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How local health departments work towards health equity☆

Rebeccah Sokol[a,*], Beth Moracco[a], Sharon Nelson[b], Jill Rushing[b], Tish Singletary[b], Karen Stanley[b], Anna Stein[b]

[a] Department of Health Behavior, Gillings School of Global Public Health, University of North Carolina at Chapel Hill, 135 Dauer Drive, Chapel Hill, NC 27599-7440, USA
[b] Division of Public Health, Chronic Disease and Injury Section, North Carolina Department of Health and Human Services, 5505 Six Forks Road, Raleigh, NC 27609, USA

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ABSTRACT

Background: Health inequities are exacerbated when health promotion programs and resources do not reach selected populations. Local health departments (LHDs)[1] have the potential to address health equity via engaging priority populations in their work. However, we do not have an understanding of what local agencies are doing on this front.

Methods: In the summer of 2016, we collaborated with informants from thirteen LHDs across North Carolina. Via semi-structured interviews, the research team asked informants about their LHD's understanding of health equity and engaging priority populations in program planning, implementation, and evaluation.

Findings: All informants discussed that a key function of their LHD was to improve the health of all residents. LHDs with a more comprehensive understanding of health equity engaged members of priority populations in their organizations' efforts to a greater extent than LHDs with a more limited understanding. Additionally, while all LHDs identified similar barriers to engaging priority populations, LHDs that identified facilitators more comprehensively engaged members of the priority population in program planning, implementation, and evaluation.

Conclusions: LHDs are ideally situated between the research and practice worlds to address health equity locally. To promote this work, we should ensure LHDs hold an understanding of health equity, have the means to realize facilitators of health equity work, and recognize the complex context in which health equity work exists.

1. Introduction

Health equity occurs when every individual has the opportunity to attain her or his optimal health, regardless of social position or circumstances (Braveman, 2003; Whitehead, 1992). While several definitions of health equity exist, most connote an ethical and moral obligation to address social determinants of health in order to ensure all people have equal potentials to pursue health (Braveman & Gruskin, 2003; Dean, Roberts, Bouye, Green, & McDonald, 2016; Whitehead, 1992). Although similar, health *inequity* is distinct from health *inequality*. Health inequality refers to differences in health status, such as differences in cardiovascular fitness between younger and older individuals. However, health inequity denotes systematic differences in health between more and less advantaged social groups. Whitehead describes health inequities as: "differences which are unnecessary and avoidable but, in addition, are also considered unfair and unjust".

Over the past several decades, a focus on health equity has been evident in national policy. In 1999, the Centers for Disease Control and Prevention initiated the Racial and Ethnic Approaches to Community Health program, and in 2010, the Affordable Care Act called for the creation of Offices of Minority Health within six agencies of the Department of Health and Human Services. Presently, an overarching goal of Healthy People 2020 is to "[a]chieve health equity, eliminate disparities, and improve the health of all groups" (Koh, Piotrowski, Kumanyika, & Fielding, 2011). Despite these and numerous other examples of federal agencies working to develop policies and programs to improve health equity, some sub-groups of people continue to face higher disease incidence, morbidity, and mortality. For example, there remains a large disparity in life expectancy between the Black and white population in the United States (Kochanek, Arias, & Anderson, 2013).

Structural inequalities—including but not limited to income disparities, the built environment, education achievement gaps, and racism—are foundational to health inequities (Braveman,
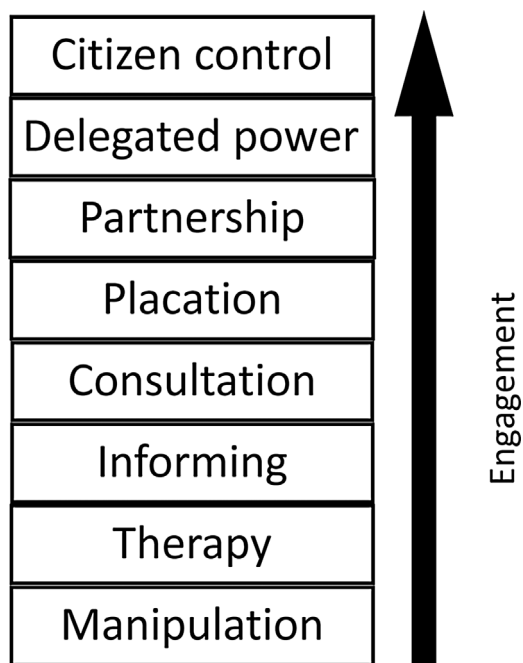

Fig. 1. Modification of Arnstein's ladder of citizen participation (Arnstein, 1969).

