Policy Approaches to Advancing Health Equity

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Public health policy approaches have demonstrated measurable improvements in population health. Yet, "one-size-fits-all" approaches do not necessarily impact all populations equally and, in some cases, can widen existing disparities. It has been argued that interventions, including policy interventions, can have the greatest impact when they target the social determinants of health. The intent of this article was to describe how selected current policies and policy areas that have a health equity orientation are being used with the aim of reducing health disparities and to illustrate contemporary approaches that can be applied broadly to a variety of program areas to advance health equity. Applying a health equity lens to a Health in All Policies approach is described as a means to develop policies across sectors with the explicit goal of improving health for all while reducing health inequities. Health equity impact assessment is described as a tool that can be effective in prospectively building health equity into policy planning. The discussion suggests that eliminating health inequities will benefit from a deliberate focus on health equity by public health agencies working with other sectors that impact health outcomes.

KEY WORDS: equity lens, health disparities, health equity, health impact assessment, Health in All Policies, social determinants of health

Policy implementation has long been recognized as one of the important cornerstones of public health and, together with assessment and assurance, makes up the core functions of public health.[1] The US Centers for Disease Control and Prevention (CDC) defines policy as "a law, regulation, procedure, administrative action, incentive, or voluntary practice of governments and other institutions."[2] It further states that "health can be influenced by policies in many different sectors, e.g., transportation policies can encourage physical activity (pedestrian- and bicycle-friendly community design); policies in schools can improve nutritional content of school meals."[2]

Several policy approaches have demonstrated effectiveness at the level of the general population.[3] For example, several of what are considered the 10 greatest public health achievements of the 20th century are due, in part, to policies such as seat belt and child restraint laws and smoke-free policies.[4,5] However, policy interventions can impact communities differentially and, in some cases, can widen health disparities.[6] There is some evidence that "downstream" interventions, which focus on change at the individual level, are more likely to increase health inequality than are "upstream" interventions, which focus on social change or policy change.[6]

The intent of this article was to describe how selected current policies and policy areas that have a health equity orientation are being used with the aim of reducing health disparities and to illustrate contemporary approaches that can be applied broadly to a variety of program areas to advance health equity. To illustrate current federal efforts, we describe key federal policies and policy agendas aimed at reducing health disparities and point out where they intersect with state, local, and nongovernmental efforts. We argue that policies addressing differential access to living and working conditions needed for health may be more effective when health equity is the goal. To illustrate how such

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upstream strategies can be developed, we describe a CDC activity that uses the World Health Organization's (WHO's) Commission on the Social Determinants of Health model as a framework to generate strategies. We describe how applying an equity lens to the Health in All Policies (HiAP) approach can foster health equity and describe how an equity lens has been applied to the practice of health impact assessment (HIA) for more equitable impact. With the exception of our examples at the federal level, which we consider to be among the most prominent federal efforts to reduce health disparities, our policy examples were not chosen to reflect or even be representative of the universe of relevant policies; rather, they were chosen to be illustrative.

Policy Interventions to Reduce Health Disparities and Achieve Health Equity

The implementation of policies to reduce health disparities is a central feature of federally sponsored and supported health initiatives.[7] In 2010, passage of the Affordable Care Act (ACA) created an opportunity for millions of previously uninsured Americans to gain access to health care insurance, providing a potential opportunity to reduce disparities in health and health care.[8] In addition to increasing access to care, this landmark legislation included other needed provisions such as creating Offices of Minority Health at agencies of the US Department of Health and Human Services (HHS) to raise the level of focus on health disparities across operating divisions (ACA section 10334), strengthening workforce diversity (ACA sections 5402, 5404), and requiring nonprofit hospitals receiving community benefit tax exemptions to conduct community health needs assessments that incorporate community feedback (ACA section 9007). The community health needs assessments are intended to identify community health improvement projects that will improve health outcomes. The ACA called for a revision in national data collection standards outlined in section 4302; implementation guidance indicates that the "minimum data standards ... on race, ethnicity, sex, primary language, and disability status must be included in all population health surveys conducted or sponsored by HHS."[9] The minimum racial categories include American Indian or Alaska Native, Asian, black or African American, Native Hawaiian or other Pacific Islander, and white; and the minimum ethnicity categories are Hispanic or Latino and Not Hispanic or Latino. This revision facilitates more granular data collection, which allows for better identification of specific population health needs.

