Local Health Department Practices to Advance Health Equity

Minnesota Department of Health

MDH

HEALTH PARTNERSHIPS DIVISION
PUBLIC HEALTH PRACTICE SECTION

STATE COMMUNITY HEALTH SERVICES
ADVISORY COMMITTEE

Local Health Department Practices to Advance Health Equity:
Final Report and Recommendations from the SCHSAC Advancing Health Equity Workgroup

August 2016

Health equity occurs when every person has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities. Health equity means achieving the conditions in which all people have the opportunity to attain their highest possible level of health.

About the Cover: Health equity is shaped by society's systems and structures, such as the economy, educational systems, transportation, housing, and more. Inequities in those structures can have a profound influence on the daily lives of individuals. The three-panel graphic shows this. In the first panel, the person exposed to the rain represents populations who are "left out" of many systems and structures. Those people do not get the opportunity to be healthy and also experience many adverse health outcomes. In the middle panel, the person under the umbrella shows that some populations live under uncertain conditions. When "life happens" they can suffer serious consequences and have a difficult time recovering. In the last panel, the person standing under a sturdy roof represents those who enjoy a good education, safe and stable housing, social inclusion and participation, access to good paying jobs, and supportive systems of care. Those populations have the greatest opportunity to experience optimal health.

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Contents

Introduction

Minnesota often appears to be one of the healthiest states in the country, based on statewide averages. But this impression dissipates as soon as a closer look is taken: great disparities in health status exist in Minnesota, especially across racial and ethnic lines, but also by income, education, geography, gender, and age.

Many local public health leaders and staff see these disparities but are sometimes overwhelmed by the enormity of "advancing health equity." This report by the Advancing Health Equity Workgroup of the State Community Health Services Advisory Committee (SCHSAC) attempts to assist local health departments to begin this important work by providing a set of six practices/areas of work and a corresponding online library of resources for advancing health equity. This report also provides a brief introduction to health equity, and includes recommendations for governmental public health to build the state's capacity and hold each other accountable for achieving health equity across all communities in Minnesota.

What is Health Equity?

The workgroup adopted the following definition of health equity:[1]

> **Health equity occurs when every person has the opportunity to realize their health potential—the highest level of health possible for that person—without limits imposed by structural inequities.**

To "advance health equity" means working to achieve the conditions in which all people have the opportunity to attain their highest possible level of health. The practices, resources, and recommendations contained in this report reflect the importance of health equity for Minnesota and for Minnesota's public health system.

Why Advance Health Equity?

Because Health Equity Is Good Public Policy

Justice and fairness are foundations of America's democracy. The disparities that exist in health outcomes are largely the results of past policy decisions, which have (intentionally or unintentionally) created less fair circumstances for different groups of people. Today's policymakers have an opportunity to correct these injustices where they find them; that's not only fair, it is good policy.

The construction of Interstate 94 in the 1960s and 1970s devastated St. Paul's Rondo neighborhood. The community's recent success in increasing the number of light rail stops on University Avenue, however, now benefits family-run, minority-owned businesses, and increases the variety of eating and shopping options for everyone.

Because Health Equity Offers an Economic Advantage

Healthy people are productive people, and that's not just good for business, but it also creates an economic advantage for the community. All parts of Minnesota face potential workforce shortages and need to expand the pool of healthy workers to assure economic vitality and sustainability. Advancing health equity is a means to assure that Minnesota workers are ready and able to participate in the economic life of the community.

The same factors that contribute to health equity also help assure a strong workforce. Communities across Minnesota increasingly recognize that creating a welcoming, inclusive, and accommodating environment is essential to attract and retain all potential workers, including those from populations that experience the greatest inequities in education and employment.[2]

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[1] See also Appendix A, p. 16: *A Brief Introduction to Health Equity*.

[2] Center for Rural Policy and Development. (2015). Addressing the coming workforce squeeze. Online: http://www.ruralmn.org/publications/addressing-the-coming-workforce-squeeze/.

Because Health Equity Benefits the Whole Community

Assuring that everyone can be healthy does not just help those who experience inequities. Advancing health equity, in fact, benefits the whole community. The results of efforts to address underlying unfair circumstances are enjoyed by many in the community, not just the group that was disadvantaged.

Curb cuts in sidewalks at intersections are not only essential to the independent mobility of people who need to use a wheelchair, but also are beneficial to the elderly, people pushing strollers, and children learning to ride bikes.

The SCHSAC Advancing Health Equity Workgroup submits this report to SCHSAC with the hope that efforts to advance health equity will become the public health way of doing business, for as long as it takes to make it possible for all people in Minnesota to enjoy healthy lives and healthy communities.

About the Workgroup

SCHSAC, recognizing that health equity is an urgent and compelling public health concern, charged the Advancing Health Equity Workgroup "to provide local elected officials and local public health leaders with the language, understanding, and practical help to advance health equity throughout Minnesota's public health system."

The workgroup met from the fall of 2015 through the summer of 2016 to meet this charge. Through their discussions and the work of staff, the workgroup is now forwarding to SCHSAC for review and approval their final products.

The workgroup has developed:

1. A set of **six practices** for local health departments and an **online library of resources** to help them implement these practices in their communities to advance health equity. This library groups various reports, examples, assessments, and other resources into the six practices to assist local health departments as they lead their staff, local elected officials, and the public to improve conditions for health in their communities. The library is designed to allow local health departments to select, from among the range presented, the resources that best meet their needs and capacity (starting on p. 8).

2. A set of **recommendations** for advancing health equity, directed to MDH, local elected officials, local health departments, and SCHSAC. These recommendations spell out specific ways in which these different government entities can use their unique positions and capacities to advance health equity (starting on p. 13).

The workgroup presented their preliminary findings and participated in a discussion with the full membership of SCHSAC in June 2016. SCHSAC members reiterated the importance of health equity for public health, and expressed their excitement about the new opportunities health equity brings to make a difference in their communities. They said the work of advancing health equity is exciting because:

- It provides tools for identifying where inequities are in Minnesota
- It moves the system from blaming the individual for poor health to understanding that there are deeper root causes to health outcomes that are not dependent on the individual's actions
- It creates opportunities to have conversations with the community and to broaden the range of public health partnerships
- It gives communities who have been experiencing the greatest inequities the chance to finally have conversations about what is shaping their health and to develop collaborative strategies for action

Workgroup Members and MDH Staff

Workgroup Members

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Local Health Department Practices to Advance Health Equity

The Role of Local Health Departments in Advancing Health Equity

When considering how challenging it is to address broad social and economic factors that contribute to health inequities, it is tempting for a local health department to decide that nothing can be done: the problems are too big, too complex, and too far beyond the scope and capacity of any single government agency to make a meaningful difference. Local public health professionals understand that stable housing is important to health, but they don't build houses; that good jobs and a secure income are essential for health, but they don't run businesses; that transportation is critical for shaping the opportunity to be healthy, but they don't decide where the roads go. But local health departments can talk to and work with those who do. In fact, public health has never worked alone.

