How to Use Law & Policy to Affect Health Equity

Full Script

This script was published in October 2024.

Introduction & Presentation Overview

Slide 1

Welcome to the Public Health Law Academy's training, How to Use Law & Policy to Affect Health Equity. This module is Part 2 in a two-part series exploring the social determinants of health, health equity, and the law and is brought to you by ChangeLab Solutions and the Centers for Disease Control and Prevention's Public Health Law Program.

Adopting an equity-focused approach to address widening health disparities is critical to achieving the primary purpose of public health: improving health outcomes at a population level. From an evaluation perspective, populations with worse health outcomes also stand to benefit the most from public health interventions that are done equitably. Moreover, many preventable health problems share the same root causes, so identifying intersections, sharing expertise, and joining forces with community members and other cross-sector partners is critical, particularly when resources are limited and health department capacity is stretched thin.

This module explores concrete steps that health departments can take to close gaps in health outcomes and seeks to build health departments' capacity to use the tools of law and policy to address the social determinants of health and advance health equity.

Slide 2

Before we begin, we want to remind you that the information provided in this training is for informational purposes only and does not constitute legal advice. ChangeLab Solutions does not enter into attorney-client relationships.

Slide 3

Furthermore, while every effort has been made to verify the accuracy of these materials, legal authorities and requirements may vary from jurisdiction to jurisdiction. The contents of this presentation have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy. Always seek the advice of an attorney or other qualified professional with any questions you may have regarding a legal matter.

Slide 4

Before you take this training, we encourage you to watch Part 1 of this series, which examines how structural racism is rooted in our country's legal legacy and history and contributes to the inequities we see today.

Slide 5

Today, in Part 2 of this series, we will explore how public health practitioners can use law and policy to address health inequities. In today's session, we will:

- First, provide a quick refresher about some of the key concepts we discussed in Part 1 specifically related to the social and economic conditions that affect health, as well as the key role that the law plays in affecting health and health equity.
- Next, we'll take a deeper dive into how the law is a key driver of health inequities by examining the fundamental drivers of inequity.
- Then we'll explore the role that public health practitioners can play in addressing inequity and identify concrete actions that health departments can take to advance equity through law and policy change.
- Finally, we'll walk through a hypothetical example illustrating how these concepts all fit together and can be applied in practice.

We emphasize that public health practitioners and agencies can play many roles with respect to health equity. These include serving as researchers, employers, and educators. As we'll discuss in detail over the course of this module, all of those roles can serve to promote health equity.

Slide 6

Throughout this training, we encourage you to think about how to ensure health equity is centered in your work. As we go through the training, note the equity practice tips that we'll use to highlight opportunities to apply equity-promoting strategies in your day-to-day work. We also encourage you to think of examples from your own experience.

Slide 7

To start working on health equity, we need to acknowledge that law and policy have been central to creating today's health inequity. In Part 1 of this series, we explored how structural racism is rooted in our country's legal legacy and history. We highlighted historic examples, including Jim Crow laws, exclusionary zoning, racial covenants in real estate, New Deal programs, urban renewal, and redlining, and we discussed how they are linked to the health inequity we see today.

Before taking a deeper dive into the role of health departments and public health practitioners in addressing inequity, let's spend a few minutes reviewing what the social determinants of health are – and how they are shaped by laws and policies.

Slide 8

As a quick refresher, our first question is: The social determinants of health account for about 50% of a person's health outcomes. True or false?

Slide 9

If you picked "True," that's correct! As you may recall from Part 1, there are many factors that affect health. Chief among them are environmental factors – including those in the physical environment and the social and economic environments in which a person lives – which account for about 50% of a person's health status. They influence all of the other factors on the continuum, including health behaviors.

Slide 10

The Centers for Disease Control and Prevention (CDC) defines the social determinants of health as "the nonmedical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems."

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

Slide 11

As we discussed in Part 1, the law plays a powerful role in determining the distribution of money, power, and resources, which in turn shape the social determinants of health.