The ACA also created the National Prevention, Health Promotion, and Public Health Council—referred to as the National Prevention Council (NPC). This federal multijurisdictional effort is chaired by the US Surgeon General and comprises 20 federal departments including Agriculture, Health and Human Services, Housing and Urban Development, Defense, Education, and Transportation. Establishment of the NPC represents Congress' recognition that health is both affected and improved by more than the health care sector. The NPC enhances communication and coordination across federal departments and ideally supports decision making that promotes the nation's health. The National Prevention Strategy: America's Plan for Better Health and Wellness, released in 2011 by the NPC, includes priorities and actions that reflect multisector efforts to improve health and reduce health disparities.[10]

In a separate effort, the National Partnership for Action to End Health Disparities and its complementary components—the HHS Action Plan to Reduce Racial and Ethnic Health Disparities and the National Stakeholder Strategy for Achieving Health Equity—engage federal, state, and local partners to work toward reducing racial and ethnic health disparities.[11] While the HHS Action Plan to Reduce Racial and Ethnic Health Disparities lays out the federal government's commitment to actions to reduce disparities, the National Partnership for Action to End Health Disparities is the first actual roadmap provided by the federal government for reducing health disparities, outlining goals for all health agencies within HHS, in partnership with state and local jurisdictions, including Regional Health Equity Councils.[11]

Further evidence of the federal commitment to eliminating health disparities and achieving health equity is found in *Healthy People 2020*, the nation's health objectives, which included for the first time in its 40-year history a topic area devoted to the social determinants of health.[12] The topic area is organized around 5 domains: Economic Stability, Education, Health and Health Care, Neighborhood and Built Environment, and Social and Community Context.[12]

In addition to specific provisions within the ACA that support reducing health disparities, the National Partnership for Action to End Health Disparities, and *Healthy People 2020*, other policy levers, including Executive Orders (EO), have been employed to address specific goals of eliminating health disparities at the national level. Executive Orders are directives issued by the President of the United States regarding operations of the Executive Branch.[13] To address factors contributing to health disparities, for example, Executive Orders have been used to improve language access to services since 2000 (EO 13166) and increase diversity and inclusion in the federal workplace since 2011 (EO 13583).

At the state and local levels, the Public Health Accreditation Standards, which are used to guide the public health department accreditation process, include standards for the integration of health equity into the work of governmental departments of public health. Revised standards, released in December 2013, emphasize a focus on specific populations with greater health risks, inclusion of such populations in state or community health assessments, and consideration of addressing the social determinants of health in community health improvement processes.[14]

While it is beyond the scope of this article to comprehensively describe the numerous and varied policy efforts at federal, state, and local levels to address health inequities, we have documented that policy is integral to public health efforts to achieve health equity, as well as address specific risk factor disparities. Although disease- and risk factor–specific policies are needed, a broader approach to policy that includes societal conditions can help address factors leading to health inequities—differences in health that are avoidable and unfair—across a broad range of outcomes and populations.[15] It has been argued that interventions, including policy interventions, can have the greatest impact when they target socioeconomic factors and can have greater impact on outcomes than other types of interventions.[16]

Addressing the social determinants of health is increasingly understood as necessary if population health is to be improved and health inequities are to be eliminated. This task is often described as "policy, systems, and environment change," an approach that expands the focus beyond health behaviors and clinical services.[17] Associations between community and societal contexts and individual and family health status are generally understood within the field of public health, and the commonly used socioecological model[18] has been an important tool for communicating these relationships. For example, resources such as the CDC Practitioner's Guide for Advancing Health Equity focus on specific policies used by communities, in combination with other interventions that can be effective in reducing disparities.[19] The Institute of Medicine's Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities also examined how issues such as race and racism, residential segregation, and lack of community infrastructure influence the environments that impact health and recommend a focus on these influences in the development of policies to address health disparities.[20]

Growing attention to the ethical and practice imperatives for pursuing health equity in public health is gaining traction in the public and private sectors.[21] However, addressing health inequities requires understanding how *systematic* differences in social conditions and processes effectively influence health.[22] Without a solid understanding of these conditions and processes, the concept of social determinants can be overgeneralized and efforts to address health inequities will be limited and run the risk of not achieving the expected impact on the community's health.