What public health can and does do, however, is grounded in the historical roots of public health and in the 10 Essential Public Health Services.[3] Local health departments have a long history of looking "upstream" to identify the root causes of poor health, and informing, engaging, and activating the community to address those causes. Local health departments use data to monitor health status, engage with the community to develop solutions and take action, and work with a wide range of partners to create policies and plans that ensure the health of all. The work to advance health equity is in direct line with the history of local health departments working with their communities to shape conditions for population health.

The SCHSAC Advancing Health Equity Workgroup, with MDH staff, has developed an online library of resources for local health departments to build their capacity and engage in the work of health equity.[4] The online library is organized by six practices local health departments can use to advance health equity. The different practices blend into, cross-over, and support one another. For example, while community engagement is the focus of the practice to "work in true partnerships," it also is an element of other practices, such as "work at the policy level." The practices presented in this framework are grounded in the 10 Essential Public Health Services and the Public Health Accreditation Board (PHAB) Standards and Measures.[5] The practices, described in more detail below, are:

1. Build a shared understanding of and commitment to health equity
2. Develop organizational knowledge and skills to advance health equity
3. Align programs and resources with the organizational commitment to health equity
4. Work in true partnership across the community
5. Improve data collection, analysis and use of data to advance health equity
6. Work at the policy level to advance health equity

PHAB Standards and Measures Related to Practices used to Advance Health Equity

In 2010, SCHSAC agreed that PHAB standards and measures represented the core functions of public health and that all community health boards, regardless of their intent to apply for national public health accreditation, should work to

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[3] Centers for Disease Control and Prevention. (2014). The public health system and the 10 essential public health services. Online: http://www.cdc.gov/nphpsp/essentialServices.html.

[4] Minnesota Department of Health. (2016). Resource library for advancing health equity in public health. Online: http://www.health.state.mn.us/divs/opi/healthequity/resources/.

[5] Public Health Accreditation Board. (2013). Standards and measures version 1.5. Online: http://www.phaboard.org/accreditation-process/public-health-department-standards-and-measures/.

achieve the standards and measures.[6] For this reason, the SCHSAC Advancing Health Equity Workgroup considered the PHAB standards and measures in the development of the six local health department practices to advance health equity.

The practices for advancing health equity that the workgroup has identified are evident throughout the PHAB standards and measures. Sometimes health equity is explicitly named: for example, Measure 3.1.1 states "the health department must document efforts to address health equity." This documentation includes analysis of health inequities, efforts to address community factors, and internal policies for health equity considerations.

Other times the PHAB standards and measures are less explicit, but still relate to health equity. For example, community engagement, using data, working with elected officials, and monitoring policies for potential health impacts are practices seen throughout the standards and measures. This means that while working to achieve the PHAB standards and measures, a local health department or community health board will also be working to advance health equity in their jurisdiction. The PHAB standards and measures that are relevant for each of the six practices are noted below with their respective practices.

Local Health Department Practice 1: Build a Shared Understanding and Commitment to Health Equity

To advance health equity, local health departments must engage in intentional practices to expand the understanding of what creates health, and call attention to existing health inequities. These efforts must occur within the local health department, within the larger city and/or county organization, with partners, and with the broader community. Local health departments already engage in many activities that have the potential to increase understanding and build commitment to health equity, including community health assessment and planning, health education and promotion, and engagement with elected officials.[7]

Why Focus Here?

- Public health cannot advance health equity alone; understanding in the community is essential to build commitment to health for all.

- The extent of health disparities and inequities are often underestimated and/or misunderstood. If community leaders and decision makers are unaware or misinformed about what creates health, they cannot use their influence to create healthy conditions for all.

- Approaches to improve health and health inequities are limited when the general understanding is that health is created by health care and personal choices. A broader understanding of what creates health will build commitment to tackle the root causes of health inequities.

Stories from the Field: Student Government Day[8]

One audience the Renville County Public Health Department works with to build understanding in the community about health equity is high school students. Renville County hosts a Student Government Day every year for local students, to assist young people in learning more about the work of county governments. The public health director is invited to talk about public health.

Among the things the director shares with the students is that the health department regularly examines data about young people. She asks the students what statistics they think the public health department monitors to help understand what is going on and to help identify issues or challenges for youth that the public health department might want to address. She says: "They usually guess things like drinking, drugs and sexual activity. I go on and tell them that I also look at graduation

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rates. Students invariably ask me why the health department cares about whether students graduate. I respond by telling them that education has a lasting impact on your health." She continues the conversation by explaining how education, income, housing, and jobs contribute to health over the course of their lives.[9]

Local Health Department Practice 2: Develop Organizational Knowledge and Skills to Advance Health Equity

While public health professionals may recognize the role social, economic and geographic forces play to shape health outcomes, many are not equipped with the knowledge and skills needed to take action on the root causes of health inequities, such as economic practices that limit job opportunities, school discipline policies that disproportionately impact certain groups, and housing/home ownership patterns based on race or socioeconomic status.

The Bay Area Regional Health Inequities Initiative has identified multiple competencies essential for advancing health equity, including: personal attributes such as passion, self-reflection, listening skills, and a commitment to health and equity for all; understanding the social, environmental, and structural determinants of health; knowledge of affected communities; collaborative and community organizing skills; and cultural competency and humility.

Why Focus Here?

- The field of public health is broadening its scope of practice as described in the National Association of County and City Health Officials' *Expanding the Boundaries: Health Equity and Public Health Practice*.[10] The skills of the public health workforce must develop to be able to engage in these practices.

- Advancing health equity requires staff to work differently; for this, they need training and support.

- Capacity building in this area cannot be accomplished through training alone; time and space for personal growth, and authentic engagement and courageous conversations both with leaders and affected populations also are necessary.

Stories from the Field: Building Capacity for Health in All Policies

After the Hennepin County Health in All Policies Task Force met a few times, they realized that an outside perspective would be helpful if they were to make progress. The county administration was asking questions like, "Who else has done this?" and "What kind of results did they get?" The task force needed someone from outside the organization who had more experience, and who could present the broader picture of what it means to have health in all policies.

The county decided to hire an outside consultant who provided a three-hour training called "Health in All Policies: Innovation through Collaboration." The consultant was able to provide real-life examples of other governmental agencies doing this work from all over the country. Knowing that other jurisdictions were doing this work with positive results reaffirmed the county's commitment, and supported the message that every part of government plays an active role in achieving healthy communities.[11]

Local Health Department Practice 3: Align Programs and Resources with an Organizational Commitment to Health Equity

Local health departments must focus efforts internally as well as externally. Health equity must be incorporated into organizational policies, processes, programs, and budgets if local activities are to achieve optimal health outcomes for all.

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[9] Source: Jill Bruns, Renville County Public Health.

