HEALTH CARE EQUITY EQUITY IN HEALTH

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CARLESSIA A. HUSSEIN
RN, BS, MS, DR.P.H.

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Maryland Department of Health and Mental Hygiene

TOPICS

- I   DEFINING EQUITY IN HEALTH
- II   HEALTH (EQUITY) IN ALL POLICIES
- III EQUITY IN OPPORTUNITY
- IV EQUITY IN MARYLAND BY 2020
- V   VISIONING THE FUTURE

I. DEFINING EQUITY IN HEALTH

- World Health Organization (WHO), European Region adopted in 1980s a common health policy that included 38 regional targets. The first target is *EQUITY*. Margaret Whitehead was asked to review existing documentation to distill a definition of *EQUITY IN HEALTH* using the collective wisdom available at that time.[1]

1. Margaret Whitehead, 1992 Concepts & Principles of Equity and Health – WHO

DEFINING EQUITY IN HEALTH
(CONTINUED)

- ***Health Inequities***: differences in health status of individuals within groups and between groups within the same geographic areas. Some of the differences are expected while others are not. Those unexpected differences are considered ***INEQUITIES.*** (WHO)

DEFINING EQUITY IN HEALTH
(CONTINUED)

- *Health Inequities* have a moral and ethical dimension. It refers to differences which are **UNNECESSAY** *and* **AVOIDABLE** *but in addition, are also considered UNFAIR and UNJUST. "* (WHO)

DEFINING EQUITY IN HEALTH
(CONTINUED)

Avoidable and Unnecessary:

- Unhealthy behavior - choice of healthy lifestyles are restricted or out of reach;

- Exposure to unhealthy, stressful living and working conditions;

- Natural Selection: tendency for sick people to move down social scale – Intergenerational Transmission

- Inadequate access to essential health and other public services.

DEFINING EQUITY IN HEALTH
(CONTINUED)

- **AIM:** "Equity is concerned with creating equal opportunities for health and with bringing health differentials (disparities) down to the lowest level possible" (Whitehead). The aim of *Equity in Health* is to reduce or eliminate those factors found to be avoidable and unfair.

- **DEFINITION:** "Equity in health care is defined as equal access to available care for equal need, equal utilization for equal need and equal quality of care for all (Whitehead).

- **CAUTION:** Access to care, does not guarantee equity in health care. Access is merely an important first step. Policies need to be in place that ensure quality, quantity, and the appropriateness of care, that are not disparate. Access + quality + quantity + appropriateness = Health Care Equity.[2]

2. Goldberg, A., participant on the IOM Roundtable on Promotion of Health Equity, 2012).

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II. HEALTH EQUITY IN ALL POLICIES

- **Health-in-all-Policies (HiAP)** articulates the concept that health is mainly created by factors outside of health care services. This idea was put forth in the 19th century in Europe and is expressed in the WHO Constitution and the UN General Assembly meeting on the Prevention and Control of Non-Communicable Diseases. [3]

- **Health-in-all-Policies (HiAP) takes into account:**
- Public policies across sectors that impact the health and welfare of populations;
- Implications of decisions, seeks synergies with other decisions and avoids harm;
- Population health and health equity, considers whole groups and equity impact;
- Partnerships include sharing power and accountability across sectors;
- Sustainability of political will and leadership commitment to equity through administrations and terms of office.

3. Health in All Policies, WHO 2013; History Chpt. 2

HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

- A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to improve the <u>accountability of policy-makers</u> for health impacts at all levels of policy-making" (WHO, 2013).

- On the world stage, 16 countries and sub-country areas are implementing their own version of Health-in-all-Policies: Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Quebec, Scotland, South Australia, Sri Lanka, Sweden, Thailand and Wales in 2010 (WHO,2013).

HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

In the U.S., the Institute of Medicine addressed the need and benefits of HiAP.

They recommended:
- States and federal government employ HiAP to consider both positive and negative health effects on the public's health, and;
- State and local governments create health councils with relevant government agencies, under the Chief Executive, in a HiAP planning process. [4]

4. HiAP: Improving Health Through Intersectoral Collaboration, IOM, 2013

HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

- The Public Health Institute, the California Department of Public Health and the American Public Health Association collaborated to publish *Health in All Policies: A Guide for State and Local Government, 2010.*[5]

- Five key elements listed in the Guide:

- Promote health, equity and sustainability: incorporating health, equity and sustainability into specific policies and embedding health, equity and sustainability into government decision-making;

- Support intersectoral collaboration: brings together partners from many different sectors;

- Benefit multiple partners: values co-benefits and win-wins;

- Engage stakeholders: include many stakeholders, community members to ensure that work is responsive to needs of the many different recipient communities; and

- Create structural or process change: over time, this work leads to institutionalizing an HiAP approach throughout the organization and the whole of government. This must lead to permanent change.