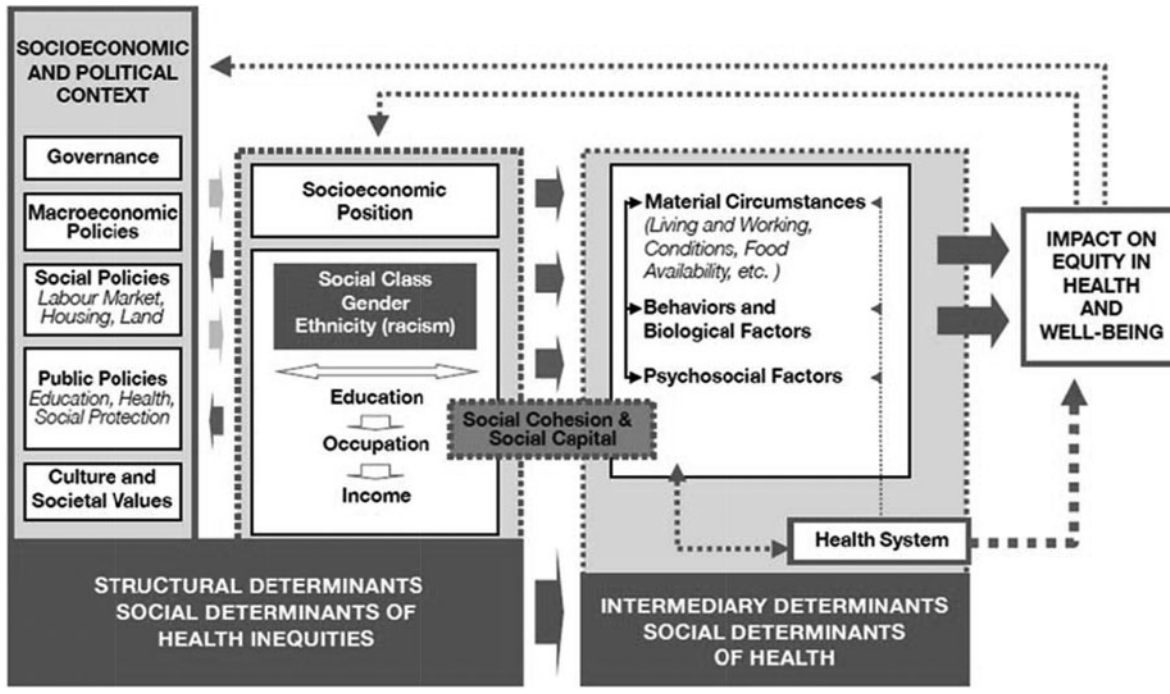
Applying a Social Determinants of Health Framework to Policies to Achieve Health Equity

To support the development of effective action, the WHO's Commission on Social Determinants of Health (CSDH), a global collaboration of policy makers, researchers, and civil society members, proposed a comprehensive framework for understanding and addressing the social determinants of health inequities[23] (see Figure).

The CSDH framework draws on many models that preceded it but provides needed specificity to inform in-depth explorations of the mechanisms and pathways through which structural policies and processes contribute to differential exposure, differential vulnerability, and, consequently, differential health outcomes. Briefly, the main domains of the CSDH framework are as follows:

- *Structural determinants: Socioeconomic political context*. The structural, cultural, and functional policies and processes that shape how societies are organized—governance structures, macroeconomic policies, social policies, public policy, culture and societal values, and epidemiologic conditions.
- *Structural determinants: Socioeconomic position*. This domain describes how structural policies and processes interact to effectively assign socioeconomic position based on social characteristics (eg, race/ethnicity, gender) through more or less access to essential resources including education, occupation, social class, and income.
- *Intermediary determinants*. Broadly encompassing living and working conditions, this domain also includes psychosocial, behavioral, and biological characteristics, as well as the health system.
- *Crosscutting determinants (on the framework, social capital, and social cohesion)*. This domain acknowledges human agency and the role of people in the shaping of policies and processes that effectively determine how societies are organized.
- *Health equity*. The comparison of the health of populations based on hierarchies of social advantage and disadvantage (eg, race/ethnicity, income, gender).

FIGURE ● Policy Approaches to Advancing Health Equity[a]



[a]Reprinted with permission from Solar and Irwin.[23]

The CSDH framework seeks to explain how the differential impact of structural policies and processes influences socioeconomic position based on race, ethnicity, gender, and other social categories, and how this positioning creates vulnerability through more or less access to living and working conditions needed for health.[23] An understanding of this difference between structural and intermediary determinants is needed to set reasonable expectations for outcomes. For example, interventions addressing intermediary determinants may improve the situations of those currently living in vulnerable conditions. However, addressing the structural determinants that give rise to these conditions in the first place is necessary to ensure equitable, sustainable opportunities for health and safety over the life course and over generations.[24] Finally, and importantly, the framework accounts for human agency in the generation of structures, policies, and processes that create and distribute life chances and opportunities for health by emphasizing the need to include groups historically and currently excluded from societal decision-making processes that impact their health and life opportunities.[24] The distinction between the determinants (eg, macro-level policies) and the processes that give rise to their distribution (eg, social and political power) is critical for the development of effective actions to eliminate health inequities.

