# SECTION 2: Background

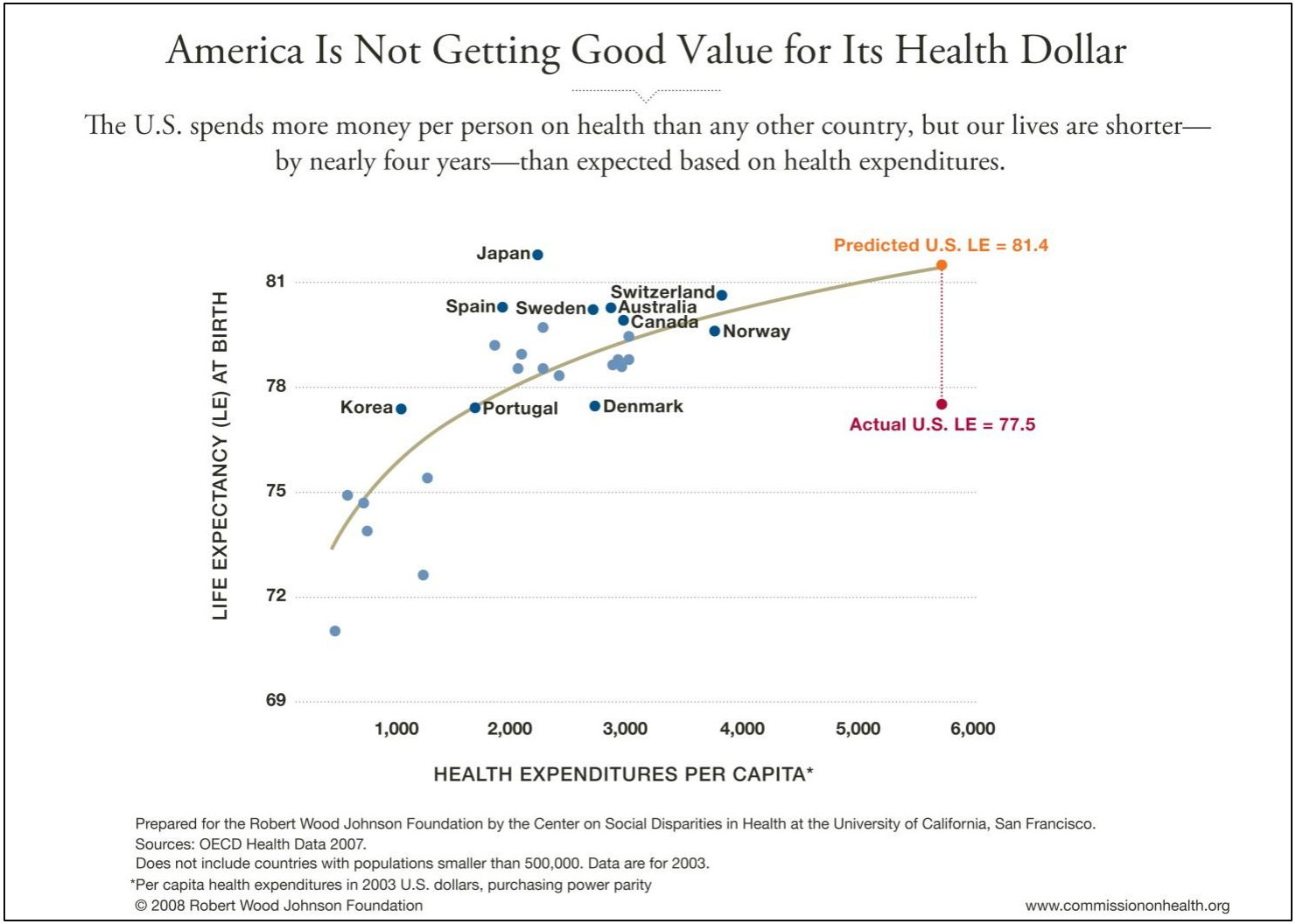
This section provides information regarding the population health profile of the United States, including statistics that highlight the various types of health inequities (and their magnitude) seen across the country. It defines key terms and summarizes select national efforts to advance health equity through a "social determinants of health" lens. Included is a brief summary of DPH's efforts underway over the past three years – efforts that created the need and opportunity for this document. It concludes with a set of suggested principles and values to guide our future work in Delaware.

## Health Profile of the United States

The average life expectancy in the United States has increased substantially over the past century to an estimated 79.6 years in 2014 (Central Intelligence Agency, 2013). However, this places the U.S. 42$^{nd}$ in the world, despite being one of the wealthiest developed countries (Central Intelligence Agency, 2013).

The U.S. also ranks near the bottom among wealthy developed countries (and some developing countries) in infant mortality, which is another indicator frequently used to describe the overall health of a population. The U.S. ranks 169$^{th}$ in the world, with an infant mortality rate of approximately six per 1,000, which equates to approximately 25,000 infant deaths per year (Central Intelligence Agency, 2013). Of particular concern is that these indicators are moving in the wrong direction, with the U.S. falling in the rankings in recent years. It is also clear that the U.S. is not receiving a good return on its investment in terms of health care expenditures, as seen in Figure 2, reproduced courtesy of the Robert Wood Johnson Commission to Build a Healthier America (RWJF, 2008). The graph indicates that in 2003 the projected life expectancy in the U.S. based on the amount of money spent on health care should be 81.4 years; however, the actual life expectancy was substantially lower at 77.5 years.

**Figure 2. Life expectancy at birth by per capita health expenditures in 2003**




*Source: Robert Wood Johnson Commission to Build a Healthier America (RWJF, 2008).*

*Healthy People 2020*, the national strategic plan for improving the health of all Americans, provides a comprehensive set of 10-year goals and objectives with targets for health improvement (see www.healthypeople.gov). A progress report produced by the U.S. Department of Health and Human Services in March of 2014 shows progress on many indicators. For instance, fewer adults are smoking cigarettes and fewer children are being exposed to secondhand smoke. Similarly, the percent of children receiving recommended vaccines increased and adolescent alcohol and drug use is down slightly. Yet the overall suicide rate increased and the percent of adolescents with major depressive episodes rose. Other indicators show mixed results (U.S. DHHS, 2014).