5. http://www.phi.org/uploads/files/Health_in_All_Policies-A_Guide_for_State_and_Local_Governments.pdf

HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

UNCONSCIOUS BIAS:

A barrier for Health Equity and Equity in Opportunity:

A growing body of knowledge alerts us that unconscious bias may have a larger impact on negative patient outcomes than previously known.[6]

- The Implicit Association Test (IAT) widely used since 1998, measures the unconscious attitudes by observing the individual's association between concepts of race and good and bad. [7]

- A 2011 survey of entering medical students (2009/2010) found a preference for White persons but no association between the students clinical assessments and race of patient; while to the contrary, other studies show clinical bias in relation to race among practicing physicians; questions are raised about the training of physicians and implicit bias.

6. Blair, et.al., 2011, Permanente Journal
7. Implicit.harvard.edu

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HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

- **What Kind of Asian Are You?**
- Video clip:
- www.youtube.com/watch?v=DWynJkN5HbQ

What kind of Asian are you? - YouTube
www.youtube.com/watch?v=DWynJkN5HbQ ▾
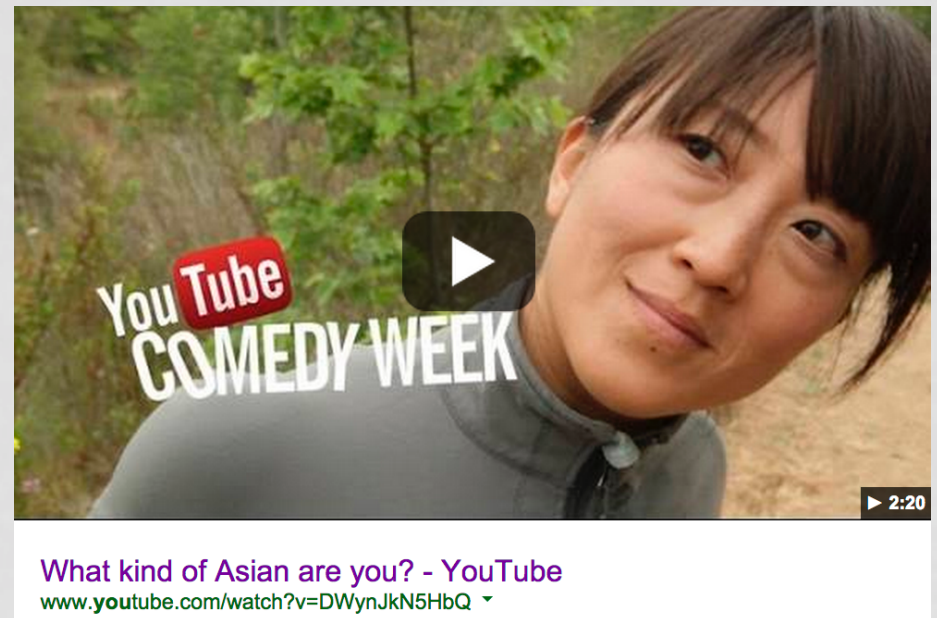
HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

Actions to address Implicit Unconscious Bias:

- Conduct self assessment of bias and build in controls, "Patrolling Your Blind Spots"; [8]

- MHHD Cultural Competency and CLAS Standards training touch on unconscious bias and use a number of exercises to help participants become self-aware;

- Provide Integrated Professional Education (IPE) where students from different fields learn together, enabling them to integrate the differences and connect the similarities from their respective trainings and diversity;

- Implement unconscious bias training in major health-related organizations; Dr. Nakamura, Director, NIH Center for Scientific Review (SCR) took a self assessment test and learned he had bias.[9] He has implemented actions to identify/reduce bias.

8. Hannah & Carpenter-Song, 2013 from Harvard;
9. Maximizing Fairness in Peer Review, 2014

HEALTH EQUITY IN ALL POLICIES
(CONTINUED)

Explicit Conscious Bias:

- Post racial area is proclaimed by some, following election of President Obama, but events, personal experiences and proliferation of hate groups, suggest otherwise; since 2000, there is a 56% increase in hate groups; since Pres. Obama's election, patriot groups grew to 1,360;

- Mr. Thomas Eric Duncan; (Ebola) Texas hospital's handling of a sick man and his family may have both explicit and implicit bias at play. Failure to follow protocol, staff negative statements about Liberia, absence of effective patient – provider communication, differential treatment efforts, threats of prosecution, and lack of cultural competence.