The National Academies of Sciences, Engineering, and Medicine, among other institutions, has acknowledged that law and policy are directly linked to the social determinants of health (SDOH). Because of this interconnectedness, Professor Larry Gostin identifies the law as a determinant of health, using the term "legal determinants of health" because it "demonstrates the power of law to address the underlying social and economic causes of injury and disease."

Slide 12

When he was director of the CDC, Dr. Tom Frieden developed the five-tiered health impact pyramid shown on this slide, which provides a framework that describes the impact of different types of public health interventions. While implementing interventions across all tiers is necessary to achieve the greatest possible public health benefit, interventions on the two foundational tiers at the base of the pyramid – socioeconomic factors and changing the context to make individuals' default decisions healthy – have the greatest potential impact.

Public health interventions at all tiers are affected by or could entail public health policies and laws. That said, laws and policies are more likely to be the means of intervention at the lower levels, whereas programmatic changes are more likely to be implicated at the higher tiers.

Slide 13

An example of a law and policy that addresses a key determinant of health – in this case, early childhood education – is universal pre-K. The city of San Antonio, Texas, for example, created Pre-K 4 SA, a full-day program for 4-year-olds, as a result of community conversations about priorities for San Antonio in 2011. It was funded through a 1/8 cent increase in the city sales tax.

Cities and states have used a variety of policy mechanisms to establish and fund universal pre-K programs. Research reveals myriad health benefits of early childhood education. For example, access to early childhood education can lead to future educational attainment through increased school attendance and achievement, which in turn is associated with greater adult health. It is also connected to improved physical health over one's lifetime, including access to health care, healthier behaviors, and general well-being and decreased illness. It can also improve mental health. The long-term risk of depression is reduced in individuals who participated in a high-quality preschool program. Moreover, for every dollar spent on early education initiatives, there is a societal return on investment of $8.60.

Slide 14

Let's pause for a quick multiple-choice question: "San Antonio's universal pre-K policy is an example of what tier of the pyramid of public health interventions?"

A. Counseling and education

B. Long-lasting protective interventions

C. Making the default decisions healthy

D. Changing socioeconomic factors

Slide 15

If you selected D, "changing socioeconomic factors," you are correct. Ensuring all 4-year-olds in San Antonio have access to early childhood education is an example of an intervention focused on improving access to education, a key socioeconomic factor. This type of change is at the foundational tier of Dr. Frieden's health impact pyramid and has potential for the greatest impact on people's health.

Slide 16

Taken in combination, the preceding slides help illustrate why law and policy are such important vehicles for public health intervention because they operate at the societal rather than the individual level.

Slide 17

To help test your understanding of another concept for the first training: What is health equity?

A. A state where everyone has a fair and just opportunity to be as healthy as possible

B. Applying public health interventions to everyone in the same way, irrespective of need

Slide 18

If you selected A, you're correct! In Part 1, we discussed the distinction between equality and equity. An intervention focused on equality would apply the same one-size-fits-all solution to everyone, regardless of need. An equitable approach means we're focused on ensuring that people have what they need to thrive. And beyond that, it acknowledges the reality that not everyone starts off at the same place. As Dr. Paula Braveman, one of the nation's leading experts on health equity and health disparities, explains, "Health equity means that everyone has a fair and just opportunity to be as healthy as possible."

Slide 19

With this distinction in mind, you may be wondering how a policy like universal pre-K, which we discussed a few moments ago, connects to health equity and perhaps even whether universal pre-K is preferential to pre-K access based on need and, if so, why.

In the case of pre-K, universal access is preferable. While need-based pre-K subsidies are often used in different jurisdictions, these take a variety of forms and often require significant navigation for parents to access, reducing accessibility and the impact on health equity. Universal pre-K, in contrast, is established on the understanding that universal access will most directly benefit children who are typically excluded from early education access.

Slide 20

As we discussed in Part 1 and will talk about in more depth later in this module, public health practitioners can play a key role in addressing the social determinants of health and health equity.

According to the CDC, "The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. To achieve equity, the Essential Public Health Services actively promote policies, systems, and overall community conditions that enable optimal health for all and seek to remove systemic and structural barriers that have resulted in health inequity. Such barriers include poverty, racism, gender discrimination, ableism, and other forms of oppression."

