Public Health

“Public health is what we, as a society, do collectively to assure the conditions in which (all) people can be healthy.”

Institute of Medicine (1988), Future of Public Health
What is health?

“Health is a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity.”

“Health is a resource for everyday life, not the objective of living.”

World Health Organization 1948, 1986
Health occurs in a context
Healthy Minnesota 2020

All people in Minnesota enjoy healthy lives and health communities.

- Capitalize on the opportunity to influence health in early childhood
- Strengthen communities to create their own healthy futures
- Assure that the opportunity to be healthy is available everywhere and for everyone
Seeing a wider set of relationships to advance health equity:

- Health
- Capacity to Act
- Living Conditions
What does “health equity” mean?

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

• A health disparity based in inequitable, socially-determined circumstances. Because health inequities are socially-determined, change is possible.
Structural inequities

- Structures or systems of society — such as finance, housing, transportation, education, social opportunities, etc. — that are structured in such a way that they benefit one population unfairly (whether intended or not).
Health equity and structural racism:

• Structural racism is the normalization of an array of dynamics — historical, cultural, institutional and interpersonal — that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color and American Indians.
Health inequities in Minnesota are significant and persistent, especially by race:

In Minnesota, an African American or Native American infant has more than twice the chance of dying in the first year of life as a white baby.
What needs to be done

• Achieving health equity requires valuing everyone with focused and ongoing efforts to address avoidable systematic inequalities, historical and contemporary injustices, and the elimination of health and health care disparities.
Forces for Change

People

Resources

Narrative
Health Equity Report

• Summarize data on disparities and health equity
• Identify policies, processes and systems
• Recommendations for MDH
• Identify best practices
• Recommendations for data to document and monitor and evaluate – accountability
Equity in health outcomes requires:

• 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.
Seven AHE Recommendations

• Adopt a “health in all policies” approach

• Change MDH grant making

• Strengthen data collection and analysis
Seven AHE Recommendations

• Continue efforts that work
• Provide statewide leadership
• Strengthen community relationships
• Make health equity an emphasis
Tensions

• Parts and the whole
• Past and the future

Other:

Terms and Concepts
Bad and good
Best practice and paradigm shift
Accountability and innovation
Next Steps

• Establish the Minnesota Center for Health Equity

• Convene and coordinate a cabinet-level health equity and health in all policies effort

• Begin the process of implementing the recommendations

• Supporting internal efforts
Angela Pope, JD
Health Policy Coordinator
Minnesota Department of Health
Office of Statewide Health Improvement Initiatives
Statewide Health Improvement Program (SHIP)

• MN Healthcare Reform
• Reduce healthcare costs
• Goal is to help Minnesotans live longer, healthier, better lives by preventing risk factors that lead to chronic disease
• Funds local public health
• Focus on policy, systems, and environmental changes VS. programmatic
Health Inequities in MN

• Profound and persistent inequities in health, housing and homeownership, employment, education, and socioeconomic status among racial/ethnic groups compared to whites.

• Populations of color in Minnesota experience significantly higher rates of chronic and infectious diseases and premature death, as well as lack of health insurance coverage.
In 2013, the SHIP statute was amended to include health equity language:

- **Grantee activities shall address the health disparities and inequities that exist in the grantee’s community**

- **Award contracts to provide technical assistance and training in the area of health equity**
Reasons for Addressing Health Equity

• Restore funding to the Statewide Health Improvement Program
• Changing demographics
• Economic issue & healthcare costs
• Healthy Minnesota 2020 and Health in All Policies
• Disinvestment in populations experiencing health disparities
Office of Statewide Health Improvement Health Equity Team

- Create a powerful health equity vision for OSHII
- Integrate a health equity lens to SHIP
- Identify opportunities to engage the community and foster partnerships
- Operationalize health equity within OSHII
- Capacity building
Office of Statewide Health Improvement Health Equity Team
2012 - 2013

- Integrated Health Equity into SHIP 3
  - Developed Health Equity Framework for SHIP 3
  - RFP health equity requirements
  - SHIP Health Equity Implementation Guide
- Developed the Health Equity Coordinator position description
- Identified Health Equity TA/Training needs
- Convened two MDH Health Equity Community Stakeholder Meetings

7/10/2014
Angela Pope, JD - MDH, Office of Statewide Health Improvement Initiatives
Reflections: The Challenges

- Common understanding of health equity, definition of health equity, and health equity lens
- Leading the effort while learning at the same time
- Theory versus Practice
- Time and Timelines
- Staff engagement
- Work not in isolation of other MDH divisions and trying to maintain uniformity and promote cross-collaboration
Reflections: Lessons Learned

- Achieving health equity is a slow and tedious process
- A dedicated team that is multi-diverse and multi-disciplinary is GOLD
- Engage stakeholders and leadership across the department/organization
- Transparency is crucial
- Create a safe space and address discomfort
- Burnout is real. It is okay to step away and reassess the situation.
- Internal practices must reflect external messaging
- Formulate mechanisms of sustainability and accountability
Lessons Learned: Barriers to Health Equity

• **Co-Option** - To adopt (an idea or work) for one's own use. Also happens with community participation when local representatives are chosen, but have no real input or power.