## Health Differences

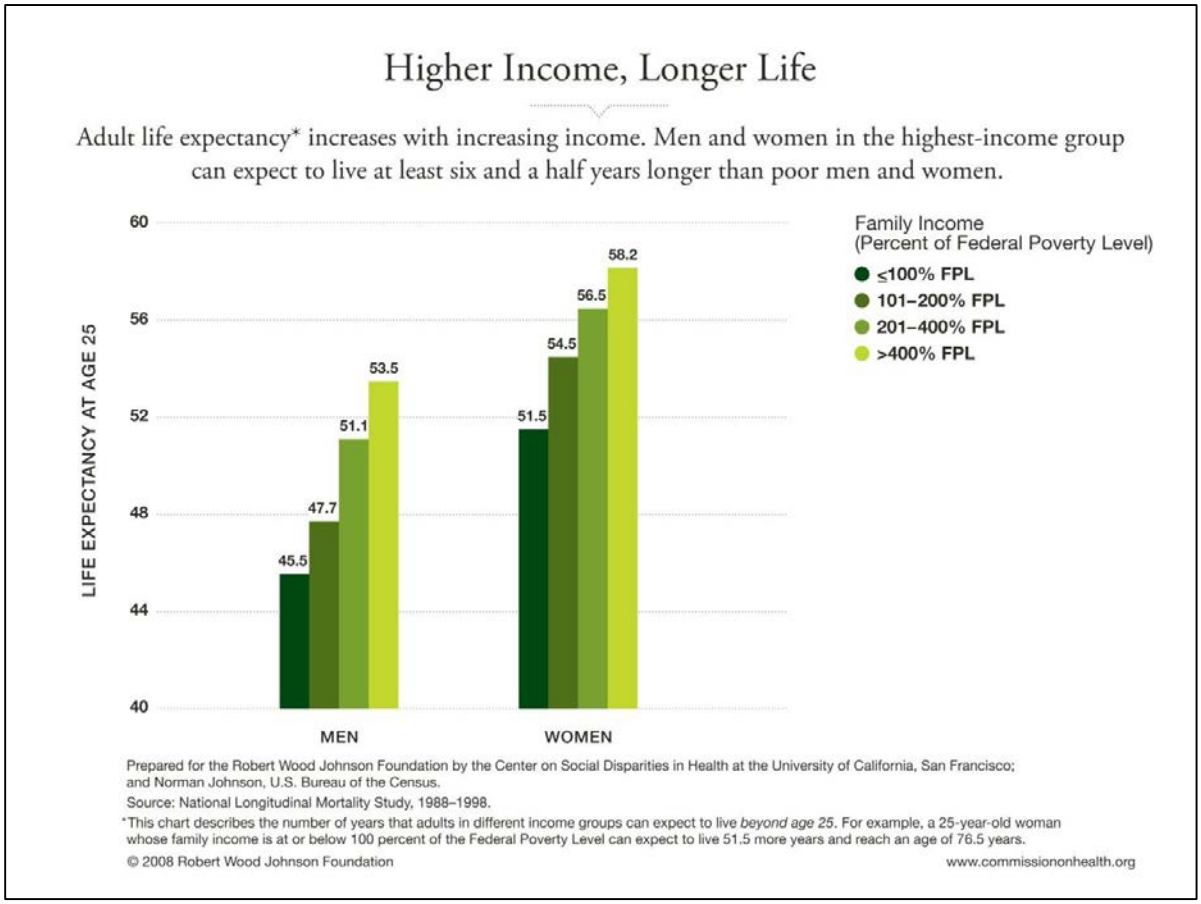
Differences in health among different groups of people, often referred to as health disparities, are well documented, persistent, and increasing in many areas across the United States. These differences in health among groups may be viewed in the context of race, gender, income, education level, or geographic location, among others. Examples of such differences are highlighted below:

- Infant mortality rates by race/ethnicity are highest for non-Hispanic Black[1] women (12.7), with a rate 2.4 times that for non-Hispanic White women (5.5) and 2.8 times that for Asian or Pacific Islander women (4.5) (Mathews & MacDorman, 2012).

- Poor Americans live, on average, 6 ½ years less than wealthy Americans (Figure 3; RWJF, 2008).

[1] The authors of this guide are sensitive to the use of labels to describe people. However, when making comparisons it is useful to categorize individuals (e.g. by race or ethnicity, sexual orientation, income, etc.). According to the American Psychological Association, both the terms "Black" and "African American" are widely accepted. For consistency, we use the term “Black” (except where citing a source that uses a different term).

**Figure 3. Life expectancy at age 25 years by family come level**




*Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.*

- Life expectancy can differ dramatically by neighborhood. There is as much as a nine-year difference across the Washington, D.C. metro area and as much as a 6 ½ year difference across the greater Philadelphia area (RWJF, 2008).

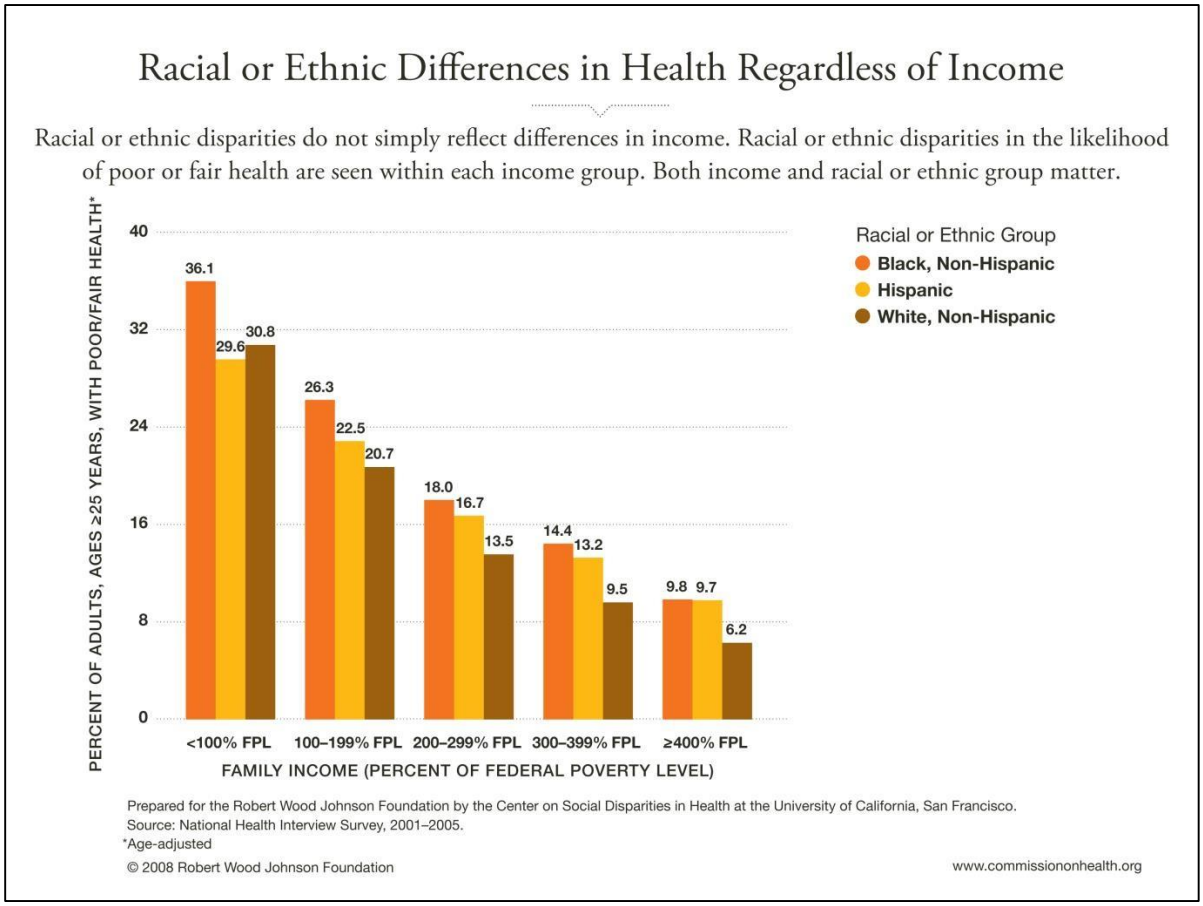
- Rates of preventable hospitalizations increase as income decreases, and Blacks experience preventable hospitalizations at a rate that is more than double that of Whites (CDC, 2011).

