizant of these potential harms, although that is not a reason not to develop inside-outside strategies. Indeed, our view is that the harm inflicted on communities by unfair and unjust social arrangements far exceeds those created by participating in movements. By not allying with movements for more fairness and justice, public health risks endorsing a harmful status quo.

Thinking about health departments as part of an ecosystem of organizations pursuing fairer and more just social arrangements helps to surface two important and related ideas. The first is to update our understanding of *community resilience*. Although poorly theorized,[34] this term has tended to mean the capacity of residents in a place to withstand stress and serious challenge. However, this definition fails to appreci-

ate that how agencies operate influences the capacity of residents. A more accurate understanding of community resilience, then, is the *collective* capacity of individuals and agencies living, working, and operating within a neighborhood to adapt positively to change and adversity.[34] This collective orientation brings us to the second idea: the relationship between residents and agencies. In general, local communities have little or no direct oversight of the agencies that serve them, despite the agencies being tax funded. An ecosystem orientation opens up that possibility, an idea that is being described as democratizing public institutions or co-governance.[17] Indeed, some practitioners have proposed that one of the aims of an inside-outside strategy is for health departments to help communities make demands of government agencies, including the health department.

Inside-outside strategies can create mutual understanding, trust, and shared goals between health departments and CPBOs. They require building relationships between those on the inside and those on the outside, building capacity on both sides for collaborative work, collectively understanding the political context to know what's possible, and aligning around strategies for structural change,[17] all of which builds the collective power of health departments and CPBOs. The work involves blending biomedical and sociopolitical approaches to public health. Ultimately, it is about optimizing the performance of local democracy by facilitating the ability of traditionally marginalized communities to hold institutions accountable for fairer and more just social arrangements. There will inevitably be tensions, especially in our increasingly polarized political landscape, but no one organization can truly advance structural change. It takes many groups working together.

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Acknowledgments: We thank Jonathan Heller of the University of Wisconsin and the National Collaborating Centre for Determinants of Health (Canada) for sharing his thoughts on how the term *inside-outside* has been used in public health since his early writing and for reviewing the article. We thank Lili Farhang and Julian Drix of Health in Partnership for sharing their in-press work on inside-outside strategies, and the latter also for reviewing an early draft of this article. We thank Juliet Sims of the Prevention Institute for reviewing the article. We thank Tiffany Romo and Cristin Mondy of the Los Angeles County Department of Public Health for telling us about their work in Boyle Heights and for reviewing and approving the text about it. We thank Centro de Trabajadores Unidos, James Bloyd (formerly of the Cook County Department of Public Health), and Kiran Joshi (currently of the Cook County Department of Public Health) for their valuable contributions to the Healthy Work Collaborative (HWC), as well as Tessa Bonney and Elizabeth Jarpe-Ratner of the University of Illinois Chicago School of Public Health for their leadership in the design and evaluation of the HWC.

Funding/Support: Pritpal S. Tamber's contribution to this article was made possible by a grant from The California Endowment. The California Endowment also provided grants to Eastside LEADS and Public Counsel for their work in Boyle Heights. To the extent any activities described in this report constitute lobbying for IRS purposes, these activities are described only to provide the full context of Eastside LEADS and Public Counsel's work on this issue. Such lobbying activities were separately funded and were not supported by funds provided by The California Endowment. Funding for the Healthy Work Collaborative was through the University of Illinois Chicago (UIC) Center for Healthy Work, a National Institute for Occupational Safety and Health (NIOSH) Center of Excellence for Total Worker Health (Grant: U19OH011232). The Worker Protection Program (WPP) was established with support from the Illinois Department of Public Health COVID-19 Contact Tracing Grant (2020–2021), awarded to and administered by the Cook County Department of Public Health (CCDPH). Continued implementation and expansion of WPP was supported by CCDPH through the CDC's National Initiative to Address COVID-19 Health Disparities Among Populations at High Risk and Underserved, Including Racial and Ethnic Minority Populations and Rural Communities (CDC-RFA-OT21-2103, 2021–2024). Additional investments were made possible through braided funding managed by CCDPH, including CCDPH Corporate Funds, the Equity Fund of Cook County, and American Rescue Plan Act (ARPA) funding. The views expressed in written materials do not necessarily reflect the official policies of the Department of Health and Human Services, nor does the mention of trade names, commercial practices, or organizations imply endorsement by the US government.

Conflict of Interest Disclosures: The authors declare that they have no potential or actual conflicts of interest to disclose.

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