Egerter, & Williams, 2011). These health inequities are in turn exacerbated by a lack of (or inappropriate) interventions and resources directed at priority populations, making such populations hardly reached (Sokol, Fisher, & Hill, 2015). Priority populations are groups of people that a service provider (such as a health department) identifies as being at risk for poorer health outcomes on the basis of structural inequalities (Healthcare Research and Quality Act of 1999, 1999). However, priority populations' passive receipt of services may lend to feelings of powerlessness, and empirical research suggests powerlessness is a broad risk factor for disease that can exacerbate health inequities (Wallerstein, 1992). Engaging priority populations in the planning, implementation, and evaluation of health promotion programs—so that programs are implemented *with* rather than delivered *to* communities—is one way to combat this powerlessness and work towards health equity (Wallerstein & Duran, 2008).

Not all engagement is equally effective, however. Arnstein's ladder of citizen participation (Fig. 1) depicts various levels of engagement, from *nonparticipation*, to *tokenism*, to *citizen power*—where the higher rungs (i.e. citizen power) are recognized as being more effective avenues for improving health outcomes but also require a greater power transfer from the service deliverers to the priority population (Arnstein, 1969). In the current context, the aim of engagement is to allow members of priority populations to gain enough power to make the program and resource gatekeepers responsive to their views, aspirations, and needs.

Local Health Departments (LHDs) have the potential to conduct this type of engagement: LHDs are connected to both a State Division of Public Health (or similar organization)—where they receive resources to implement health programs and interventions—as well as to their local communities, where they understand their communities' assets, needs, and culture. Various groups have developed handbooks and toolkits detailing how LHDs can advance health equity (BARHII, 2010; Iton, 2016; NACCHO, 2014). For example, the Bay Area Regional Health Inequities Initiative created a toolkit that helps local public health leaders identify and work towards realizing the skills, practices, and infrastructure needed to address health equity (BARHII, 2010). These materials provide valuable information regarding how LHDs can address health equity in numerous ways, including researching and evaluating the impact of their programs, collecting data to determine

where disparities exist, and working to enact social determinants of health related policy.

Engaging members of priority populations in the planning, implementation, and evaluation of LHD programs is one cited strategy that may facilitate these health equity actions (Iton, 2016; NACCHO, 2014). However, we know little about how this process unfolds at the LHD level. In order to learn more about this means to address health equity, we conducted in-depth interviews with LHDs in North Carolina. We used North Carolina as a case study to: 1) understand the degree to which different LHDs in the state work towards health equity and engage priority populations; and 2) describe the barriers and facilitators for engaging priority populations at the local level.

2. Methods

In the summer of 2016, the project team recruited key informants from LHDs across the state to participate in telephone interviews. Two experts at the North Carolina Division of Public Health in regular contact with all 85 LHDs in North Carolina divided these LHDs into two groups based upon progress reports the LHDs submitted to the State Division: 1. LHDs that regularly engaged priority populations; and 2. LHDs who did not regularly engage priority populations. We randomly and equally sampled from these two groups by emailing potential key informants. Key informants were community health educators or other personnel responsible for overseeing community engagement activities. We conducted interviews and coded transcripts on a rolling basis, stopping when we reached saturation of information. Saturation occurred after we had conducted interviews with 13 LHDs, and contacted a total of 26 LHDs (50% response rate). The 13 LHDs and their corresponding counties covered a broad range of the population sizes, median household incomes, and poverty rates found in all counties in North Carolina (Table 1).

Telephone interviews lasted 30–45 minutes. Following a semi-structured interview guide, we asked questions regarding: 1) the LHD's understanding of health equity and engaging priority populations; and 2) barriers and facilitators for engaging priority populations in health department programs and initiatives at the local level. As the research involved key informants reporting on institutions, the University of North Carolina Chapel Hill Institutional Review Board deemed it exempt from approval.

We developed a codebook using the semi-structured interview guide as an outline for primary codes, and iteratively created secondary and tertiary codes as they arose throughout the analysis process. Once we created a new secondary or tertiary code, we reviewed previously coded transcripts to account for these additions. The team used ATLAS.ti™ (Muhr, 1997) to code and retrieve data. A primary coder reviewed and analyzed all transcripts and brought preliminary findings to the project team and key informants for their examination, input, and approval at several points throughout the process. Of note, the primary coder classified LHDs into different levels of health equity knowledge, planning engagement, implementation engagement, and evaluation engagement based on emergent categories (described below). Arnstein's ladder of citizen participation informed the

Table 1
Population level demographic characteristics for sampled counties compared to all North Carolina counties.

	Average for sampled counties (range)	Average for all counties (range)
Population size, n[a]	178.8 (11.0–500+)	88.7 (4.0–500+)
Median income, USD[a]	42.4 (30.8–55.3)	41.0 (28.4–63.7)
Percent white, %	81.3 (53.0–97.0)	74.2 (33.0–97.0)
Percent in poverty, %	19.0 (13.2–31.3)	19.6 (6.0–32.3)

Notes: Data from 2010 US Census data and 2012 US Census estimates; [a]in thousands.