[10] To view this document online and other health equity resources from the National Association of County and City Health Officials (NACCHO), visit: NACCHO: Health equity and social justice: http://www.naccho.org/programs/public-health-infrastructure/health-equity

[11] Source: Karen Nicolai and Susan Palchick, Hennepin County Public Health.

Local health departments can work to integrate health equity into a variety of areas including urgent and non-urgent communications policies; health education and promotion policies; and staff recruitment, retention and training policies.[12]

Why Focus Here?

- Advancing health equity is not, and cannot be seen as "extra work" or a new "program." It must become standard practice; i.e., "the way we do business."

- Increasing expectations for local health departments without aligning or shifting resources to support a commitment to health equity limits the possibilities of real change.

- The local health department may not be taken seriously by the communities and organizations they seek to engage if they have not first taken a hard look at their own workforce, and at their policies and structures to determine whether these advance health equity or perpetuate inequities.

Stories from the Field: Hiring Community Health Workers

The local health department in St. Louis County wanted to hire a community health worker from a community experiencing health inequities, who would work within the City of Duluth, to reflect the department's commitment to advancing health equity. While contracting for the position might have provided more freedom in hiring, the local health department decided to create a formal job classification within the county system. Having a permanent position was a better option for the employee and would better support the county's commitment to health equity.

With the support of county human resources, the local health department invited community members of the target population to help with the entire process, including recruiting applicants and connecting applicants to resources to help with their applications. Community members also sat on the interview panel. While this took a little more time because of busy schedules, it proved invaluable for identifying qualified candidates. The information collected on county job application forms did not allow the true depth of experience of the applicants to shine through—experience important for the community health worker position. Some of the best candidates who moved forward through the hiring process might have been overlooked if the department had relied solely on the county application form. By interviewing as many people as possible the department was able to hire a person who understands the community within which she works, has passion for her job, and fits in well with the project team. They are excited to watch her grow in her position.[13]

Local Health Department Practice 4: Work in True Partnership Across the Community to Advance Health Equity

To advance health equity, local health departments must explicitly include and engage with communities of color, American Indians, those in poverty, immigrant communities, and others experiencing health inequities. This engagement must be authentic; the local health department must go beyond forming intermittent relationships for the purposes of gaining feedback, and seek to build and sustain lasting relationships. In these relationships the local health department must be willing to listen and allow the community to lead the work. Engagement should not be used as a way to confirm or advance a preexisting idea or agenda. Local health departments can strengthen community relationships through their current engagement efforts in community health assessment and planning, health education and promotion, understanding and addressing barriers to health care access, and efforts to change policy.[14]

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[12] For more details, see PHAB standards 2.4, 3.1, 3.2, 7.2, 8.2, and 11.1.

[13] Source: Amy Westbrook, St. Louis County Health Department.

[14] For more details, see PHAB standards 1.1, 1.2, 3.1, 4.1, 4.2, 5.1, 5.2, 6.1, and 7.1.

Why Focus Here?

- Efforts to advance health equity will be more successful if they are designed with (not simply for) communities experiencing health disparities.

- The local health department cannot advance health equity on its own; health is shaped at the community level, and the whole community is needed to address community conditions for health.

- Community history, wisdom, and knowledge is a critical source of information and experience that should be considered together with public health practice and evidence.

- Public health practice, like any profession, can unintentionally develop and sustain structural inequities. Genuine engagement with the community is one way to assure that the local health department recognizes needed changes and is taking appropriate action.

Stories from the Field: Latino Childcare Network

Because of cost, culture and language issues, Latino immigrant families often prefer to use family, friends, and neighbors (FFN) for childcare rather than licensed providers. Without licensure, these providers lack access to training and information to help young children be healthy and prepared to enter the American school system. Concerned Latino parents in Bloomington and Richfield realized that their children were not as healthy or ready for school as others. Staff from the Bloomington Division of Public Health and from the Church of the Assumption's La Mission parish group joined with these parents to develop the Latino Childcare Network. This network is a support system for Latino FFN providers that assures they have the knowledge and tools needed to prepare healthy, school-ready children.

More than 175 Latino women have participated in the network, which meets regularly for trainings conducted in Spanish. Participants in the network earn certificates and receive public recognition—often their first—for their contributions and achievements. They now serve healthier foods and provide more school readiness activities, outdoor time, and physical activity for the children in their care. The network also reduces isolation, provides support to solve problems, and gives participants access to educational opportunities, skill building, community resources, books, and other supplies.[15]

Local Health Department Practice 5: Improve Data Collection, Analysis, and Use of Data to Advance Health

A health equity approach to data requires a process that both identifies health differences between population groups and examines and identifies the causes of these population differences in health. This means expanding data collected to include information about smaller ethnic and cultural communities, using data that focuses on the conditions that create health, and incorporating qualitative data to shed light on the root causes of health inequities and lead to solutions. It means looking beyond averages, engaging the community to understand what the data says, and using visuals, stories, and community voices to make data compelling and actionable. Local health departments can build on their current use of data to call attention to issues and create urgency for action.[16]

Why Focus Here?

- Using data to identify health inequities is key to identifying where changes are needed in programs, practices, and policies.

- Harnessing the power of data to document health inequities can help build commitment to change, acquire necessary resources, lead to specific actions to advance health equity, and monitor progress.

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[15] Source: Joan Bulfer and Bonnie Paulsen, City of Bloomington Public Health Division.

[16] For more details, see PHAB standards 1.1, 1.2, 3.1, 3.2, and 7.1.

Stories from the Field: Expanding the SHAPE Survey

Washington County conducts an annual survey designed to evaluate residents' health (the Survey of the Health of All the Population and the Environment, or SHAPE). Recent SHAPE survey results indicated that the residents of Washington County are pretty healthy, overall. The local health department recognized, however, that the general adult survey did not offer a full picture of every resident's health. They realized that they needed to expand their data collection efforts to identify differences in health across the diverse populations in the county. Using resources from multiple sources, they increased the SHAPE survey's reach to more diverse populations, focusing on community members that experience health disparities. They were able to partner with county programs, food shelves, faith communities, and many others to reach these populations (the local housing and redevelopment authority, for example, participated by hand-delivering surveys to over 1,000 residents).

The results of the expanded survey showed a much different picture of health than the general adult health survey. For example, almost 53 percent of the targeted sample indicated they were food insecure, compared to 10 percent in the general survey. The expanded set of data will be used to educate decision makers and other stakeholders.[17]

Local Health Department Practice 6: Work at the Policy Level to Advance Health Equity

Creating the conditions in which people can be healthy requires policy solutions. Local health departments must learn to engage beyond health care and the education of individuals, and work with people outside of health on policies that shape the social and economic conditions in which people go about their daily lives (e.g., planning, zoning, recreation, transportation, and more). The work of local health departments in the area of policy includes maintaining an awareness of a broad range of policies under consideration; identifying policy solutions; and engaging, informing, and influencing those who set policies.[18]

Why Focus Here?

- Health inequities are shaped and sustained by policy decisions, and cannot be undone by increasing services to individuals. Policy solutions are essential to advance health equity.