Considering the growing literature on Health Equity and the long standing efforts around the world for implementing Health in All Policies, I and others are adding the concept of 'equity' in the strategy of Health in All Policies. **Health Equity in All Policies.**

III. HEALTH EQUITY IN OPPORTUNITY

Two case studies:

In the US, two notable examples of the implementation of HiAP and including the concept of Health Equity, are found in King County, Seattle WA and throughout the state of California.

HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

King County, City of Seattle: "**Race and Social Justice Initiative: Three-Year Plan 2012-2014 To Advance Opportunity and Achieve Equity.**"[10]

* In 2005 no city in US had focused on institutional racism as a social challenge or as a goal for reducing its negative impact on society. Surprised finding!!!
* Many groups in Seattle seeking to address various problems faced by communities found that they shared a central theme, INEQUITIES, often followed racial lines. Twenty-five groups joined together for change. They noted that unconscious bias was built in institutions, in programs and in individuals. The Race and Social Justice Initiative (RSJI) was born in Seattle.
* The RSHI was launched across all departments, endorsed by all elected officials and staffed by an interdepartmental team.

10. Seattle government http://www.seattle.gov/Documents/Departments/RSJI/RacialEquityToolkit_FINAL_August2012.pdf

HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

Seattle: In-depth assessment by 2012 showed: contracting tripled purchasing dollars to women and minority-owned businesses; City employees trained on race and equity; expanded outreach to historically under-represented communities; and mandated interpretation and translation services.

- Developed an Outreach and Public Engagement Guide, 2009; use alternative methods for input and engagement; identify internal team for feedback; assess/manage impact on disparities; ensure transparency; and share decision-making;
- Employed three Equity strategies: (1) applying racial equity tools to programs and projects, (2) building racial equity into policies and citywide initiatives, and (3) partnering with other institutions and the community;
- Focused on housing, jobs, education, health, criminal justice, community development, and the environment.

Racial Equity Toolkit
to Assess Policies, Initiatives, Programs, and Budget Issues

Step by step. The Racial Equity Analysis is made up of six steps from beginning to completion:

Step 1. Set Outcomes.
Leadership communicates key community outcomes for racial equity to guide analysis.

Step 2. Involve Stakeholders + Analyze Data.
Gather information from community and staff on how the issue benefits or burdens the community in terms of racial equity.

Step 3. Determine Benefit and/or Burden.
Analyze issue for impacts and alignment with racial equity outcomes.

Step 4. Advance Opportunity or Minimize Harm.
Develop strategies to create greater racial equity or minimize unintended consequences.

Step 5. Evaluate. Raise Racial Awareness. Be Accountable.
Track impacts on communities of color overtime. Continue to communicate with and involve stakeholders. Document unresolved issues.

Step 6. Report Back.
Share information learned from analysis and unresolved issue with Department Leadership and Change Team.

How do I use this Toolkit?

Seattle government
http://
www.seattle.gov/
Documents/
Departments/RSJI/
RacialEquityToolkit_FIN

AL_August2012.pdf

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HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

California Health in All Policies Task Force, 2010: A governor's order established the Task force under the auspices of the Strategic Growth Council (SGC)and required facilitation by the CA state health department. Subject was climate change.[11]

Task Force developed key elements for Health in All Policies:
- (a) health, sustainability & equity,
- (b) intersectoral collaboration,
- (c) co-benefits: benefit multiple partners,
- (d) engage stakeholders, and
- (e) create structural or procedural change.

11. California Health in All Policies Task Force 2010

HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

Lessons learned in California:

- Health in All Policies is shorthand for Health, Equity and Sustainability in all policies;
- Addressing the social determinants of health is the shared purpose of Health in All Policies;
- Policy interventions often do not reduce health inequities without intentional efforts;
- The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it (collaboration) fails;
- The value of community-based knowledge is often overlooked, in understanding health inequities; with little true community input, programs are designed that do not fit **all of the target populations**;
- To evaluate inequities, data are needed at a granular level to reveal geographic pockets and subpopulations experiencing inequities.

Carlessia A. Hussein RN, DrPH
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HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

- Embedding (institutionalizing) HiAP in the structures and processes of government is a fundamental shift needed to achieve EQUITY: bill analyses, budget guidelines, state guidance documents, grant guidelines, grant writing teams, contract requirements, strategic planning, program evaluation are a few examples;

- De-siloing requires many ingredients; high levels of dedication from top leadership, integration of collaboration goals (infrastructure), shared commitment to policy goals, and responsiveness to stakeholders;

- Location, timing, and language of public hearings and workshops; absence of paid advocates, absence of health literacy, lack of familiarity with the process, and distrust of government <u>may impede</u> participation.

