From Concepts to Practice: Health Equity, Health Inequities, Health Disparities, Social Determinants of Health (1/2 hour)

Health and its Determinants  
While many definitions of health exist, the World Health Organization defines health as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.   
Determinants of Health are the range of personal, social, economic, and environmental factors that influence health status.   
There are a number of ways to categorize the determinants of health, but for the purposes of this module, we have chosen Healthy People 2020 categories.   
These determinants fall under the broad categories of:  
Policymaking,  
Health Services,  
Individual Behavior,  
Biology/Genetics, and  
Social Factors which we will be the main focus of this module  
For more information on the determinants of health, visit Healthy People 2020.

Public Health  
  
Public Health is the promotion and protection of the health of people and the communities where they live, learn, work, and play.   
The essential services of public health describe the activities that all public health professionals should undertake and serve in order to ensure the health and safety of the population. According to the CDC, the 10 Essential Public Health Services include the following:  
  
1. Monitor health status to identify and solve community health problems.  
2. Diagnose and investigate health problems and health hazards in the community.  
3. Inform, educate, and empower people about health issues.  
4. Mobilize community partnerships and action to identify and solve health problems.  
5. Develop policies and plans that support individual and community health efforts.   
6. Enforce laws and regulations that protect health and ensure safety.  
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.  
8. Assure competent public and personal health care workforce.  
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.  
10. Research for new insights and innovative solutions to health problems.  
  
For more information on the 10 Essential services of public health, visit the CDC website.

What is Health Equity?  
  
Health Equity is the attainment of the highest level of health for all people.  
Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.  
  
Health Equity is on the forefront of many major organizations' strategic plans. The Health Resources and Services Administration aims to improve health and achieve health equity through access to quality services, a skilled health workforce and innovative programs. The mission of the American Public Health Association is to improve the health of the public and achieve equity in health status. The association aims to create the healthiest nation in one generation by working to advance the health of all people and all communities. Only through addressing health inequities can we close the gaps and become a healthier nation overall.

What are inequities and why do we see them? - What are health disparities?  
  
Let's look at the population of people in New York City who report having hypertension, or high blood pressure.   
4% of people 25-39 report having hypertension, whereas 64% of those 60 and over report having hypertension.   
This is a difference or disparity by age among people who have hypertension.  
According to Healthy People 2020, if a health outcome is seen to a greater or lesser extent between populations, there is a disparity. Race or ethnicity, sex, sexual identity, age, disability, socioeconomic status and geographic location all contribute to an individual's ability to achieve good health.

What are inequities and why do we see them? - What are health inequities?  
  
According to the CDC, health inequities are differences or disparities in health outcomes that are systematic, avoidable, and unjust. They are the result of social, economic, and environmental conditions.   
When we look at these same hypertension data by race, we see that people of color have higher rates of hypertension than White people in New York City.   
And when we look at age and race together, we see even greater differences. Let’s compare the White and Black populations of New Yorkers ages 25-44. If all New Yorkers had an equal ability to achieve good health, we would expect that the prevalence of hypertension would be approximately equal across racial groups. However, only 8% of White people report having hypertension, while instead 17% Black people the same age report having hypertension.

What are inequities and why do we see them? - What are health inequities? (continued)  
  
These data are even more striking when you consider the size of the populations affected.  
The most recent Census indicates that there are roughly 500,000 black people, and 1,000,000 white people ages 25-44 in New York City.  
Despite a much smaller population of 25-44 year-olds, the Black population is much more impacted by hypertension than the White population.   
While we expect to see differences in hypertension by age based on how our bodies change as we get older, we should not see differences in any outcomes by race among people in the same age category.   
We call these differences or disparities in any health outcome by race, and other social constructs (gender identity & expression, class, immigration status, sexual orientation, incarceration history etc.), “health inequities” because they are avoidable, unfair, unjust, and rooted in social and structural inequities.  
  
Clicking on the Review icon shows the following text:   
Health Disparity = difference in a health outcome between populations  
  
Health Inequity = difference in a health outcome by a social construct (such as race) that are avoidable, unfair, unjust, and rooted in social and structural inequities.

Understanding the difference between health disparity and health inequity  
  
Inequities are created when barriers prevent individuals and communities from accessing conditions that allow them to reach their full potential. Examples of such barriers include unstable housing, lack of access to clean water, and lack of neighborhood safety. Inequities differ from health disparities, which are differences in health status between people that are related to social or demographic factors such as race, gender, age, income or geographic region. Health disparities are one way we can measure our progress toward achieving health equity.

Why do health inequities exist?   
  