- Other sectors are also working to address inequities in their areas (although they might be unaware of the impact of their efforts on health), and can potentially be powerful partners in local efforts to advance health equity.

Stories from the Field: County Comprehensive Planning

The Olmsted County Public Health Services Advisory Board takes an active role in raising awareness and assuring that health equity is integral to community planning efforts. In late 2014 and early 2015, the board provided input into the City of Rochester's "destination medical center" plan. This economic development initiative will likely have an impact on the entire southeast Minnesota region over the next 20 years. The board presented three recommendations to the Rochester City Council to consider in adopting the plan, with a special focus on the importance of health equity: 1) to leverage and align existing work in the community with the plan (e.g., the statewide health improvement program, and the community health needs assessment and plan); 2) to recognize and incorporate the social determinants of health into the evaluation of development proposals and future measures of health status for all in the community; and 3) to incorporate effective community engagement strategies in the development and review of future proposals (e.g., health impact assessments).

The board also intends to provide similar input into the City of Rochester's comprehensive plan, to assure local planning efforts advance health equity. In addition to the recommendations above, the board is also developing recommendations specific to a number of community design and zoning elements that have an impact on health (e.g., housing, transportation, and the environment).[19]

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[17] Source: Tommi Godwin, Lowell Johnson, and Jean Streetar, Washington County Department of Public Health and Environment.

[18] For more details, see PHAB standards 5.1, 5.2, and 6.1.

[19] Source: Pete Giesen, Olmsted County Public Health Services

Recommendations of the SCHSAC Advancing Health Equity Workgroup

These recommendations were approved by the SCHSAC Advancing Health Equity Workgroup in August 2016.

The concept of health equity is new, and thus the understanding of the role of systems in creating health, is still developing. It will take concerted and combined efforts over many years to increase this understanding and undo the effects of the systems that have created inequities in opportunity and health outcomes. The leadership and skills of all are needed to make this happen.

The recommendations from the SCHSAC Advancing Health Equity Workgroup, therefore, are directed toward key groups of leaders, each of which have an important and unique role to play, starting with the Minnesota Department of Health and including local elected officials, local health departments, and SCHSAC. All of the recommendations should be read with the following in mind:

- As an emerging area of public health, it will take time for organizations and individuals to develop the capacity necessary to make the change that will lead to health equity.

- The scope of health equity as an issue is potentially overwhelming, and there are many facets to equity. Leaders should find a place to start that fits their unique circumstances.

- Equity in health is really the result of equity across all areas of life. Leaders should seek connections and make efforts to work across institutional and community boundaries.

- Challenging the status quo, calling attention to racism, and addressing controversial and complex issues puts leaders in an uncomfortable space. This work requires leadership and courage. Leaders in public health need to support one another's efforts, and create an environment open to dialogue and change.

- Health equity is not a one-time issue that can be resolved with one set of recommendations. MDH, local elected officials, community health boards, local health departments, and SCHSAC must all keep attention focused on health equity as a priority of Minnesota's public health system.

Recommendations for the Minnesota Department of Health

As a state agency, the MDH has unique statewide, regional, and national leadership opportunities.

1.1.   MDH must set an example for the rest of the state by modeling the practices (e.g., working in true partnership) that local health departments are expected to adopt to advance health equity. At the same time, MDH must acknowledge that it is learning with its partners and does not have all the answers.

1.2.   MDH should recommend that the Governor allocate resources and make health equity a budget priority.

1.3.   MDH should engage with other state agency commissioners and other state, regional, and national leaders to expand the understanding of what creates health, to assure that health is considered in all policies, and lead toward meaningful action.

1.4.   MDH should be a role model for hiring and retaining a diverse workforce that reflects all the populations of the state.

1.5.   MDH should budget for resources, provide training, and give local health departments and other community partners their ongoing support and consultation to advance health equity.

    1.5.1.   MDH should dedicate resources to maintain and continue to develop the online Resource Library for Advancing Health Equity in Public Health. [20]

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[20] MDH, Resource library for advancing health equity in public health.

1.5.2.   MDH should develop tools and other resources (e.g., narrative training, infographics, data summaries, etc.) for local health departments and other partners to use to improve in their efforts to advance health equity.

1.5.3.   MDH should support local efforts to hold challenging conversations on the issues that affect health equity, including poverty, class, race, and gender.

1.6.   MDH should develop measures for documenting progress on health equity across the state, including evaluating current measures and developing new ones.

1.7.   MDH should connect health equity work for local health departments across many existing areas, including community health board requirements for local assessment and planning, quality improvement and performance management activities, workforce development, and efforts in other programs such as the Statewide Health Improvement Program (SHIP) and family home visiting.

Recommendations for Local Elected Officials

As policy makers, local elected officials are in a unique position to advance health equity by working to assure that all local policies support health.

2.1.   Local elected officials should become knowledgeable about the health disparities and inequities in their jurisdiction. For example, local elected officials should:

2.1.1.   Ask for data that assesses inequities in their jurisdiction, and use this data to shape policies to remove structural barriers to equity. (Note: The local health department is a key resource for this data.)

2.1.2.   Engage with members of the communities experiencing the greatest health inequities to identify and understand the structures and systems that are preventing them from being as healthy as they could be, and learn to recognize and celebrate the many strengths and assets that they bring to the community and the state.

2.1.3.   Expand their knowledge about the historical experiences and structural barriers facing populations in their communities.

2.2.   As they grow more aware of inequities in their communities, local elected officials should make achieving health equity and equitable conditions across the community a priority.

2.2.1.   Local elected officials should identify and act on opportunities to make sure health and equity are considered in every policy, planning effort, and program (see, for example, the Olmsted County Comprehensive Plan story on p. 12).

2.2.2.   With the understanding that advancing health equity requires working across boundaries, local elected officials should work to establish goals for equity across all areas of local government, and work with staff across many departments to strategize and set appropriate milestones to advance equity.

2.3.   Local elected officials should champion and support local efforts, including those of the local health department, to develop the practices necessary to advance health equity. This includes seeking additional resources, making a long-term commitment, and being willing to take leadership on controversial issues.

Recommendations for Local Health Departments

As integral parts of Minnesota communities, local health departments are uniquely positioned to understand the inequities in their jurisdictions and bring people together to shape more equitable communities.

3.1.   Local health departments should actively work to advance health equity. To begin, they should review the six local health department practices to advance health equity (starting on p. 8) and identify a place to start that fits their unique capacity and local circumstances. The following are offered as suggestions for moving into these practices:

- Engage at least one local elected official in the process of advancing health equity
- Engage in a conversation with other local leaders in areas such as planning and zoning, public safety, transportation, community development, or education about how they have an impact on health
- Select and use a resource from the online Resource Library for Advancing Health Equity in Public Health[21] to get started on health equity in their community
- Create a safe space for staff to start engaging in conversations about poverty, class, racism, sexism, and other challenging issues that affect the possibility of achieving health equity in the community
- Prepare organizational leaders to expect and accept that some tension will accompany efforts to advance health equity
- Recognize and celebrate the benefits brought to the community by all populations, including those experiencing health inequities, and share findings with others

3.2.   Local health departments, working with MDH, should seek a variety of ways to monitor their efforts to advance health equity and hold themselves accountable for making progress.