A consideration of the evidence of the impact of policies on the determinants laid out in this framework reveals evidence in some areas, but that gaps remain. The impact of certain types of policies on social determinants has been well documented, such as in the areas of affordable housing, and some education interventions. For example, evidence of the impact of affordable housing on health demonstrates health benefits ranging from freeing up resources for food and health care, reducing stress through stability, improving mental health through greater control over one's environment, reducing environmental problems caused by poor quality housing, and providing stable linkages to community services, such as mobility services for seniors.[25]

The evidence base for the impact of educational policies on health equity is growing. In its systematic review of education interventions, the US Community Preventive Services Task Force found the following interventions effective in improving the health prospects of low-income and racial and ethnic minority children: full-day kindergarten programs and high school completion programs for students at high risk for noncompletion.[26] However, evidence of effectiveness of policies in other areas of health equity is less well-known and must be further researched. Challenges to understanding how policy can effectively address the

social determinants of health include the complexity of the context, the length of time needed to demonstrate impact, the difficulty in navigating interorganizational and intersectoral partnerships needed, and competing priorities of less complexity.[27]

An Example of Using the CSDH Framework to Explore Health Inequalities: Child Abuse and Neglect

The CSDH framework can be used as a practical tool to inform public health research and practice. For example, the CDC's Division of Violence Prevention (DVP) has used the framework to explore mechanisms and pathways potentially contributing to the differential burden of child abuse and neglect.[28] Following is a brief overview of this exploration.

DVP is working to ensure that no child ever experiences abuse or neglect. To achieve this goal, it is critical to understand why some children are at greater risk than others. Estimates of child abuse and neglect vary depending on the source, definitions, and measures. Although the National Incidence Study[28] underestimates the incidence of child abuse and neglect relative to self-report data,[29] it is useful in that it disaggregates the data by race/ethnicity and socioeconomic status to understand the distribution of the burden. While all children may be at risk for abuse or neglect, all children do not have the same risk: African American children are nearly twice as likely as white children to experience abuse and neglect, and children living in families with low incomes have nearly 5 times greater risk of abuse and neglect than children living in families with higher incomes.[30]

Some part of this differential burden may be attributable to parental/caregiver education level or limited parenting skills; the fact that children living in low-income families are far more likely to experience abuse and neglect raises important questions about how the conditions in which some parents and caregivers are raising children may contribute to greater risk for harm. Examining the intermediary determinants domain, it is known that living and working conditions associated with increased risk for child abuse and neglect include poverty or low family income,[31] parental unemployment,[32] residential instability,[33] high poverty neighborhood,[34,35] and high violence neighborhood.[34,35]

Given the relationship between living and working conditions and risk for child abuse and neglect, it is important to understand how access to these conditions is achieved and why some families are less likely than others to have the opportunity to raise their children in healthy environments. Examining the socioeconomic position domain, examples of education, occupation, and income patterns potentially contributing to more or less access to conditions needed for health include lower high school completion rates among African Americans and Latinos than among whites[36] and among people living in poverty than among those not living in poverty,[36] overrepresentation of minority racial and ethnic groups in service sector and low-paying jobs,[37] higher risk for unemployment among people without a high school diploma than among college graduates,[38] higher risk of poverty for African Americans and Latinos,[39] higher wealth in white households than in black and Hispanic households,[40] and gender wage inequities at all education levels.[41]

Understanding how socioeconomic patterns may be shaped by structural policies and processes is important to the overall goal of improving conditions for health and safety. A few examples of structural determinants that may be contributing to these socioeconomic patterns include the following: *education*—less funding for schools in districts with a high concentration of poor students than low poverty school districts[42]; *labor market*—discriminatory hiring practices[43,44]; *housing*—increased risk for high-risk, high-cost loans by race/ethnicity within the same income groups[45]; and *justice*—differential sentences for drug offenses based on race/ethnicity.[46]

This brief exploration provides an understanding of how structural policies and societal processes can cluster, systematically limiting access to conditions needed for health. It shifts the narrative around child abuse and neglect from "bad parents" to parents raising children in stressful, unhealthy conditions. The excessive stress experienced by families and communities dealing with several or all of these compounding obstacles no doubt places children at greater risk for abuse and neglect. These societal obstacles cannot be solved by families on their own.