The Role of Social Determinants of Health  
Social determinants of health are the complex, integrated and overlapping social structures and economic systems that are responsible for more health inequities, and which are shaped by the distribution of money, power, and resources throughout local communities, nations, and the world.  
Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.   
How many examples of the social determinants of health can you recognize? In this activity, check each condition that is a social determinant of health.

Visual Depiction  
Social Determinants of Health  
  
The five key areas related to social determinants of health include economic stability, education, social and community context, health and health care, neighborhood and built environment.  
Under each social determinant of health, you can see component parts of each. How many did you select correctly?

Why is this Important?  
  
The National Association of County and City Health Officials' handbook for action, "Tackling Health Inequities through Public Health Practice" states, "Health practitioners in local health departments face many dilemmas and struggles in seeking to protect and improve the public's health. As the front line of the public health response in local communities, they often must cope with immediate crises and chronic issues with limited resources, restrictive statutory mandates, categorical funding, and political pressures from state and local officials. Addressing the root causes of inequities in the distribution of disease and illness might seem like a luxury. But it is not. Persistent, severe health inequities are increasing significantly, with serious implications for the nation's wellbeing...the day-to-day consequences [of health inequities] are a major threat to public health. They must be challenged. The good news is that success will mean fewer resources need to be spent on coping with the consequences. With leadership, strategic alliances, commitment, and public support, local health departments can meet the challenge."  
If you want to solve or prevent a problem for the long term, you have to deal with it root causes. If you address the root causes, you are more likely to successfully address the issue for the short term as well. To cure a disease, you have to treat more than the symptoms. Dealing with social determinants will not only resolve the issue over the long term, but will make alleviating the current effects of the issue possible also.  
  
What can PH practitioners do to advance health equity/ address health disparities/social determinants of health?  
  
Healthy People 2020 has proposed and outlined specific objectives broken down by determinant to create social and physical environments that promote good health for all.   
  
Objectives related to economic stability are:  
  
- Increase proportion of children ages 0-17 years living with at least one parent employed year round, full time  
- Decrease the proportion of persons living in poverty  
- Decrease the proportion of households that experience housing cost burden  
- Eliminate very low food security among children  
- Reduce household food insecurity and in doing so reduce hunger  
  
Objectives related to education are:  
- Increase the proportion of high school completers who were enrolled in college the October immediately after completing high school  
- Increase the proportion of students who graduate with a regular diploma 4 years after starting 9th grade  
- Increase the proportion of children with disabilities, birth through age 2 years, who receive early intervention services in home or community-based settings  
- Increase the proportion of parents who read to their young  
  
Objectives related to health and health care are:  
  
- Increase the proportion of persons with medical insurance  
- Increase the proportion of persons with a usual primary care provider  
- Increase the proportion of persons of all ages who have a specific source of ongoing care  
- Reduce the proportion of persons who are unable to obtain or delay in obtaining necessary medical care, dental care, or prescription medicines  
  
Objectives related to Neighborhood and Built Environment are:  
  
- Reduce the rate of minor and young adult perpetration of violent crimes  
- Reduce the rate of minor and young adult perpetration of serious property crimes  
- Reduce the number of days the Air Quality Index exceeds 100  
- Reduce Homicides  
- Reduce physical assaults  
- Reduce children's exposure to violence  
  
Objectives related to Social and Community Context are:  
  
- Increase the proportion of adolescents who have an adult in their lives with whom they can talk about serious problems  
- Increase the proportion of adults with disabilities who report sufficient social and emotional support  
- Increase the proportion of parents who use positive communication with their child  
  
There are additional complementary Health People 2020 objectives that are highly relevant to the social determinants of health objectives.   
Next we will discuss specific strategies public health professionals can use to advance health equity by addressing social determinants of health in order to effectively reduce health disparities.

Specific Strategy: Place-based approach  
  
Strategies informed by the environments where people live, work, attend school, and spend their time are placed-based approaches.  
A "place-based" approach requires us to look at individual communities separately in order to identify the factors that influence health outcomes in that place. This approach is vital in diagnosing the problem and in identifying strategies to best address the issues.  
  
A direct relationship exists between the quality of these communities and the health outcomes of the people living in them. Good individual and family health start with good community health and equal access to health-promoting opportunities (Policy Link. 20 May 2014. Health Equity: Moving Beyond "Health Disparities". Health Equity and Place Publications.).  
When implementing a place based approach it is important and necessary to consider how community conditions impact health for many reasons:   
To ensure that meaningful solutions are not just focused on the individual or on simply increasing access to healthcare, but on crafting holistic solutions with overall wellness at the center, taking into account the need for environmental changes.   
Effective place-based solutions also increase attention on prevention efforts, identify multi-sector partners and community members, and change policies and systems.   
Ultimately, the goal is to explore ways the environment affects health and initiate strategies that impacts choices, behaviors and outcomes.