Recommendations for SCHSAC

Because of its legislative mandate, membership, methods, and history (operating since 1976), SCHSAC has a unique partnership with MDH, serves as an advocate for public health with local and state leaders, and shapes the actions of local health departments across the state. SCHSAC has been an enduring presence in Minnesota throughout many changes in state administration, providing direction, stability, and quality improvement for public health.

4.1.   SCHSAC should keep health equity on its work plan for as long as needed, maintaining this commitment even through changes in state administration, to continue to make progress and improve health in every community.

   4.1.1.   SCHSAC should engage with and develop simple tools for educating newly elected and appointed state and local leaders, including new state commissioners and new SCHSAC members, so they can become knowledgeable about health equity as quickly as possible and know where to start and what to do.

   4.1.2.   SCHSAC members should proactively seek to engage the new commissioner of MDH as early as possible in 2019 to assure that health equity remains on both the SCHSAC and MDH agendas.

   4.1.3.   SCHSAC should find ways to engage communities experiencing inequities in its activities to advance health equity.

4.2.   SCHSAC should hold MDH accountable for continuing the work of MDH to identify and address structural inequities and advance health equity.

4.3.   The SCHSAC Performance Improvement Steering Committee should continue to monitor local health department capacity to advance health equity via the annual reporting system for community health boards, and should align annual reporting measures with both the six local health department practices to advance health equity and the relevant PHAB standards and measures.

4.4.   SCHSAC members and alternates should educate their peers (other local elected officials, public health system leaders, etc.) about equity, make the case for the public benefit of equity in every community, and advocate for the participation and support of community leaders in efforts to advance health equity.

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[21] MDH, Resource library for advancing health equity in public health.

Appendix A: A Brief Introduction to Health Equity

Health disparities in Minnesota are significant, persistent, and cannot be explained by biological or genetic factors. They are more than differences: they are inequities that are life-threatening and urgent. The Minnesota Department of Health reported on many of these inequities in its 2014 report, *Advancing Health Equity in Minnesota: Report to the Legislature*.[22] For example:

- African-American and American Indian babies die in the first year of life at twice the rate of white babies. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years.
- American Indian, Hispanic/Latino, and African-American youth have the highest rates of obesity.
- Intimate partner violence affects 11 to 24 percent of high school seniors, with the highest rates among American Indian, African-American, and Hispanic/Latino students.
- Gay, lesbian, and bisexual university students are more likely than their heterosexual peers to struggle with mental health.
- African-American and Hispanic/Latino women in Minnesota are more likely to be diagnosed with later-stage breast cancer.
- On average, persons with serious and persistent mental illness die 25 years earlier than the general public.[23]

Looking at the kinds of things that shape health in Minnesota—a good education, opportunities for work, safe places to live and play—it becomes apparent that many kinds of inequities, or differences in these opportunities to be healthy, lead to health disparities. Populations experiencing the greatest disparities in health status are also the populations experiencing the greatest inequities in the opportunity for health, in education, income, health care, and living environments. Populations of color and American Indians, women (especially single women with children), those with lower incomes (who also are often single mothers, people of color, or American Indians), LGBTQ persons, and people with disabilities consistently face greater daily challenges than Minnesota's white population in everything from employment to housing to education to transportation to access to needed services. *Advancing Health Equity* also noted that:

- Poverty rates for children under 18 in Minnesota are twice as high for Asian children as for white children, three times as high for Hispanic/Latino children, four times as high for American Indian children, and nearly five times as high for African-American children.
- Unemployment is highest among populations of color, American Indians, and people who live in rural Minnesota.
- While 75 percent of the white population in Minnesota own their own home, only 21 percent of African-Americans, 45 percent of Hispanic/Latinos, 47 percent of American Indians, and 54 percent of Asian Pacific Islanders own their own homes.
- African-Americans and Hispanic/Latinos in Minnesota have less than half the per capita income of the state's white population.
- Lesbian, gay, bisexual, and transgender youth are at increased risk for bullying, teasing, harassment, physical assault, and suicide-related behaviors compared to other students.
- Low-income students are more likely to experience residential instability (as indicated by the frequency of changing schools) than their higher-income peers in every racial and ethnic category.
- American Indian, Hispanic/Latino, and African-American youth have the lowest rates of on-time high school graduation.
- African-Americans and American Indians are incarcerated at nine times the rate of white persons.[24]

Race/ethnicity-based disparities are not the only issues of concern, however. Health equity and inequities in the conditions that create health are also critical for many people in in rural areas. A few examples include:

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[22] Minnesota Department of Health. (2014). Advancing health equity in Minnesota: Report to the legislature. Online: http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

[23] MDH, Advancing health equity in Minnesota: Report to the legislature.

[24] MDH, Advancing health equity in Minnesota: Report to the legislature

- Rural workers have less access to paid sick leave, have fewer employment options, are more frequently underemployed and have less income growth than urban workers.[25]
- Business owners and prospective business owners have more difficulty getting access to capital in rural communities.[26]
- Nearly one quarter (23 percent) of rural households with children have access to sufficient food (or are food insecure), compared to 19 percent of urban households.[27]
- Rural women experience poorer health outcomes and have less access to health care than urban women.[28]

Making the changes necessary to shape these conditions of daily life in such a way that every person in Minnesota has the opportunity to be healthy: **this is the work of advancing health equity**.

In 2013, the State Community Health Services Advisory Committee (SCHSAC) participated in the development of a Minnesota Department of Health (MDH) report, *Advancing Health Equity in Minnesota: Report to the Legislature*.[29] The report, delivered to the legislature on January 31, 2014, raises the question of what creates health and demonstrates the critical influence on health played by public and private policies, social and economic conditions, the design of systems (such as transportation and education), and physical and social environments. Throughout 2014, SCHSAC continued to discuss and explore issues of health equity, health disparities, and health in all policies.

Through their discussion, SCHSAC members recognized that local health departments and local elected officials have critical roles to play in the work of advancing health equity to eliminate health disparities. In the spring of 2015, the committee charged a workgroup with the task of providing local elected officials and local public health leaders with the language, understanding, and practical help to advance health equity throughout Minnesota's public health system. The charge includes integrating health equity into public health policies and practice and providing a forum to promote tangible steps that community health boards, MDH, and community partners can take.

What is Health Equity?[30]

Health equity is achieved when every person has the opportunity to attain their health potential, and no one is unjustly kept from achieving this potential.

Health equity can be defined in multiple ways: it refers to equity in the conditions that create health—education, employment, housing, etc.—as well as to equity in health outcomes, such as rates of disease and injury. Persistent, significant, and socially-determined differences in the **conditions** that create health and the opportunity to be healthy currently generate large inequities in health **outcomes** among different populations in Minnesota. When the differences in conditions are eliminated, equity in health becomes possible.