The CSDH framework has also been used as an assessment tool to map existing DVP child abuse and neglect prevention activities that identified critical work primarily in the intermediary determinants domain including behavioral interventions and health systems changes. More recently, DVP's child abuse and neglect prevention activities have expanded to include an evaluation of structural policies that contribute to differential risk for child abuse and neglect[47] and support for state partnerships to promote positive development of children and families.[48] These efforts are part of *Essentials for Childhood: Assuring Safe, Stable, Nurturing Relationships and Environments for All Children*, DVP's unifying vision and strategic approach to preventing child maltreatment.[48]

More broadly, efforts to address the intermediary and structural determinants of health inequities are growing among community organizations, state and local health departments, and other organizations.

A recent publication by the National Association of County & City Health Officials, *Expanding the Boundaries: Health Equity and Public Health Practice*, provides important perspectives for developing new approaches and new partnerships to address health inequities; brief case studies from local and state health agencies; and elements of emerging practices, including reframing relationships with communities to address health inequities.[49] Additional examples of experiences employing these approaches are needed to contribute to an evidence base from which practitioners can draw to address structural and intermediary determinants of health and health inequities.[50]

Addressing Health Equity Through HiAP Approaches

One approach to addressing social determinants of health within the context of the CSDH framework is HiAP. HiAP has been defined as "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity."[51(pi2)] Underlying the HiAP approach is the premise that, because many of the influences on health come from outside of the health sector, partnership with other sectors is needed.[52] Globally, in 2013, the Helsinki statement called for the WHO to support Member States and provided recommendations to national governments in the implementation of HiAP. Among these is a commitment to health and health equity as a political priority and the inclusion of communities, social movements, and civil society.[53] The WHO has since provided guidance and is monitoring best practices of global HiAP efforts.[54]

HiAP is an approach to decision making that recognizes public policies have the potential to influence health equity either positively or negatively.[55] To achieve a result that advances health equity, an explicit focus on equity is necessary. Some implementers of HiAP note implementation challenges when embracing an equity lens, including opposition to directing resources to poor communities and communities of color.[56] However, benefits have also been identified and include a change in values across sectors leading to a greater understanding of the value of equity and the importance of an equity focus.[56]

Role of Health Equity Impact Assessment

HIA has been described as way to make clear the link between policies in social sectors, those targeted by a HiAP approach, and health.[57] The National Research Council of the National Academies defines HIA as:

> a systematic process that uses an array of data sources and analytic methods and considers input from stakeholders to determine the potential effects of a proposed policy, plan, program, or project on the health of a population and the distribution of those effects within the population. HIA provides recommendations on monitoring and managing those effects.[58(p5)]

Similarly, health equity impact assessments (HEIA) employ methodologies to determine the outcomes and benefits of proposed or existing policies and explicitly assess, through an equity lens, what groups or individuals are differentially impacted by the outcomes and seek to prospectively build health equity into policy planning.[59] Like HIA, HEIA requires the involvement of the groups impacted by policies in identifying needs, barriers, challenges, as well as potential solutions,[59] which, for traditional HIA, continue to prove challenging.[60]

Both HIA and HEIA differ in that HIA methodology, when not explicitly addressing equity, may lack sufficient guidance and definitions and therefore omit important values such as fairness and social justice.[61] To acknowledge the explicit inclusion of equity as a core value of an HIA, a set of equity indicators has been developed by the Society of Practitioners of Health Equity Impact Assessment.[62]

Examples of a national HiAP effort

Within the United States, the NPC was charged with the development of a strategy for advancing health and prevention. The National Prevention Strategy: America's Plan for Better Health and Wellness includes the elimination of health disparities as a strategic direction and makes 5 recommendations for reducing disparities[63]:

1. Focus on communities at greatest risk;
2. Increase access to quality health care;
3. Increase workforce capacity to address disparities;
4. Support research to identify effective strategies to eliminate disparities; and
5. Standardize and collect data to better identify and address disparities.

Within the more than 200 implementation steps included in the NPC Action Plan,[63] several explicitly address health disparities:

- Support and expand cross-sectoral activities to enhance access to high-quality education, jobs, economic opportunity, and opportunities for healthy living (eg, access to parks, grocery stores, and safe neighborhoods).