- Men are two to three times more likely to die in a motor vehicle crash than are women (CDC, 2011).

- Asthma is more prevalent among women than men (CDC, 2011).

- Although race/ethnicity and income are often interrelated, racial or ethnic differences in health exist independent of income level (Figure 4; RWJF, 2008).

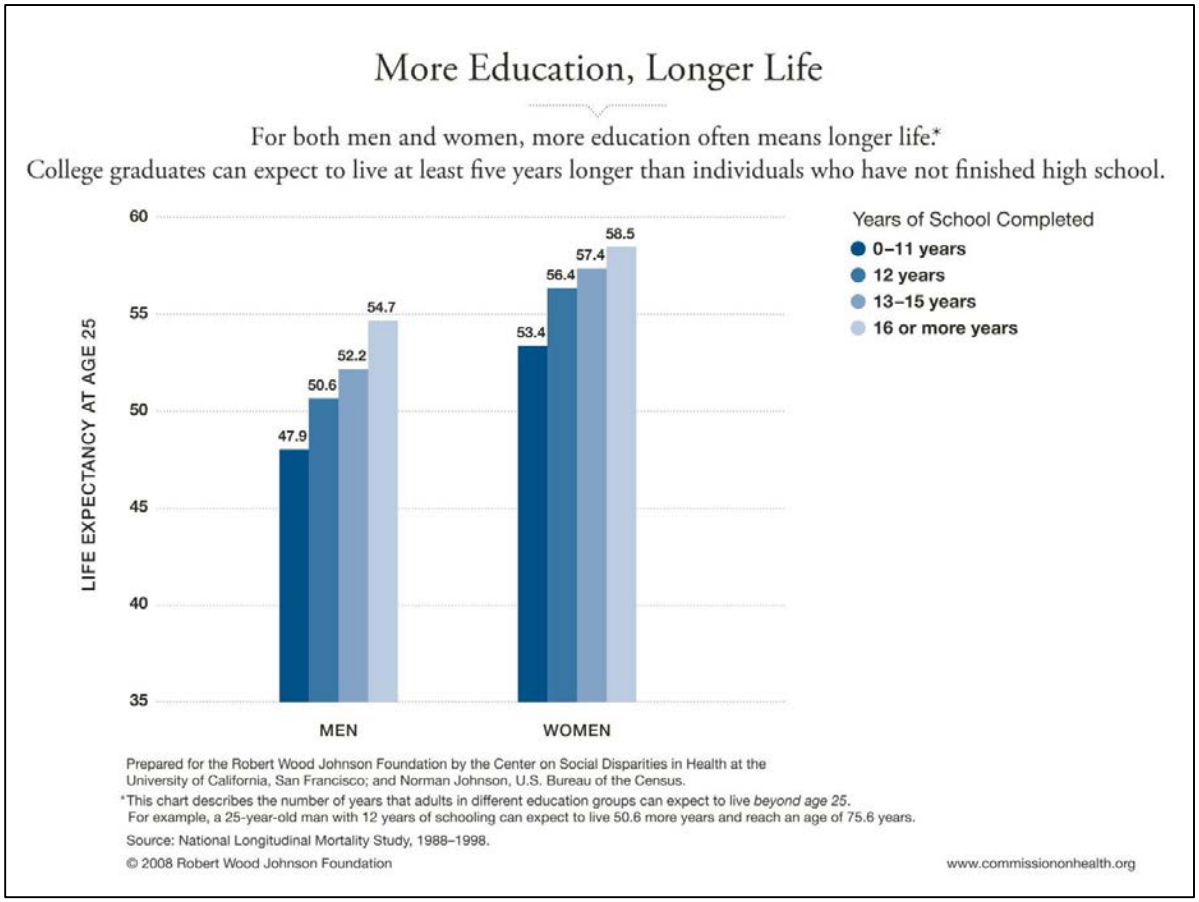
**Figure 4. Percent of adults in poor or fair health according to race/ethnicity and income**




*Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.*

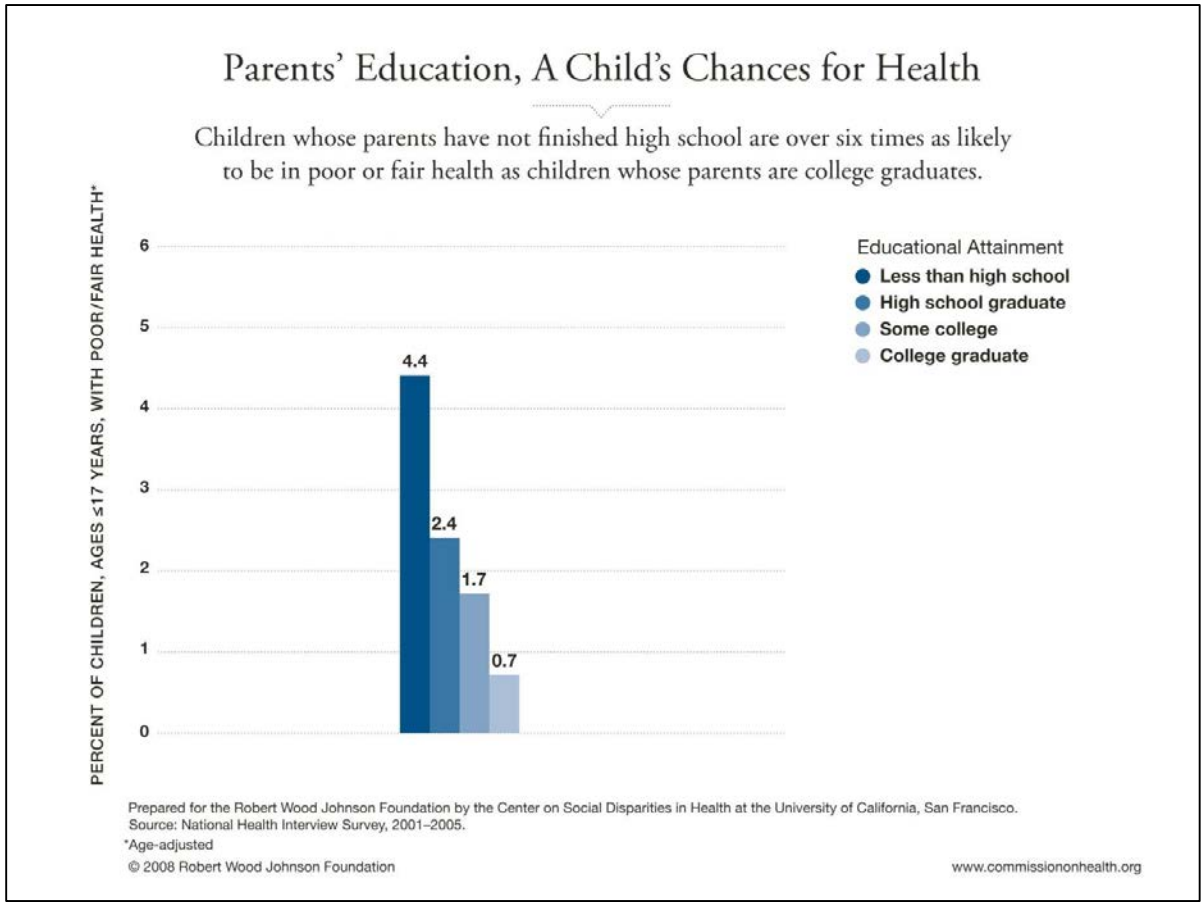
- Compared with college graduates, adults who have not finished high school are more than four times as likely to be in poor or fair health. The relation between education and health persists through generations, and children whose parents have not finished high school are over six times as likely to be in poor or fair health as children whose parents are college graduates (Figures 5 and 6; RWJF, 2008).

