Health Disparities, Social Determinants of Health, and Health Equity

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Disclaimer

The findings and conclusions in this presentation are those of the author and do not necessarily represent the official position of the Centers for Disease Control and Prevention.
Imagine this…

- Mid-size city of ~300,000 people
- About 200 miles north of the Mason-Dixon line
- High rates of type 2 diabetes, obesity, HIV infection, deaths due to heart disease and strokes
- Median income: ~$35,000/year
- High school dropout rates are >60% for boys
- Unemployment: >15%
Imagine this...

- End of summer celebration with your college roommate
- Southeastern U.S.
- Upscale stores
- Bike lanes, walking trail, parks
Presentation Objectives

- Provide a brief overview of OMHHE.
- Share why health equity is important to public health.
- Describe our Operating Principles for Advancing Health Equity.
- Contribute to the tools available to public health practitioners to pursue health equity.
REACHING FOR Health Equity

A world where all people have the opportunity to attain the best health possible.
Advance health equity and women’s health issues across the nation through CDC’s science and programs, and increase CDC’s capacity to leverage its diverse workforce and engage stakeholders toward this end.
OMHHE Priorities

- Focus on solutions for reducing health disparities, improving women’s health, and ensuring a diverse and inclusive public health workforce.
- Facilitate the implementation of policies and strategies across CDC that promote the elimination of health disparities in communities of highest risk.
- Advance the science and practice of health equity.
- Collaborate with national and global partners to promote the reduction of health inequalities.
Health Disparities, Social Determinants of Health, and Health Equity

Old Challenges and New Opportunities
The Heckler Report

In 1985, the United States Department of Health and Human Services (HHS) released a landmark report which documented the existence of health disparities among racial and ethnic minorities in the United States and called such disparities "an affront both to our ideals and to the ongoing genius of American medicine."

From HHS, OMH, History of the Office of Minority Health at http://www.minorityhealth.hhs.gov/omh/

# Conceptualizations of the Social Determinants of Health

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Adapted from: Dennis Raphael (2011) *A discourse analysis of the social determinants of health, Critical Public health, 21:2, 221-236*
Defining health disparities

Health disparities are differences in health outcomes and their determinants between segments of the population, as defined by social, demographic, environmental, and geographic attributes.

Truman BI et al. Rationale for regular reporting on health disparities and inequalities—United States. MMWR Surveill Summ. 2011;60(suppl):3-10.
Health disparities...

Adversely affect groups of people who have systematically experienced greater obstacles to health based on their:

- racial or ethnic group;
- religion;
- socioeconomic status;
- gender;
- age;
- mental health;
- cognitive, sensory, or physical disability;
- sexual orientation or gender identity;
- geographic location; or
- other characteristics historically linked to discrimination or exclusion.
Defining health inequities

A health inequity is a health difference or disparity that is:

- Systematic
- Unfair
- Avoidable


Defining health inequalities

Health inequalities, which is sometimes used interchangeably with the term health disparities, is more often used in the scientific and economic literature to refer to summary measures of population health associated with individual – or group-specific attributes (e.g., income, education, or race/ethnicity).

Truman BI et al. Rationale for regular reporting on health disparities and inequalities—United States. MMWR Surveill Summ. 2011;60(suppl):3-10.
Defining social determinants of health

Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Healthy People 2020 Social Determinants of Health
Defining health equity

- Health equity is the attainment of the highest level of health for all people.
- Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

U.S. Department of Health and Human Services
Arriving at health equity

1. **Problem**: Health Disparities
2. **Pathway**: Social Determinants of Health
3. **Goal**: Health Equity
Why is health equity important?
How poverty and food insecurity make people sick

#DailySnippet: 1 in 6 American families live in food insecure households.

Green spaces have lasting positive effect on well-being

The Living Wage Gap: State by State
Uninsured: Adults aged 18-64

NOTE: Preliminary estimates for the first 6 months of 2015 are shown with a dashed line.

SOURCE: CDC/NCHS, Health, United States, 2015, Figure 26. Data from the National Health Interview Survey (NHIS).
Disparities in Heart Disease and Stroke in the U.S.

- Nearly 50 percent of black men and women have some form of cardiovascular disease\(^1\).
- Blacks are nearly twice as likely as whites to die early from heart disease and stroke\(^2\).
- These avoidable deaths are defined as deaths from an underlying cause of heart disease, stroke, or hypertension among decedents under the age of 75.

Diabetes

Age-Adjusted Percentage of Civilian, Non-Institutionalized Population with Diagnosed Diabetes, by Race/Ethnicity, United States, 1980–2015

Data Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, data from the National Health Interview Survey.

Notes: People of Hispanic origin may be of any race. The race groups include people of both Hispanic and non-Hispanic origin. Prevalence estimates were age-adjusted using 2000 U.S. population as the standard. Prior to 1997, data were insufficient to estimate prevalence for Hispanics and Asians.
Obesity: Non-Hispanic White Adults

Prevalence of Self-Reported Obesity Among Non-Hispanic White Adults by State and Territory, BRFSS, 2013-2015

Source: Behavioral Risk Factor Surveillance System

*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥30%
Obesity: Hispanic Adults

Prevalence of Self-Reported Obesity Among Hispanic Adults by State and Territory, BRFSS, 2013-2015

Source: Behavioral Risk Factor Surveillance System

*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥30%
Obesity: Non-Hispanic Black Adults

Prevalence of Self-Reported Obesity Among Non-Hispanic Black Adults by State and Territory, BRFSS, 2013-2015

Source: Behavioral Risk Factor Surveillance System

*Sample size <50 or the relative standard error (dividing the standard error by the prevalence) ≥30%
Cancer: Incidence

All Cancers Sites Combined, Incident Rates* by Race and Ethnicity, U.S., 1999–2012¶Ɨ§

Abbreviations: AI/AN = American Indian/Alaska Native; A/PI = Asian/Pacific Islander.