• **Colorblindness** - Colorblindness is the racial ideology that posits the best way to end discrimination is by treating individuals as equally as possible, without regard to race, culture, or ethnicity.
Lessons Learned: Barriers to Health Equity

- **Tokenism** - The practice of doing something only to prevent criticism and give the appearance that people are being treated fairly.

- **Paternalism** - The attitude or actions of a person, organization, etc., that protects people and gives them what they need but does not give them any responsibility or freedom of choice.
Lessons Learned: Barriers to Health Equity

• **Turf Protection** - Guarding what you see as your rightful control over an issue, a funding source, a job function, or other area, even when sharing that control could both make your job easier and make your efforts more effective.
Parting Words of Wisdom…

“It really boils down to this: that all life is interrelated. We are all caught in an inescapable network of mutuality, tied into a single garment of destiny. Whatever affects one directly, affects all indirectly.”

- Martin Luther King Jr.
Donna McDuffie MPH, CPH, RDN, LN
State Nutrition Coordinator
Minnesota Department of Health
Office of Statewide Health Improvement Initiatives
Health Equity on the Ground

Closing the gap
Snapshot Minnesota
Demographics
Minnesota Child Health Indicators

Percentage of population aged 0-24, Minnesota 2008

- Age 0 to 24 years: 34% (1,764,380)
- Age 25 and over: 66% (3,456,013)

Detailed breakdown:
- Under 5 years: 7%
- 5 to 9 years: 6%
- 10 to 14 years: 7%
- 15 to 19 years: 7%
- 20 to 24 years: 7%
Minnesota Child Health Indicators

Race/ethnicity, ages 0-24, Minnesota 2006-2008

- White: 79.5%
- Black: 6.0%
- American Indian: 1.2%
- Asian/Pacific Islander: 4.1%
- Two or more races: 3.1%
- Hispanic/Latino (any race): 6.1%
Minnesota Child Health Indicators

Infant Mortality Rates by Race/Ethnicity of Mother, Minnesota 2003-2007

Rate per 1,000 births

- HP2010 Objective: 4.5
- All births: 4.8
- African American: 8.9
- American Indian: 10.2
- Asian/PI: 4.3
- Hispanic*: 4.1
- White: 4.3

*Hispanics can be of any race.
Minnesota Child Health Indicators

FIGURE 5. Deaths per 100,000 for Minnesota youth 12-19 years of age: 2005-2009.

Source: Minnesota Center for Health Statistics
## TABLE 7. Percent of 9th grade students reporting high levels of emotional distress during the last 30 days, 2010 (highest rate in bold).

<table>
<thead>
<tr>
<th>Percent who feel nervous, worried or upset all or most of the time</th>
<th>African American</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic</th>
<th>White</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19%</td>
<td>21%</td>
<td>17%</td>
<td>19%</td>
<td>12%</td>
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<tr>
<td>Percent who feel sad all or most of the time</td>
<td>19%</td>
<td>22%</td>
<td>17%</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td>Percent who feel under heavy stress</td>
<td>15%</td>
<td>20%</td>
<td>13%</td>
<td>15%</td>
<td>12%</td>
</tr>
<tr>
<td>Percent who feel very discouraged or hopeless</td>
<td>19%</td>
<td>23%</td>
<td>19%</td>
<td>21%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Source: Minnesota Student Survey, 2010
Minnesota Child Health Indicators

<table>
<thead>
<tr>
<th>Percent who thought about killing themselves in the last year</th>
<th>African American</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic</th>
<th>White</th>
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<tr>
<td></td>
<td>20%</td>
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<tr>
<td></td>
<td>5%</td>
<td>8%</td>
<td>3%</td>
<td>6%</td>
<td>3%</td>
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</tbody>
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<tr>
<th>Percent who hurt themselves on purpose (“cutting”, burns, bruises) in the last year</th>
<th>African American</th>
<th>American Indian</th>
<th>Asian</th>
<th>Hispanic</th>
<th>White</th>
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</table>

Source: Minnesota Student Survey, 2010
Minnesota Child Health Indicators

Age-adjusted* percentage of people aged 20 years or older with diagnosed diabetes, by race/ethnicity, United States, 2010–2012

- Non-Hispanic whites: 7.6%
- Asian Americans: 9.0%
- Hispanics: 12.8%
- Non-Hispanic blacks: 13.2%
- American Indians/Alaska Natives: 15.9%

*Based on the 2000 U.S. standard population.
Minnesota Child Health Indicators

FIGURE 6: Percent of Women Who Reported Smoking During Pregnancy, Minnesota 2001-2005

- American Indian: 37.8%
- African American: 8.9%
- Asian: 2.4%
- Hispanic: 3.2%
- White: 10.4%

Source: Minnesota Department of Health Center for Health Statistics
Minnesota Child Health Indicators

Figure 5.3. Age adjusted mortality rates for heart disease in Minnesota men, by race and ethnicity, all ages, 1995-2009.

- White, Not Hispanic
- Black, Not Hispanic
- American Indian, Not Hispanic
- Asian/Pacific Islander, Not Hispanic
- Hispanic
What We Know

If We Want Something Different... 

...We Have to Do Something Different
What Has Not Worked

• Medical Model Approach
• Education-only Strategies
• Pre-designed Action Plans
What We Think Might Work
What We Think Might Work

- Resiliency-Based Approach
- Policy, Systems, and Environmental Change Strategies
- Action Plans Conceived, Designed, and Implemented by Tribal Leaders
Thank you!

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