**Figure 5. Life expectancy at age 25 years according to education level**




*Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.*

**Figure 6. Percent of children in poor or fair health according to parents' education level**




*Source: Robert Wood Johnson Foundation Commission to Build a Healthier America, 2008.*

Differences in health also exist according to disability status and sexual orientation, though better data collection is needed to understand these gaps. Trends in Delaware generally reflect those of the U.S. and are discussed in greater detail in the next section.

### *Clarifying Terms: Health Disparities, Inequalities, and Inequities*

We hear these terms often within community health; sometimes used interchangeably and sometimes with implied differences in meaning. Until recently in the United States, the phrase *health disparity* was commonly used to denote a difference between two or more groups, leaving the causes and nature of the difference open to interpretation. The phrase has generally been used in relation to differences in health between racial and ethnic groups, implying some sort of social disadvantage. This is in contrast to differences in the rate of breast cancer between men and women, for instance, which has not generally been referred to as a *disparity*.

The phrase *health inequalities* has sometimes been used interchangeably with health disparities, most frequently in the scientific and economic literature or in reference to socioeconomic differences among broadly defined groups. Internationally, differences in health between those in distinct positions on the social hierarchy have been more frequently referred to as *inequities*. *Health inequities* are often defined as "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (Whitehead, 1992). The World Health Organization further notes that health *inequities* are "health differences which are socially produced."

There is a great deal of attention in the literature and among advocates about the appropriate use of these terms that is only touched upon above. While we appreciate the significance of this discussion and the importance of language and meaning, we also recognize that different terms may be used in practice depending on the audience and purpose (e.g. policy makers may be most familiar with *disparities*). However, for the sake of clarity and because of the need to draw attention to issues of fairness and justice, this guide will henceforth use the term *inequity* to refer to socially produced health differences (except where citing a source that uses a different term).

## Health Equity Framework

Although the terms "disparity," "inequality," or "inequity" may be used somewhat interchangeably (see text box), a shift to a health equity framework is particularly meaningful and an important foundation of this guide. *Healthy People 2020* defines health equity as "attainment of the highest level of health for all people." Additionally, according to *Healthy People 2020*, achieving health equity "requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities."

This shift is more than semantics and is distinguished from a disparities-driven approach in several important ways. First, an equity framework draws attention to the concepts of fairness and justice in the distribution of resources. Furthermore, it highlights the idea that social inequities in health are avoidable through collective action and that inaction is unacceptable. In addition, a health equity framework provides a positive vision to work towards—it is inclusive, affirming, and empowering.

Importantly, achieving health equity does not necessarily mean seeing equal outcomes across the population. DPH envisions "health equity for all Delawareans, where everyone will achieve their full health potential." This is important as the full health potential for one individual may be different than that of another due to genetic or biological factors, for instance. Thus, a health equity framework draws attention to the need for equity in access to and quality of the resources needed for health and moves away from a disease-specific or individual risk factor orientation. Some experts have referred to this as needing to "create a level playing field" (Knight, 2014). Achieving health equity requires a greater focus on improving underlying social and economic conditions, such as income and education. These conditions are structural and systemic in nature, much like the strong bridges and fences of the stream parable. In essence, a health equity lens moves us farther upstream to address the social determinants of health and health equity.

> *"Health equity is about fairness and justice, and is indistinguishable from equity generally" (Knight, 2014).*

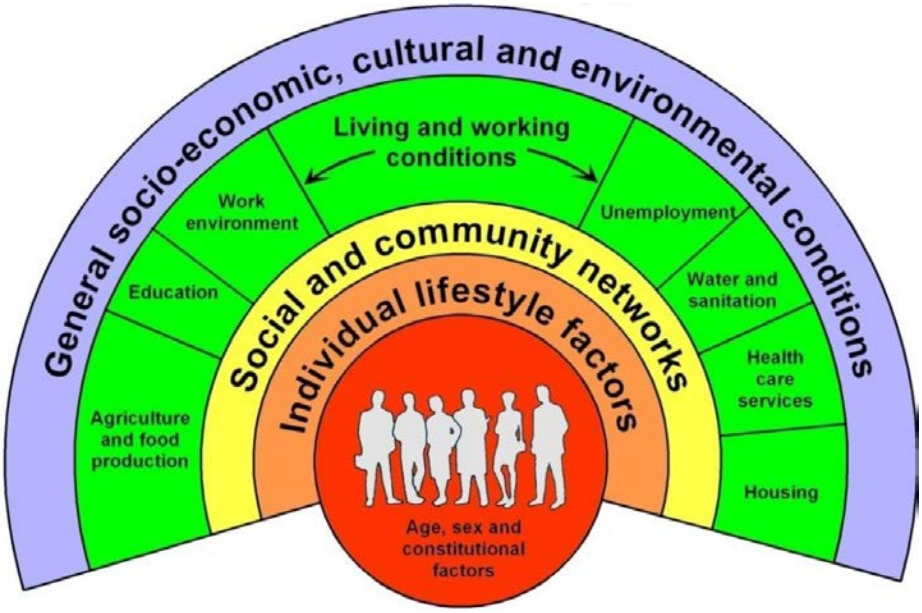
## Social Determinants of Health (SDOH)

The social determinants of health (SDOH) are often defined as the circumstances in which people are born, grow up, live, work, and age. The World Health Organization (WHO) explains that these circumstances are in turn shaped by a wider set of forces: economics, social policies (such as education, social security and welfare), and politics (including power and decision-making). This understanding of the SDOH is important in relation to health equity, as it recognizes that economic, social and political conditions are not naturally occurring. Instead, these conditions are the result of public policy and other community or collective actions. Therefore, the SDOH are rooted in long-term structures and traditions that may be resistant to change.

Efforts to define, understand, and address the SDOH have been growing since the 1990s. Various research organizations and public health institutions have sought to identify the various social influences on health and explain their relations with population health and the health of specific population groups. Conceptual frameworks were developed to help explain levels of

influence and identify opportunities for intervention. One such model, developed by Dahlgren and Whitehead at the forefront of the field (see Figure 7), is frequently used to describe the various determinants of health. The model highlights levels of influence, with the most distal factor, the prevailing socioeconomic and cultural conditions, as the very structure of society in which each of the other levels function. The model puts living and working conditions, such as housing and education, within the context of these societal structures, suggesting that they are not naturally occurring conditions. Rather, living and working conditions come about as a result of overall societal structure, culture, and both historic and current public policies. Another way of thinking about this is that living and working conditions are not inevitable; they are amenable to change. The model also highlights the fact that individual behavior and lifestyle choices are made within the context of one's social and community networks as well as the broader environment.

**Figure 7. Social determinants of health and levels of influence (Dahlgren & Whitehead, 1991)**




*Source: Dahlgren & Whitehead, 1991.*

Attention to the SDOH has grown substantially in the United States in recent years. A major goal within *Healthy People 2020* is to "create social and physical environments that promote good health for all." *Healthy People 2020* distinguishes between social and physical determinants in the environment but recognizes their interrelated nature in contributing to the places where people are born, live, learn, work, play, worship, and age.