HEALTH EQUITY IN OPPORTUNITY
(CONTINUED)

California: Successful implementation of HiAP will require:
- Strong and <u>visionary leadership</u> with commitment to a whole government approach;
- Clearly articulated <u>vision of health</u> and healthy communities;
- Permanently and adequately funded lead organizational structure, located <u>at the chief executive level</u>;
- Legal mandates and <u>legislated</u> support;
- Robust and resourced community and stakeholder <u>engagement</u>, and;
- Conscientious and explicit prioritization of human well-being and development, health, equity and sustainability as <u>core responsibilities</u> and goals of government. [11]

11. California Health in All Policies Task Force 2010

Carlessia A. Hussein RN, DrPH
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Maryland – A State of Prosperity

Maryland

EQUITY IN OPPORTUNITY

FOR

EVERYONE

PROSPERITY

HEALTH

EDUCATION

TRANSPORTATION

HOUSING

EMPLOYMENT

2014 -- 2020

IV. EQUITY IN MARYLAND 2020
"EQUITY IN OPPORTUNITY FOR EVERYONE"

In Maryland and in communities throughout the nation, some people flourish while too many **struggle to achieve** a good quality of life.

The Marginalized:

- Lack a living wage, affordable housing, quality health care, safe neighborhoods, education, healthy environment, control over their destiny, and hope for the future;
- Live in neighborhoods burdened with inequities and struggling for survival, paving the way for intergenerational health inequities;
- Fail to achieve their potential and as a result, cannot support the next generation to rise up; the cycle regenerates;
- Are observed and labeled as hard to reach, at risk, vulnerable, disadvantaged, unmotivated, and non compliant. The well intentioned bring programs to help, seek volunteers (unpaid) to disseminate aid, promote healthy lifestyles (un-resourced), and collect data to report effort.

EQUITY IN MARYLAND 2020
"EQUITY IN OPPORTUNITY FOR EVERYONE"
(CONTINUED)

The Marginalized:

- Then illness strikes, they enter the ED, pray and wait for help. If lucky enough to be admitted to the hospital, they experience the best health care that western society has to offer;

- All too quickly they are discharged, back into the communities that bred poor health. They are given instructions for their 'support system' to aid with recovery. The health care system unaware that this individual is 'The Support System' for a host of others, not quite ready to go to the ED. The cycle continues. We soon may have, less than a 30 day re-admission;

- The plight of individuals struggling to survive impacts the larger society. The workforce is reduced, healthy volunteers are fewer, shortage of family supports, military eligibles are fewer, and a shortage of diverse inventors/artists/scientist/educators are present to advance society.

EQUITY IN MARYLAND 2020
"EQUITY IN OPPORTUNITY FOR EVERYONE"
(CONTINUED)

INVEST IN PEOPLE! Our most valued, widespread and available asset is the people in our neighborhoods and communities. To set as a societal policy, a true, thoughtful and measured investment in people could bring untold rewards.

VISION: *A Maryland where there is OPPORTUNITY EQUITY for everyone and where individuals, communities and organizations thrive.*

MISSION: *To achieve measurable progress in increasing OPPORTUNITY EQUITY in critical areas that support the quality of life for Marylanders, that is sustainable into future decades.*

EQUITY IN MARYLAND 2020
"EQUITY IN OPPORTUNITY FOR EVERYONE"
(CONTINUED)

OPPORTUNITY TARGETS:

- Education
- Employment
- **Well Prepared and Diverse Workforce**
- Clean Environment
- Public Safety
- Housing
- Criminal Justice with Equity
- Community Development
- Health

V VISIONING THE FUTURE "BUILDING OPPORTUNITIES AND EQUITY FOR ALL MARYLANDERS"

- Institute Health in All Policies throughout government at the state and local levels;
- Partner with academic and other researchers to identify the measurable benefits, value and critical elements in HiAP;
- **Top leadership take** unconscious bias training and self reflection exercises **and extend it down throughout the organization;**
- Integrate professional education in academic institutions to promote cultural competence, team work and affinity for working with diverse health care providers and workers;
- Establish diverse stakeholder groups that are representative of the varied recipients of services being planned; Populate the stakeholder group with at least 33% of target groups;
- Strive for transparency and effective communication (health literacy) with all parties to establish and maintain clarity on the goal, methodologies and progress.
- Maryland has the elements present in Californian and Seattle to move our institutions toward health equity and opportunity for all.

CLOSING

Malala Yousafzai

"My Dad Did Not Clip My Wings"

"Do Not Block Their Opportunities"