Specific Strategy: Policy and cross-sector partnerships  
  
Making the broad changes needed to address health inequities requires collaboration and partnerships across sectors. It also requires integrating health considerations in the development, implementation, and evaluation of policies and programs.  
In some instances, formal agreements have been created to develop partnerships between health institutions and divisions such as housing, education, planning, and transportation that serve to guide processes and activities  
It is important that multiple perspectives are included in these partnerships to represent all the players who influence health access and services.  
  
One example of such a cross-sector partnership in Region 2 is the partnership in New York developed between a television production studio, an asthma care and education center, a medical school, and additional public health organizations to address asthma among Children in East Harlem.   
eHarlem TV, East Harlem Asthma Center of Excellence, Mount Sinai School of Medicine and community health experts partnered to produce 2 spots and 2 shows showcasing the seriousness of asthma and disseminating information on its causes and treatment options.

Community Engagement  
  
- Community engagement is the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.  
  
(What is Community Engagement? (2011). Retrieved from http://www.atsdr.cdc.gov/communityengagement/pce\_what.html.)  
  
- Many times, priority populations, such as communities of color, youth, immigrants, and boys and men, are excluded from the very conversations and decisions around the factors that most impact their health.   
- In identifying and implementing strategies to address health inequities, and to assess their effectiveness, authentically engaging the communities most affected is essential.   
  
This engagement may include Community-Based Participatory Research, participating on advisory boards, task forces, and working groups, mobilizing community to take action, and promoting civic engagement. Seeking partnerships with community leaders to amplify their voices and valuing their feedback is critical to successful place-based solutions.

Specific Strategy: Data and Storytelling  
  
The use of compelling data to make the case for health equity can be the first step in gaining support and advocating for change.   
  
Working with public health departments, academic researchers, and others to share data is important. Translating it in ways that are accessible to multiple audiences, including policymakers, is the next step.   
  
In an era of evidence-based approaches, capturing and analyzing data must remain an important beginning point.   
- Data can complement your overall message and raise the awareness of key stakeholders.  
- Visual and experiential data (e.g. mapping, digital storytelling) can provide vivid examples of the real experiences of communities affected by health inequities.  
- Cost data can also be used to reveal the significant financial implications of existing inequalities (e.g. unnecessary health care costs, costs associated with premature death among populations experiencing inequalities)  
  
It is important to tell stories of impact, success, and challenges to make the case for health equity.  
In addition, telling stories is a powerful and compelling tool that can help policymakers and funders better understand complex community problems.   
However, it must be told from the perspective and voice of those most impacted. It can also serve to highlight community assets.  
- Storytelling / telling of narratives is a form of consciousness raising that can be used to bring awareness to the issue of health equity  
- Consciousness raising is a process through which people come together to discuss the relationship between individual or group experiences or concerns and the social or structural factors that influence them  
  
- This approach is useful for ensuring that both "insiders" and "outsiders" develop a common understanding of issues and concerns, stimulating discussion and motivating partners to address the issues and concerns.   
- Some other methods used to raise consciousness include generating discussion by asking individuals to share their experiences, presenting hypothetical vignettes, having the group discuss responses to a picture or photograph, or reading a story or poem.

Specific Strategy: Building Community and Organizational Capacity  
  
Building Community and organizational capacity means:   
  
Working to ensure that health equity is the lens through which an entire agency or community can carry out all of its programs, policies and practices.  
Some health departments have adopted department-wide strategies to incorporate health equity into the work of all programs, in addition to developing new forms of practice.  
These five strategies are only examples of ways to successfully work towards the Healthy People 2020 objectives to address the social determinants of health. In order to advance health equity, these and other strategies may be adapted or combined to achieve the greatest impact among the population(s) in which you work.  
Now let's look at a real-life case study that focuses on addressing a social determinant of health.

Real Life Example: First Things First  
  
In order to address high school graduation, a key social determinant of health, many schools throughout the country have implemented First Things First.  
"The FTF framework aims to engage students intellectually and emotionally in their schools through instructional improvement, small learning communities, and family and student advocacy systems.  
The instructional components are designed to improve student engagement by equipping teachers with research-based teaching strategies and high-interest content. Also, all students have a teacher advocate in their small learning community who supports them emotionally and logistically and helps them address barriers to their education. Schools continually improve their efforts by using process and outcome data to evaluate the program and identify priority areas. Finally, throughout this effort, school- and district-level leadership involves community leaders and representatives to help support the program and the students."   
The national Healthy People 2020 target for on-time graduation rate is 82.4%, the baseline in 2007-2008 was 74.9%, which improved to 78.2% in 2009-2010.