Many lists of determinants and variations on the rainbow model originally presented by Dahlgren and Whitehead have been created in recent years and used for different purposes.

Experts continue to learn more about the ways in which social conditions impact health; models are improving to reflect this enhanced understanding. Notwithstanding such scientific advances and differences in purpose among varied approaches, it is important to recognize that all of the lists, frameworks, and models describing the SDOH in recent years share key elements that are critical for health promotion:

- Health is a result of a complex web of influences, including social, economic, political, physical, behavioral, and biological factors.
- Individual level influences, such as behavior, occur in the context of the broader social and physical environment, and a focus on individual level influences without appropriate attention to other contextual factors is likely to be inadequate for achieving meaningful health improvements.
- Social and physical environmental factors are shaped by societal structures and public policy.
- Health care services are less important than traditionally thought.
- Biological and genetic factors can mediate the effects of other influences, but are not the primary determinants of health.
- The determinants of health affect individuals over the course of their lifetime, often varying in importance and degree of influence.

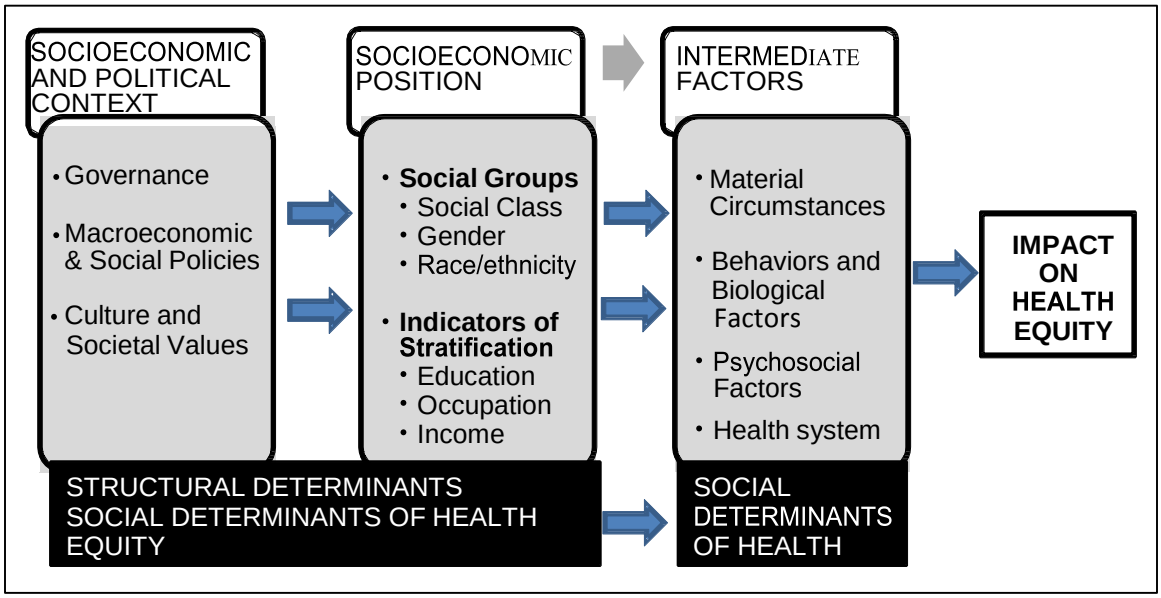
## Social Determinants of Health Equity (SDOHE)

In 2008, the WHO Commission on the Social Determinants of Health published a ground-breaking report on health inequities, which summarized decades of research from around the world. The report explained that differences in SDOH are mostly responsible for health inequities. The relation between the SDOH and health inequities can be seen very clearly in Figures 3-6, which were shared from the Robert Wood Johnson Foundation (RJWF) on pages 18-21. The staircase pattern in each of the figures illustrates what is often referred to as the social gradient in health. The data indicate that social advantages and disadvantages are relative. For example, individuals who experience extreme poverty are more likely to experience poor health than those who have even slightly more resources, while those at the highest socioeconomic level are generally the healthiest. The same pattern holds for education level and other indicators of social status. Furthermore, the effects of these factors can be cumulative. For example, individuals who are poor, Black, and have low levels of education are more likely to be in poor health than someone who has just one or two of those characteristics.

Importantly, the WHO report (and numerous related publications) point out that differences in the SDOH that underlie health inequities are themselves socially determined. In other words, the working and living conditions that determine health and health inequities are not naturally occurring. Instead, they are determined by policy decisions and other social structures and actions (e.g. media, business, etc.) that affect communities and societies at large.

Figure 8, reproduced from the WHO report mentioned above, illustrates this understanding regarding the *structural* determinants of the *social* determinants of health. This figure is useful for highlighting the need to move even farther upstream. Living and working conditions, described as SDOH, are viewed as more proximate to health and equity, whereas macroeconomic policies and other social policies—housing, education, and social security—are further upstream. Figure 8 illustrates how these policies—along with culture, societal values, and governance—are related to socioeconomic position and result in inequities between groups of people categorized by gender, race, and class. Meaningful, long-term changes that promote health equity are needed farther upstream at that structural level—identified in Figure 8 as being within the socioeconomic and political context—in a health equity framework.

**Figure 8. Conceptual Framework for the Determinants of Health Equity**




*Source: World Health Organization, 2010.*

Many advocates and public health leaders now make a distinction between the SDOH and what are increasingly being referred to as the "social determinants of health equity" (SDOHE). This distinction is also based in part on the understanding that although medical advances and many public health interventions over the past century have improved population health, they

have moved the average and have not necessarily reduced differences between groups. Finally, this distinction is based on the recognition that inequities in health primarily result from an inequitable distribution in the quality of the SDOH. This reflects imbalances in political and economic power instead of "ad hoc events, individual failure, or the inevitable consequences of modern society" (Hofrichter, 2003, p. 1).

The inequitable distribution in health-related resources has tangible and measurable repercussions for the health of groups that experience social disadvantages. For instance, each year in the U.S. an estimated 83,570 Blacks die prematurely because of racial health disparities (Satcher et al., 2005); and, on average, 195,000 premature deaths result from disparities in education each year (Woolf, Johnson, Phillips, & Philipsen, 2007). Other health gaps exist in relation to such things as gender, gender identity, sexual orientation, and disability status, to name just a few. The current social, economic, and political context suggests that population health will continue to worsen, as will health inequities, if we do not move farther upstream with our health promotion efforts.

## National Efforts to Advance Health Equity

Despite a research focus on health inequities since the 1970s and growing attention to SDOH in public health practice, health inequities remain a large, persistent problem that has garnered the attention of many state and federal agencies, foundations, and non-profit organizations. Over the past two decades, federal agencies have released numerous reports regarding health disparities, and have offered recommendations for addressing them. Those recommendations have become increasingly focused on the SDOH. The contents of three key reports: *Healthy People 2020*, the *National Stakeholder Strategy*, and the *Department of Health and Human Services' Action Plan to Reduce Racial and Ethnic Health Disparities,* are particularly relevant to this guide and influenced its development.