Health equity, therefore, is achieved when structural barriers to health, especially those based on race, socio-economic status, zip code, gender, sexual orientation, or disability, are eliminated.

Health inequities are socially determined: this means that the conditions shaping health are created by human decisions that affect community or society at large (including the policies of governments, corporate decisions, neighborhood action, media tactics, etc.). These decisions are influenced by a variety of factors, including both positive and negative social forces, such as a sense of community, economic pressures, and a general fear of that which is foreign or strange. But because

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[25] Smith K, Schaefer A. (2011). Rural workers have less access to paid sick days. *Carsey Institute Issue Brief 32*. Online: http://scholars.unh.edu/cgi/viewcontent.cgi?article=1139&context=carsey.

[26] White House Rural Council. (2011). Jobs and economic security for rural America. Online: https://www.whitehouse.gov/sites/default/files/jobs_economic_security_rural_america.pdf.

[27] Coleman-Jensen A, Rabbitt MP, Gregory C, Singh A. (2015). Household food security in the United States in 2014. *United States Department of Agriculture Economic Research Service: Economic Research Report 194*. Online: http://www.ers.usda.gov/media/1896841/err194.pdf.

[28] American College of Obstetricians and Gynecologists. (2014). Committee opinion: Health disparities in rural women. *Obstetrics & Gynecology 123*: 384-8. Online: http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women.

[29] MDH, Advancing health equity in Minnesota: Report to the legislature.

[30] For references and resources on health and health equity, please refer to: MDH, Advancing health equity in Minnesota: Report to the legislature.

health inequities are socially determined, it means that they also are subject to change: the decisions of people create inequities, thus the decisions of people can undo them.

What Creates Health and Health Equity?

Health is "a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity."[31] Health is generated through the interaction of individual, social, economic, and environmental factors and in the systems, policies, and processes encountered in everyday life. These include job opportunities, wages, transportation options, the quality of housing and neighborhoods, the food supply, access to health and mental health care, the quality of public schools and opportunities for higher education, racism and discrimination, social inclusion, civic engagement, and the availability of networks of social support.
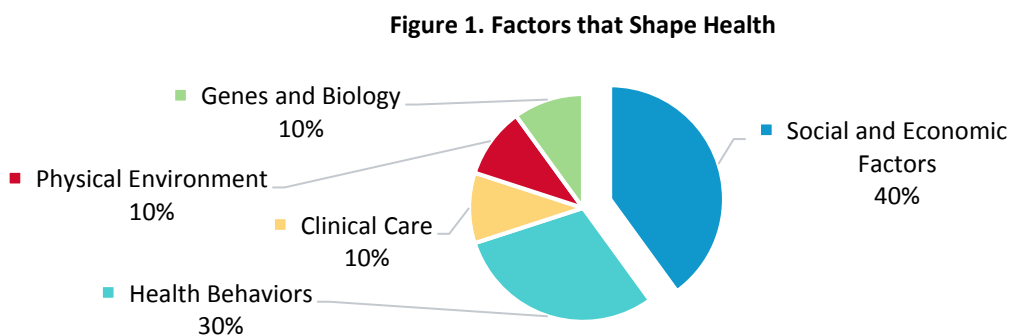
For example, income is (not surprisingly) strongly associated with health outcomes. People with a higher income generally enjoy better health and longer lives than people with a lower income. In other words, on average, the more money you make, the better your overall health. But adequate income is not only related to being able to afford food, housing, and health care. Income is also a pathway to social participation, to self-determination, and to overall quality of life. Income is, for most people, a product of employment. However, employment is linked to opportunities for training and educational systems, opportunities for socialization and social connections, and the location of jobs to housing (to name a few).

If, for example…

- the schools you attend are underfunded and overcrowded;
- businesses do not invest in your neighborhood;
- public transportation systems are not available so you can get to the work you can find;
- you are passed over for jobs because of discrimination;
- the only jobs available in your geographic area are all high risk for injury; and
- the jobs that are available nearby pay so little that you have to work two or three jobs so you do not to have to choose between rent and food…

…ultimately your health and the health of your family will suffer.

The relative impacts of various factors on health are illustrated in Figure 1.[32]

Figure 1. Factors that Shape Health

- Genes and Biology 10%
- Physical Environment 10%
- Clinical Care 10%
- Health Behaviors 30%
- Social and Economic Factors 40%

Health is created in the community by people working together to create economic, social, and environmental conditions that promote health and that are just—that is, the social and economic factors noted in the chart above, which are the

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[31] World Health Organization. (1946). Preamble. Online: http://www.who.int/governance/eb/who_constitution_en.pdf.

[32] Figure based on frameworks developed by:
- Tarlov AR. (1999). Public policy frameworks for improving population health. *Annals of the New York Academy of Sciences 896*, 281-93. Online: http://www.ncbi.nlm.nih.gov/pubmed/10681904.
- Kindig DA, Asada Y, Booske B. (2008). A population health framework for setting national and state health goals. *Journal of the American Medical Association 299*(17): 2081-3. Online: http://www.ncbi.nlm.nih.gov/pubmed/18460667.

largest overall influence on health. For equity in health outcomes to be possible, systems and structures need to be in place to shape these factors and assure every person has, for example:

- Access to economic, educational, and political opportunity
- The capacity to make decisions and effect change for themselves, their families, and their communities
- Social and environmental safety in the places they live, learn, work, worship, and play
- Culturally-competent and appropriate health care when the need arises

People and organizations make decisions that influence those conditions and the structures of society— decisions, for example, about where to construct a road or bridge, where to open a bank, how much interest to charge on loans, or how much funding to provide for public transit. When past decisions have created inequities, those inequities often persist because the decisions of today are built on the decisions of the past.

When past or present decisions are made about the structures and systems of society— e.g., finance, housing, transportation, education—and these decisions determine who has opportunity, influence, safety, and so on (and who does not), it creates a structural inequity. For example, when a freeway is built that bypasses a poor community but provides plenty of on-off ramps for wealthier communities, it sets up a structural inequity: businesses making decisions about where to locate often choose to build (and provide jobs) near the freeway exits, continuing to benefit the wealthier community and bypassing the poorer community.

The good news is that these inequities are based in policy decisions, and new policy decisions can do much to change structures and health outcomes.

Healthy Minnesota and the Triple Aim of Health Equity

Since 2010, the Minnesota Department of Health has been working with the Healthy Minnesota Partnership on efforts to advance health equity. Two items of note relate directly to the work of the SCHSAC Advancing Health Equity Workgroup:

Healthy Minnesota 2020: Statewide Health Improvement Framework

The Healthy Minnesota Partnership, working with MDH, developed *Healthy Minnesota 2020: Statewide Health Improvement Framework* (2012),[33] a five-year plan to expand conversations in the state about health to include the conditions that create health (including education, employment, transportation, and more). The approach focuses on recognizing and disrupting dominant narratives that limit the possibilities for change (like the idea that health is primarily created in a doctor's office), and developing narratives that recognize the importance of social and economic forces on people's daily lives and well-being and lead to a broader range of possible actions. The narratives emerging from this effort have influenced policy action at the state legislature on issues such as minimum wage increase, paid leave, and transportation.