Sources: CDC’s National Program of Cancer Registries and National Cancer Institute’s Surveillance, Epidemiology, and End Results program.

Rates are the number of cases per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130). For more information, see USCS technical notes (available at http://www.cdc.gov/cancer/npcr/uscs/technical_notes/index.htm).

§ Invasive cancer excludes basal and squamous cell carcinomas of the skin except when these occur on the skin of the genital organs, and in situ cancers except urinary bladder.

† Race categories are not mutually exclusive from Hispanic origin. Rates are not presented for persons of unknown or other race. Data for specified racial or ethnic populations other than white and black should be interpreted with caution. For more information, see USCS technical notes (available at http://www.cdc.gov/cancer/npcr/uscs/technical_notes/index.htm).

¶ Data are compiled from cancer registries that meet the data quality criteria for all invasive cancer sites combined for all years, 1999–2012 (covering approximately 92% of the U.S. population). See registry-specific data quality information for all years, 1999–2012 (http://www.cdc.gov/cancer/npcr/uscs/data/00_data_quality.html). Use caution when comparing incidence and death rates because of potential differences in population coverage. Behavior recode for analysis used for 1999-2012 individual years.
Cancer: Death Rates

All Cancers Sites Combined, Death Rates* by Race, and Ethnicity, U.S., 1999–2012

Abbreviations: AI/AN = American Indian/Alaska Native; A/PI = Asian/Pacific Islander.

*Rates are the number of deaths per 100,000 persons and are age-adjusted to the 2000 U.S. standard population (19 age groups – Census P25–1130). For more information, see USCS technical notes (available at http://www.cdc.gov/cancer/npcr/uscs/technical_notes/index.htm).

†Race categories are not mutually exclusive from Hispanic origin. Rates are not presented for persons of unknown or other race. Data for specified racial or ethnic populations other than white and black should be interpreted with caution. For more information, see USCS technical notes (available at http://www.cdc.gov/cancer/npcr/uscs/technical_notes/interpreting/race.htm).

§Data are from the National Vital Statistics System (NVSS). Data for death rates cover 100% of the U.S. population. Use caution when comparing incidence and death rates because of potential differences in population coverage.
HIV Diagnoses

Diagnoses of HIV Infection among Adults and Adolescents, by Race/Ethnicity, 2010-2014 – United States and 6 Dependent Areas

Note. Data include persons with diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.

Hispanics/Latinos can be of any race.

A Framework for Action to Advance Health Equity

Operating Principles
Health Disparities Subcommittee Recommendations

- Develop a CDC framework for action to achieve health equity.
- Identify and monitor indicators of health equity.
- Align universal interventions that promote better public health, with more targeted, culturally tailored interventions in communities at highest risk to reduce health disparities and achieve health equity.
- Support the rigorous evaluation of both universal and targeted interventions and, where indicated, the use of strategies, to establish best practice approaches to reduce health disparities and achieve health equity.
- Build community capacity to implement, evaluate, and sustain programs & policies that promote health equity, especially in communities at highest risk.
- Support training and professional development of the public health workforce to address health equity.
Paving the Road to Health Equity

Health Equity
is when everyone has the opportunity
to be as healthy as possible

Programs
Successful health equity strategies

Measurement
Data practices to support the advancement of health equity

Policy
Laws, regulations, and rules to improve population health

Infrastructure
Organizational structures and functions that support health equity
Operating Principles: Measurement

- Identify characteristics of groups of people associated with more/less power and privilege or higher/lower social position
- Measure change over time
- Compare multiple social statuses
- Assess social and structural determinants of health
- Specify methodological choices
- Consider stakeholder communication needs when selecting analytic methods
Operating Principles: Essential Program Elements

- Consider socio-demographic characteristics
- Understand evidence base for health disparities and inequities
- Leverage multi-sectoral collaboration
- Mobilize community engagement
- Use clustered interventions, engage with communities
- Plan and evaluate rigorously
Operating Principles: Policy

- Maximize existing national policy strategies
- Use a SDOH framework to analyze problem and generate policy options
- Develop a Health in All Policies (HiAP) framework
- Use Health Equity Impact Assessment as a tool to get to HiAP
Operating Principles: Infrastructure

- Develop/maintain culturally and linguistically competent workforce
- Develop appropriate data systems
- Assure accountability at high levels of the organization
- Effective and consistent leadership at high levels of the organization
Other Federal, National, and Global Initiatives Advancing Health Equity

- CLAS Standards (National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care): [http://minorityhealth.hhs.gov/omh](http://minorityhealth.hhs.gov/omh)
- CDC Social Determinants of Health Website: [http://www.cdc.gov/socialdeterminants](http://www.cdc.gov/socialdeterminants)
Triple Aim of Health Equity

Implement Health in All Policies

Strengthen Community Capacity

Expand Understanding of Health

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

National Collaborative for Health Equity

Working with people, partners, and purpose

Prevention Institute

Prevention and equity at the center of community well-being

Structural Drivers

1. Social networks & trust
2. Participation & willingness to act for the common good
3. Norms & culture
4. What's sold & how it's promoted
5. Look, feel & safety
6. Parks & open space
7. Getting around
8. Housing
9. Air, water & soil
10. Arts & cultural expression
11. Education
12. Living wages & local wealth
For more information, contact CDC
1-800-CDC-INFO (232-4636)

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