### Healthy People 2020

The *Healthy People* initiative provides science-based 10-year national objectives for improving the health of all Americans. Each 10-year plan is developed through a multi-year process that includes input from a wide range of experts and stakeholders. In its third iteration, *Healthy People 2020*, released in December of 2010, articulates a framework for achieving its national goals and objectives through a foundation in the determinants of health. As mentioned earlier, *Healthy People 2020* distinguishes between social and physical determinants in the environment, but recognizes their interrelated nature, as they both contribute to the places where people are born, live, learn, work, play, worship, and age. *Healthy People 2020* refers to

the social and physical determinants collectively as "societal determinants of health." This phrase captures the interrelated and complex nature of the social and physical determinants[2].

Importantly, *Healthy People 2020* recognizes that the social environment is very broad and reflects things like culture, language, political and religious beliefs, and social norms and attitudes. The social environment also encompasses socioeconomic conditions (i.e. poverty) and community characteristics (i.e. exposure to crime and violence), as well as the degree and quality of social interactions. According to the Secretary's Advisory Committee, mass media and emerging communication and information technologies, such as the Internet and cellular telephone technology, are ubiquitous elements of the social environment that can affect health and well-being. Furthermore, policies in settings such as schools, workplaces, businesses, places of worship, health care settings, and other public places are part of the social environment. Economic policy is highlighted as a critically important component of the social environment.

According to *Healthy People 2020*, the physical environment consists of the natural environment (i.e., plants, atmosphere, weather, and topography) and the built environment (i.e., buildings, spaces, transportation systems, and products that are created or modified by people). The physical environment affects health directly, such as through physical hazards like air pollution, and indirectly, such as the way in which the environment encourages or discourages physical activity. The Secretary's Advisory Committee suggests that interventions should promote environmental justice by eliminating disparities in exposure to harmful environmental factors and improving access to beneficial ones.

Given the range of factors in the social and physical environment[3] affecting health, *Healthy People 2020* calls for a multi-sector approach to address health equity. The Secretary's Advisory Committee notes that the 10-year goals and objectives "can be achieved *only* if many sectors of our society—such as transportation, housing, agriculture, commerce, and education, in addition to medical care—become broadly and deeply engaged in promoting health." The Committee acknowledges that many agencies do not have a mandate to address these cross-cutting issues, and recommends that the public health community provide leadership and encourage collaboration to promote health in the social and physical environment.

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[2] For a more detailed explanation of the societal determinants of health, including why they are believed to be so important, and how they are related to the *Healthy People 2020* goals, see a companion report of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020: http://www.healthypeople.gov/sites/default/files/SocietalDeterminantsHealth.pdf).

[3] Due to the interrelated nature of social and physical factors in the environment, the term "environment" is frequently used throughout this guide to refer to both. When a distinction is made, it is intended to draw attention to a particular aspect of the environment.

One recommendation for addressing societal determinants of health across sectors is for government to adopt a "Health in All Policies" (HiAP) approach. A HiAP approach requires intersectoral partnerships at all government levels and with non-traditional partners, with a focus on social and environmental justice, human rights, and equity. A HiAP approach has the potential to make meaningful impact in achieving health equity. An in-depth discussion of this approach, including related tools and strategies, is included in Section 6.

The Secretary's Advisory Committee acknowledges that individual/disease-specific and population-based perspectives are both necessary to achieve optimal health for all. Rather than choose one or the other, they should be viewed (and used) as two components of an integrated solution. Table 1, excerpted from the *Report of the Secretary's Advisory Committee*, provides examples of the two approaches and highlights their advantages and disadvantages from both a policy perspective and a practical perspective.

## Table 1. Relative Advantages and Disadvantages of Disease Focus and Population Focus for Addressing Health Disparities

| | Advantages | | Disadvantages | |
|---|---|---|---|---|
| **Focus** | **Policy Perspective** | **Practical Perspective** | **Policy Perspective** | **Practical Perspective** |
| ***Individual/Disease Focus*** | Provides convincing evidence that ethnic minority and low socioeconomic status (SES) populations are disadvantaged<br><br>Keeps issues of health inequities on policy agenda<br><br>Quantifies the problem | Matches NIH and other funding streams<br><br>Matches organization of medical specialties<br><br>Compatible with hi-tech medical solutions<br><br>Conveys potential for dramatic success through focused effort on high-risk or already ill individuals | Sets lack of "excess deaths" as the standard<br><br>Implies that health status of Whites or high SES represents optimal health<br><br>Emphasizes relative risks more than absolute risks<br><br>Frames issues in medical or health system terms; de-emphasizes structural variables or environmental circumstances<br><br>Makes it difficult to identify where to focus attention | Inadvertently reinforces perception of minority group inferiority or inevitability of poor health among low SES populations<br><br>Creates separate tracks for pursuing problems with many common determinants<br><br>Leads to duplication, competing priorities, and fragmentation of efforts.<br><br>Because of narrow focus, may not adequately identify unanticipated negative or positive consequences of policies or interventions in other areas |
| ***Population Health Focus*** | Facilitates focus on optimal health of the population in question<br><br>Highlights relevant historical, cultural, and political contexts<br><br>Draws attention to diversity within ethnic minority and low SES populations<br><br>Integrates domains of knowledge and discourse<br><br>Incorporates critical nonmedical health issues | Facilitates endogenous solutions<br><br>Supports attention to assets and coping abilities<br><br>By applying a more integrated approach, opportunities to identify unanticipated benefits or untoward consequences of interventions is increased | Links status on policy agenda to less popular issues<br><br>Depends on actions in non-health sectors<br><br>Poor match for National Institutes of Health (NIH) and other funding streams<br><br>Is associated with slow, incremental progress versus quick fixes. | Is challenging to biomedical paradigm<br><br>Generates less enthusiasm about hi-tech medical solutions<br><br>Is often distal to disease outcomes<br><br>More complex, multi-level solutions make it more difficult to identify key factors driving successful outcomes |

***Source:*** *Excerpt from Report of the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020; Adapted from Kumanyika SK, Morssink CB. Bridging Domains in Efforts to Reduce Disparities in Health and Health Care. Health Educ Behav 2006; 33; 440.).*

Finally, the Secretary's Advisory Committee calls for more research regarding the societal determinants of health and efforts to address them. The Committee argues that the availability of high quality data for all communities should be a priority for public health departments and clinical preventive research. Furthermore, it acknowledges the need to build the evidence for community-based interventions and recommend that HHS place more attention on examining policies that impact the social and physical environment. Finally, the Committee stresses the importance of community-based participatory research. Elements of these recommendations are included in Sections 6 (Policy-Oriented Strategies) and 7 (Data, Research, and Evaluation for Health Equity).

## National Stakeholder Strategy for Achieving Health Equity (NSS)

In response to persistent health inequities in the United States and a call to action for a national, comprehensive, and coordinated effort to eliminate disparities, the U.S. Department of Health and Human Services' Office of Minority Health established The National Partnership for Action to End Health Disparities (NPA). The NPA was created with the support of nearly 2,000 attendees of the National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health. Sponsored by the Office of Minority Health, the Summit provided a forum to strategize how to eliminate health disparities by increasing the effectiveness of programs that target health disparities and fostering effective coordination of partners, leaders, and other stakeholders.