- Identify and map high-need areas that experience health disparities and align existing resources to meet these needs.
- Increase the availability of de-identified national health data to better address the needs of underrepresented population groups.
- Develop and evaluate community-based interventions to reduce health disparities and health outcomes.
- Support policies to reduce exposure to environmental and occupational hazards, especially among those at greatest risk.
- Support and expand training programs that bring new and diverse workers into the health care and public health workforce.
- Support health center service delivery sites in medically underserved areas and place primary care providers in communities with shortages.
- Increase dissemination and use of evidence-based health literacy practices and interventions.

Complementary to efforts in the global arena, the NPC and National Prevention Strategy provide an organizing framework for a domestic US agenda that supports a HiAP approach at the national, state, and local levels.

Example of a state HiAP effort

California's HiAP Task Force, created by Executive Order in February 2010, was charged with recommending programs, policies, and strategies to improve the health of Californians while advancing the goals of the state's Strategic Growth Council including "improving air and water quality, protecting natural resources and agricultural lands, increasing the availability of affordable housing, improving infrastructure systems, promoting public health, planning sustainable communities, and meeting the State's climate change goals."[64(p9)] In 2013, California's Health and Safety code was amended through section 131019.5 to explicitly address the health status of all populations, with a priority on eliminating health and mental health disparities and inequities.[65] In coordination with the HiAP Task Force, the new requirements include a special focus on populations that have experienced socioeconomic disadvantage and historical injustice. This amendment made explicit the state's commitment to addressing disparities using the tools of governance. Through these governmental processes, the state has set aspirational goals, developed a Healthy Communities framework, prioritized an indicator project, and conducted root-cause mapping. Accomplishments of the HiAP Task Force that impact equity include but are not limited to the creation of a Farm to Fork Office; a housing siting and air quality work group; crime prevention through environmental design; and school siting guidance.[66]

Example of a local HiAP effort

In an effort to address social inequities such as varying school enrollment rates, increased incarceration of youth of color, and differing child mortality rates between white and native American children within King County, Washington, county leaders decided to actively consider health across all departments and develop an infrastructure within local government to support this priority. Similar to the statewide effort in California, King County's Ordinance 16948 uses the authorities of governance to address disparities, establishing implementation steps, and identifying 14 determinants of equity for county leaders to address the following: affordable, safe, quality housing; quality education; access to health and human services; healthy built and natural environments; family wage jobs and job training; early childhood development; economic development; strong, vibrant neighborhoods; access to safe and efficient transportation; community and public safety; equitable law and justice system; access to affordable, healthy, local food; equity in county practices; and access to parks and natural resources.[67] The county reports annually, and the Office of Performance, Strategy and Budget holds all agencies accountable for equity and social justice impacts in budgets and business plans, and all supervisors and managers are required to attend trainings on the social determinants of health to increase awareness of the health impacts of their work. Effective community engagement strategies that encourage participation in decision-making processes that impact health are a cornerstone of the King County initiative.[68]

The adoption of HiAP models within the United States is occurring at the local, state, and national levels. To date, research on, and evaluation of, HiAP approaches is limited.[69,70] Given the nascent nature of this work, application of models such as those described may contribute to and build an evidence base for the value or contributions of such approaches. Yet, research on intersectoral action is needed to understand the context in which it occurs, the critical success factors that lead to measurable change, and the barriers to success. In instances where the inclusion of health equity is made explicit, in addition to research, there is likely value in building tacit knowledge through the sharing of success characteristics and impacts, particularly those found to reduce health disparities.[71]

Conclusion

National policy levers, such as Executive Orders, professional standards, and legislation, are currently

being used to focus on eliminating health disparities and achieving health equity.[14,15] These efforts suggest that, despite improvements in increasing access to health care, progress in access alone is not likely to bring about the changes needed to achieve health equity. A social determinants of health framework, with a health equity lens, can identify where structural factors and intermediary determinants play an important role in shaping the conditions for health and health equity and when policy interventions can be instrumental in reducing inequities in health.[72] Because many of these determinants occur outside the realm of public health, a HiAP approach can be used to create cross-sectoral initiatives to improve population health and reduce health inequities. Our discussion here suggests that reducing health inequities will require a deliberate focus on health equity on the part of departments of public health and other public health agencies, as well as other sectors impacting health. Tools cited in this article have been developed by scholars and practitioners engaged in social determinants of health and HiAP approaches. These tools—and the experiences upon which they are based—can be helpful in advancing such efforts at the state and local levels.

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