Triple Aim of Health Equity

Building on the work of the Healthy Minnesota Partnership, Ed Ehlinger, MD, MPH, the Commissioner of Health and 2016 President of the Association of State and Territorial Health Officials, introduced a model for health improvement called the Triple Aim of Health Equity.[34] The three components of this model are:

TAKE A HEALTH IN ALL POLICIES APPROACH, WITH HEALTH EQUITY AS THE GOAL

It is important to acknowledge the impact of local, state and national policies on health and focusing on shaping policies in many areas—transportation, housing, education, and public safety, to name a few—to assure the conditions in which everyone can be healthy.

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[33] Healthy Minnesota Partnership. (2012). Healthy Minnesota 2020: Statewide health improvement framework. Online: http://www.health.state.mn.us/healthymnpartnership/hm2020/.
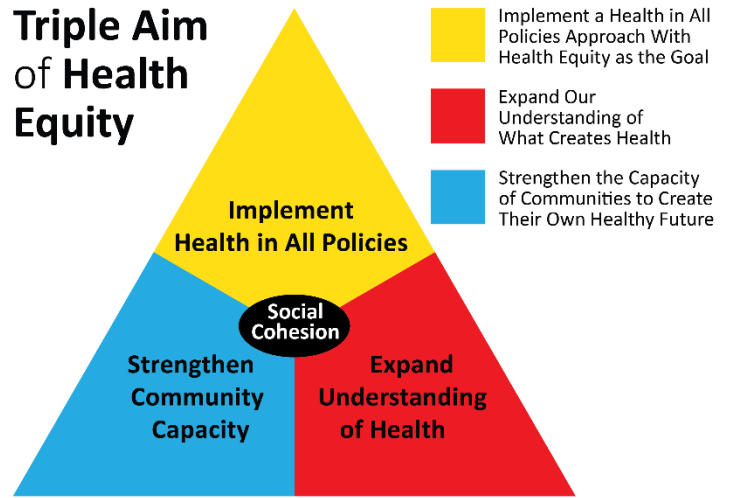
[34] Ehlinger E. (2015). We need a triple aim for health equity. *Minnesota Medicine October 2015*: 28-9. Online: http://pubs.royle.com/publication/?i=274367.

EXPAND THE UNDERSTANDING OF WHAT CREATES HEALTH

Stakeholders need to bring new voices into discussions on health, and move from a focus on health care and personal choice to embrace of the role of the community and community conditions for health.

STRENGTHEN COMMUNITIES' CAPACITY TO CREATE THEIR OWN HEALTHY FUTURE

Communities themselves need to be involved in shaping policies and systems to improve conditions for their members, and that knowledge and decision-making power should be in the hands of those most affected by the decisions so they can participate fully in creating conditions for health.

Triple Aim of **Health Equity**

Implement a Health in All Policies Approach With Health Equity as the Goal

Expand Our Understanding of What Creates Health

Strengthen the Capacity of Communities to Create Their Own Healthy Future

Implement Health in All Policies

Social Cohesion

Strengthen Community Capacity

Expand Understanding of Health

Appendix B: Rural Poverty and Health Equity

A number of counties in rural Minnesota have experienced rapid growth in immigrant populations, particularly those from Mexico and Somalia, making the issue of racial inequities particular pertinent in those communities. Another set of counties, however, still remain primarily white (95 percent of the population or more) and ethnically European. In those communities, it is important to avoid the impression that health equity is only an issue related to race and ethnicity or racial discrimination.

In fact, structural barriers to optimal health exist for persons of lower socioeconomic status. The workgroup discussed the root causes of poverty and poor health in rural Minnesota, and noted a number of factors, including:

- Attitudes in the community shape what kinds of opportunities are available for whom; class differences, class privilege, and discrimination by socioeconomic status are all factors
- Persons who have been incarcerated, no matter of what race, face barriers to employment and future success
- Limited transportation options pose significant challenges, especially for lower income people (such as the elderly) in isolated rural areas
- Federal farm policies that were put in place to assist farmers now have the effect of making it difficult for small family farms to turn a profit
- The prevalence of high-injury occupations for lower income workers creates health inequities
- The geographic dispersion of rural poverty makes it difficult to organize for change
- Corporate agriculture has imposed a different set of values and structures that limit economic opportunity for workers in rural areas
- Affordable housing, whether for low-income seniors or families with children, is not being built
- Land use planning tends to favor those with more wealth, creating forms of economic exclusion

The workgroup also identified potential roles for local health departments on socioeconomic class-related inequities. These include analyzing health disparities by education and income, advocating for policy and systems changes that make the environment healthier for everyone, being the ones to "connect the dots" for community decision makers between income inequality and health disparities, and partnering with other systems (education, law enforcement) to address inequities by socioeconomic status.

As local health departments continue to identify health inequities and find ways to advance health equity, the issues of rural poverty and discrimination by socioeconomic status need to be better understood and addressed.

Appendix C: Frequently Asked Questions about Advancing Health Equity

According to Chris McGoff, there are three kinds of listeners, people that listen with their brains (analytical), people that listen with their hearts (emotional), and people that listen with their wallets (financial).[35] These frequently asked questions and answers were created in an attempt to address all three types of listeners.

Some answers have several facts. It is not necessary to memorize all of the facts. Consider choosing one or two of the facts that are relevant to the listener or audience. Also, consider replacing the facts provided with similar facts from your own jurisdiction.

Most importantly, these are simple answers to help you get started talking about advancing health equity. For more information and resources, visit the online Resource Library for Advancing Health Equity in Public Health[36] for help with more complex discussions about this very complicated issue.

Questions and Answers

Q. WHAT IS HEALTH EQUITY?

A. Health equity, is a state where all persons, regardless of race, income, creed, sexual orientation, gender identification, age or gender are able to be as healthy as they can—to reach their full "health potential." Equality and equity are sometimes lumped together as if they mean the same thing. Equity is about fairness, where equality is about sameness. Advancing health equity is good for everyone in Minnesota/community.

A. Dr. Paula Braverman indicates that it "means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health." [37]

A. Health equity and health inequity are connected. A health inequity is a health disparity based on inequitable, socially-determined circumstances (for example, American Indians have higher rates of diabetes due to the disruption of their way of life and replacement of traditional foods with unhealthy commodity foods). Because health inequities are socially determined, change is possible. No one should be denied the possibility to be healthy based on socially-determined circumstances.

Q. WHY SHOULD WE BE CONCERNED ABOUT HEALTH EQUITY?

A. Minnesota is considered one of the healthiest states in the nation, but also has some of the largest differences in health problems because the opportunity to be healthy is not equally available everywhere or for everyone.