In 2011, the NPA released the *National Stakeholder Strategy for Achieving Health Equity (NSS)*, which was developed through a very collaborative process, including contributions from thousands of individuals representing government, non-profit organizations, academia, business, and the general public. When the NPA released the initial draft for comment, thousands of community members responded. The resulting report is described as a "roadmap" for stakeholders at local, state, and regional levels to eliminate health disparities. The main values of the *NSS* are community engagement, community partnerships, cultural and linguistic literacy, and non-discrimination. The *NSS* report includes a set of five overarching goals and 20 community-driven strategies to help achieve them. Table 2, excerpted from the *NSS*, outlines these goals and strategies. For each of the 20 strategies, the report provides a menu of objectives, measures, and potential data sources as tools for stakeholders to use in implementing any given strategy. The strategies are intended to be translated and operationalized at different geographic levels (e.g. local, state, and regional) and across sectors. The NPA acknowledges many challenges in accomplishing these tasks and offers the report as a forum for lessons learned, best practices in the field, and tracking progress.

## Table 2: Summary of National Stakeholder Strategy

| Goal | Description | Strategies |
|---|---|---|
| 1 | AWARENESS<br><br>Increase awareness of the significance of health disparities, their impact on the nation, and actions necessary to improve health outcomes for racial, ethnic, and underserved populations | **1. Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas |
| | | 2. **Partnerships** Develop and support partnerships among public, non-profit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan |
| | | 3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multitier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability |
| | | 4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health. |
| 2 | LEADERSHIP<br><br>Strengthen and broaden leadership for addressing health disparities at all levels | 5. **Capacity Building** Build capacity at all levels of decision-making to promote community solutions for ending health disparities |
| | | 6. **Funding Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services |
| | | 7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives |
| 3 | HEALTH SYSTEM & LIFE EXPERIENCE<br><br>Improve health and healthcare outcomes for racial, ethnic, and underserved populations | 8. **Access to Care** Ensure access to quality healthcare for all |
| | | 9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care |
| | | 10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging |
| | | 11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions |
| | | 12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits |
| | | 13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes |
| 4 | CULTURAL & LINGUISTIC COMPETENCY<br><br>Improve cultural and linguistic competency and the diversity of the health-related workforce | 14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities |
| | | 15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems |
| | | 16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services |
| 5 | DATA, RESEARCH, & EVALUATION<br><br>Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes | 17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations |
| | | 18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities |
| | | 19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities |
| | | 20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity |

*Source: The National Partnership for Action to End Health Disparities, 2011.*

### The HHS Action Plan to Reduce Racial and Ethnic Health Disparities

The U.S. Department of Health and Human Services' *Action Plan to Reduce Racial and Ethnic Health Disparities* was released simultaneously with the *NSS*. It represents the federal commitment to achieving health equity and the HHS response to the strategies recommended in the *NSS*. *The Action Plan* also builds on *Healthy People 2020* and leverages other federal initiatives (e.g. the National HIV/AIDS Strategy, the First Lady's *Let's Move* initiative, etc.) and many provisions of the Affordable Care Act. It outlines specific goals and related actions that HHS agencies will take to reduce health disparities among racial and ethnic minorities in the following five areas:

1. transforming health care by expanding insurance coverage, increasing access to care, and fostering quality initiatives;
2. strengthening the health workforce to promote better medical interpreting and translation services and increased use of community health workers;
3. advancing the health, safety, and well-being of Americans by promoting healthy behaviors and strengthening community-based programs to prevent disease and injury;
4. advancing knowledge and innovation through new data collection and research strategies; and
5. increasing the ability of HHS to address health disparities in an efficient, transparent, and accountable manner (U.S. DHHS, 2011).

## Delaware Division of Public Health's Health Equity Strategy

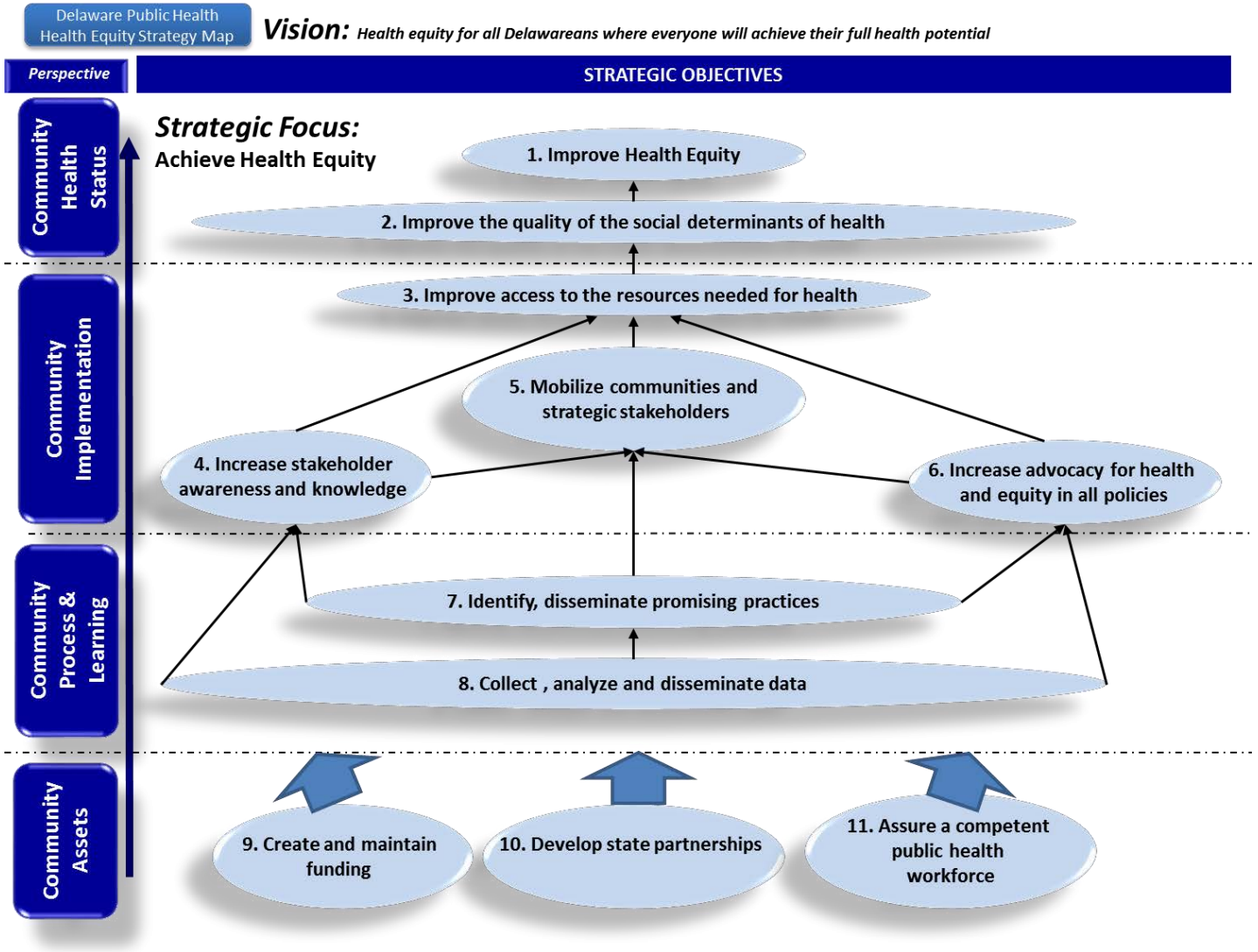
As described in the *Delaware Division of Public Health [DPH] 2014-2017 Strategic Plan* (see http://www.dhss.delaware.gov/dph/files/dphstrategicplan.pdf), DPH identified health equity as one of its strategic priorities. Over the course of three years, DPH launched an organization-wide planning effort, where staff met to develop strategic, cross-cutting objectives, related activities, and performance measures that address health equity.

Consistent with a national effort to promote quality improvement in public health, DPH used a Balanced Scorecard strategy mapping process (Kaplan & Norton, 1992) to illustrate the Division-wide performance management system (see Figure 9), which integrates a health equity strategy throughout. This DPH Equity Strategy Map complements the Division's *2014-2017 Strategic Plan*. Noted in Figure 9, DPH's overall vision is "*health equity for all Delawareans where everyone will achieve their full health potential."* Each objective is necessarily important

for achieving this vision. The objectives of the strategy map are interrelated and those on the bottom of the map provide a foundation for those on the top.

This guide is intended to support the Community Implementation Objectives outlined in the center of the strategy map, but is grounded in an appreciation for efforts underway at each level which support the overall vision. This strategy reflects a shift from a framework of health disparities that largely focused on individual risk factors and disease-specific approaches to one that focuses more on communities, systems, and the underlying conditions that determine health. Still, DPH recognizes the need to continue to enhance many of its efforts in reducing individual risk factors and improving access to quality services. DPH's approach parallels the integration of individual and population-based strategies recommended by the Secretary's Advisory Committee for *Healthy People 2020*. Drawing upon the direction of the national strategies, DPH will use the *Health Equity Guide for Public Health Practitioners and Partners* to promote collaborative efforts that address health equity in the unique context of Delaware's communities.

**Figure 9. Delaware DPH Health Equity Strategy Map**




*Source: Delaware Division of Public Health, 2013.*

## Underlying Values and Assumptions

Before proceeding to the case for change and strategies for change, a discussion is warranted to clarify and summarize the underlying values and assumptions inherent in this guide. One of the major criticisms of the United States' health care system is that funds are being directed towards costly procedures and treatments of specific diseases rather than towards upstream preventive approaches like community-based interventions, population-based approaches, and policy changes that address the SDOH. Many have argued that the current emphasis on downstream treatment is generally not conducive to eliminating the major health inequities in the U.S., and contributes to excessive health care spending. The views expressed in this guide reflect the assumption that moving upstream to mend bridges and build fences is likely to be more effective in promoting health and reducing health inequities. Additionally, an upstream approach may be considered more ethical because it prevents pain and suffering for the population as a whole, while at the same time, reduces gaps in morbidity and mortality between groups. However, opportunities also exist within the health care system to make the delivery of care more equitable. Such changes can contribute to advancing health equity by ensuring access to quality health care for everyone. Reflecting again on the stream parable, this means that everyone has the opportunity to receive quality care, should they fall in the river and become ill. For this reason, the following sections prioritize activities in the social and physical environment, including within the health care system.

Several other important assumptions about the approach taken to develop this guide should be made explicit, including the ways in which this guide is limited. Our view is that effective action to eliminate health inequities must be grounded in principles of social justice, which includes attention to social and economic equality and a fair distribution of advantages, as well as a stronger democracy where individuals have greater control over decisions that affect SDOH. Achieving health equity will ultimately require us to confront deeply entrenched values and cultural norms. As one expert stated, "there has to be public recognition of the real sources of health inequities… we have to understand that class and class exploitation, racism, sexism, and imbalances in power that create those phenomena are the basic source of health inequities" (Knight, 2014). Referring to the stream parable, this means that we have to do even more than ensure everyone has the opportunity to cross the strong bridge or live near the quality fence. It means that all communities along the stream have the power to make decisions and have control over resources to build their bridges and fences the way they believe they should be built.

Changing the power dynamic in our communities means that some will have to relinquish power as others become more empowered. This complicated (and uncomfortable) conversation about class and power is beyond the scope of this guide, as it requires major

social and political changes. Still, it is easy for these important issues to be obscured by a focus on more intermediate kinds of change recommended in the following pages. Therefore, we encourage you to use this guide as it is intended—to support upstream strategies aimed at the social determinants of health—but do not lose sight of the broader social injustices even farther upstream that require ongoing attention and commitment. Over time, through our collective efforts to promote health equity in Delaware, we hope to draw greater attention to these underlying social issues and create positive social change.

In the meantime, there is much we can do. We hope this guide will support those efforts. To move forward together, we propose the following assumptions and values to guide our work.[4] We recommend that collaborative community efforts aimed at advancing health equity begin with a discussion of these assumptions to ensure that participants understand their meaning and implications and are adopted as shared principles (or adapted accordingly):

1. Health is broadly defined as a positive state of physical, mental, and social well-being and not merely the absence of disease.
2. Everyone—regardless of race, religion, political belief, and economic or social condition—has the right to a standard of living adequate for health, including food, clothing, housing, medical care, and necessary social services.
3. Health is more than an end. It is also an asset or resource necessary for human development and well-functioning communities.
4. Health is socially and politically defined. Individual and medical definitions of health ignore important interactions between individual factors and social and environmental conditions.
5. Health is a collective public good, which is actively produced by institutions and social policies.
6. Equity in health benefits everyone because health is a public good necessary for a well-functioning society.
7. Inequities in population health outcomes are primarily the result of social and political injustice, not lifestyles, behaviors, or genes.

[4]Items 1 and 2 are adapted from the Constitution of the World Health Organization (1946) and the Universal Declaration of Human Rights (1948). Items 3-9 are adapted from Hofrichter, R. & Bhatia, R. (Eds.). (2011). *Tackling health inequities through public health practice: Theory to action* (2nd ed). New York: Oxford University Press, p. 6.

8. An accumulation of negative social conditions and a lack of fundamental resources contribute to health inequities, and include: economic and social insecurity; racial and gender inequality; lack of participation and influence in society; unfavorable housing; unhealthy conditions in the workplace and lack of control over the work process; toxic environments; and inequitable distribution of resources from public spending.

9. Tackling health inequities effectively will require an emphasis on root causes and social injustice, the latter concerning inequality and hierarchical divisions within the population.

## Glossary – Section 2

**Health disparity**: A difference in health status between population groups.

**Health inequity**: A health disparity which is unnecessary, avoidable, unfair, and unjust; a socially-determined difference in health.

**Health equity**: Achieving the conditions in which all people have the opportunity to reach their health potential; the highest level of health for all people.

**Infant mortality rate (IMR)**: The number of deaths of children less than one year of age per 1,000 live births. The rate for a given region is the number of children dying under one year of age, divided by the number of live births during the year, multiplied by 1,000. IMR is usually reported in relation to the race or ethnicity of the mother.

**Life expectancy**: The statistically predicted (average) number of years of life remaining at any given age. Life expectancy is usually reported and understood as "life expectancy at birth" unless otherwise noted.

**Population health**: The health status or health outcomes of a group of individuals, including the distribution of such outcomes within the group. Groups are often defined geographically (e.g. at the state or country level).

**Social determinants of health**: The circumstances in which people are born, grow, live, work, and age, as well as the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

**Social determinants of health equity**: The underlying social, economic, and political structures that determine the quality and distribution of resources needed for health.

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