A. Several groups of people in Minnesota experience inequities in the social and economic opportunities that create health and the health disparities that result. [38] A few include:

- Children: Nearly one in five children under age six live in poverty. According to a 2015 Wilder Foundation Report, fourteen counties have the highest rates of poverty, exceeding the national rate of one in four, including two counties exceeding one in every three children. These high-risk counties are spread throughout the state, and are not just urban counties.

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[35] McGoff C. (2010). Stake. Online: https://vimeo.com/14035425.

[36] MDH, Resource library for advancing health equity in public health.

[37] Braverman P. (2014). What are health disparities and health equity? We need to be clear. *Public Health Reports 129*(Suppl 2): 5-8. Online: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3863701/.

[38] More information on the following data, and additional data, can be found in: MDH, Advancing health equity in Minnesota: Report to the legislature.

- American Indians: Diabetes rates are now endemic among American Indians throughout the US, including in Minnesota.

- African-Americans: In 2012, the rate of home ownership in Minnesota among African-Americans is one-quarter of the rate of white home ownership.

- African Immigrants: In 2015 two percent of the population of Minnesota were African immigrants; however, 20 percent of the newly diagnosed HIV cases were in African immigrants.

- Hispanic/Latinos: While there has been a significant decrease in the rates of uninsured Latinos since 2013, 12 percent remain uninsured compared to 3 percent of whites.

- Asian-Pacific Islanders: 27 percent of Hmong living in Minnesota do not have a high school diploma or GED.

- LGBTQ: CDC notes that several studies have documented an increased risk for LGBTQ youth for bullying, teasing, harassment and physical assault compared to other students.

- Individuals/families facing mental health challenges: Persons with serious and persistent mental illnesses die on average 25 years younger than the general population.

A. Even when overall health problems have gotten better, as in the death of infants, the differences remain unchanged: American Indian and African-American babies are still dying at twice the rate of white babies.

A. Improving the health of those experiencing the greatest inequities will result in improved cities/towns, a strong workforce, great schools, neighborhoods for all and a place where everyone can achieve their full potential. For example, racial inequities in Minnesota have led to lost economic outputs every year. Minnesota's gross domestic product would have been $16.4 billion higher in 2011 if there had been no racial gaps in income (more information about this data can be found in *Minnesota's Tomorrow: Equity is the Superior Growth Model* [39]).

Q. IF WE ARE CONCERNED ABOUT HEALTH, WHY ARE WE TALKING ABOUT OTHER PROBLEMS LIKE INCOME OR EDUCATION INEQUITIES?

A. The opportunity for health begins in our families, neighborhoods, schools, and jobs. Where we live, learn, work and play can make a bigger difference how long and how well we live than medical care.

People and communities experiencing the greatest differences in health are also the people and communities experiencing the greatest differences in the opportunity for health, in education, income, health care, and living environments.

A. Ninety percent of health problems are affected by factors outside of the care provided in a clinic or a hospital. Socio-economic factors include:

- job opportunities
- wages
- transportation options
- the quality of housing and neighborhoods
- the food supply
- access to health care

- the quality of public schools and opportunities for higher education
- racism and discrimination
- civic engagement
- the availability of networks of social support

A. According to a recent study by the MDH Diabetes Unit, adults 18-64 who live in households earning less than $35,000 per year are 2.5 times as likely to report having diabetes as those with incomes higher than $35,000.[40] This finding provides an example of the relationship between income and health.

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[39] PolicyLink. (2014). Minnesota's tomorrow: Equity is the superior growth model. Online: http://www.policylink.org/sites/default/files/MNT_032514.pdf.

[40] Minnesota Department of Health. (2016). Income, employment, and diabetes. Online: http://www.health.state.mn.us/divs/healthimprovement/content/documents/DiabetesIncome_2016_03_08.pdf.

Q. WHAT IS PUBLIC HEALTH'S ROLE IN ADVANCING HEALTH EQUITY; WHY IS PUBLIC HEALTH EXPANDING ITS ROLE TO THOSE AREAS OUTSIDE OF TRADITIONAL HEALTH CARE?

A. Public health doesn't see this as expanding its role, but rather going back to its roots. Historically, public health was responsible for addressing "conditions of the poor" by focusing on housing, connections to clean water, sewage systems, and working conditions.

A. The mission of Community Health Services, signed by the SCHSAC Executive Committee in 1996, was to protect and promote the health of all people by assuring that all persons have the opportunity to achieve and maintain their best level of health and independence and lead vital, productive lives. This has been a part of our work for many years.

A. Because 90% of health problems are affected by factors outside of health care, public health has the responsibility to call attention to and work with others to address the inequities that are intolerable and unacceptable.

A. There has been a national call to action for public health to address the underlying social conditions that avoidable and unjust by the Centers for Disease Control, Healthy People 2020, the World Health Organization, the Association of State and Territorial Health Officials, the National Association of County and City Health Officials, the American Public Health Association, and many others.

Q. I WORK IN PUBLIC HEALTH, WHAT CAN I DO ABOUT PROBLEMS LIKE INCOME OR EDUCATION DISPARITIES?

A. Public health has a long history of looking "upstream" to identify the root causes of poor health, and informing, engaging, and activating the community to address those causes. The local health department practices to advance health equity (starting on p. 8) can help you identify a starting place. Then, review the Resource Library for Advancing Health Equity in Public Health.[41] This library includes various guides, videos, assessments, and other resources. The online library of resources is designed to allow local health departments to select, from among the range of resources presented, the ones that best meet their needs and capacity.

Some local health departments have started by reviewing their internal policies and structures to make sure they are not contributing to inequities. Others have found that taking a health in all policies approach was helpful as a way to engage other governmental sectors. Still others have found that using the data that focused on the conditions that create health was the way to start their journey.

Q. WHAT ARE SOME OF THE REASONS THAT HEALTH INEQUITIES EXIST?

A. When past or present decisions are made about where we live, learn, work and play that benefit one group of people at the expense of others (intended or not) an inequity is created.

For example, when a freeway is built that bypasses a poor community but provides plenty of on-off ramps for wealthier communities, it sets up a structural inequity: businesses making decisions about where to locate often choose to build (and provide jobs) near the freeway exits, continuing to benefit the wealthier community and bypassing the poorer community.

A. Structural racism—the normalization of historical, cultural, institutional and interpersonal dynamics that routinely advantage white people, while producing cumulative and chronic adverse outcomes for people of color and American Indians—is rarely talked about. Revealing where structural racism is operating and where its effects are felt is essential for figuring out where policies and programs can make the greatest improvements.

For example, when full-service banks choose not to locate in a community (such an urban area with a high proportion of lower income residents), payday loan businesses fill in the gap; payday loans are more expensive and create an ongoing disadvantage for the people in those communities.

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[41] MDH, Resource library for advancing health equity in public health.