Slide 21

It's important to recognize that public health practitioners across the country are already working to address health inequity and the social determinants of health. Let's briefly explore what those efforts include.

According to 2016 data from the National Association of County and City Health Officials, 63% of all local health departments are working to change the causes of health disparities. One of the most common ways they are working on health equity is by using data to measure and describe disparities in their jurisdictions. Another common activity (52% of all local health departments) is educating policymakers about health disparities and their causes. These are important steps to take and align with the 10 Essential Public Health Services we just discussed. It's also worth noting that these data point to the activities mentioned being more common among local health departments serving larger populations.

Slide 22

Data from the same survey of local health departments show that there is an opportunity to build capacity among public health practitioners to work on law and policy changes that address health equity. Less than a quarter of all local health departments surveyed are taking policy positions on health disparities or conducting research linking health inequity to social determinants of health.

According to 2022 data from the National Association of County and City Health Officials (NACCHO), local health departments are still more likely to be involved in traditional public health policy areas like tobacco prevention and control than policy areas related to social determinants of health, such as housing and funding for access to health care.

Community engagement and meaningful participation from affected communities is essential to the success of health equity improvement efforts. Thus, it is important to note that according to the NACCHO 2016 Profile, only 24% of local health departments are recruiting staff from communities adversely affected by health disparities. Similar to the data discussed in the previous slide, this is more common among local health departments serving larger populations.

Slide 23

Before moving on to the next section, I want to pause for a question that addresses the connections between some of the key concepts we just discussed.

True or false? Improving the social determinants of health is critical to advancing health equity.

Slide 24

The answer is "True." Again, we refer to Dr. Paula Braveman's definition of health equity: "that everyone has a fair and just opportunity to be as healthy as possible." She goes on to explain that "this requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." These are all social determinants of health.

Slide 25

In the previous slides and examples, we described the social and environmental factors that shape health outcomes. We've also highlighted how law and policy shape these social determinants of health and introduced the role that public health practitioners can play in working on law and policy changes that address health equity.

Now we'll take a deeper dive into how we in the field of public health can more effectively address health inequity. For example, when we assess how public health encompasses chronic diseases like diabetes and heart disease, we realize that population-level improvements, or "wins," can mask persistent or exacerbated gaps in health between racial/ethnic groups and across income levels.

Slide 26

Consider the decades-long public health efforts to reduce smoking. Widely considered among the greatest public health achievements, here are some powerful statistics from California's tobacco control efforts between 1989 (when the California Tobacco Control Program, or CTCP, was established within the California Department of Public Health) and 2008. There were:

- **25% fewer tobacco-related** diseases (compared to the rest of the United States)
- **6.79 billion** fewer packs of cigarettes sold, and
- **$134 billion** saved in personal health care costs.

As a result of these efforts, the number of lives saved, the positive cost savings for the health care industry, and the negative cost impact on the tobacco industry have been tremendous.

Slide 27

However, when we take a closer look at tobacco use by race and ethnicity, the limitations in the success of tobacco control efforts become more apparent. Staying with California as an example of a state that has made tremendous progress in reducing the prevalence of cigarette smoking, it has not been able to close the gap in tobacco-related disparities. For example, the California Department of Public Health reports that between 2016 and 2017, over 19% of all American Indian adults reported smoking compared with 17% of all Black or African American adults, 11.8% of white adults (not pictured on the slide: 10.2% for Latino adults and 7.8% Asian or Pacific Islander adults).

Disparities also remain for cigarette use among groups defined by race, gender, sexual orientation, and behavioral health conditions, as well as across broader determinants of health, including education levels, income, health insurance type, housing type (single-family housing versus multi-unit housing), and community density (urban versus rural) or geographic region (Midwest versus South versus Northeast versus West).

As a result, certain groups disproportionately suffer from tobacco-related diseases and death despite the overall progress made in reducing tobacco use. This is an illustrative example of how our legal and policy responses can fail to address the drivers of inequity and can, at times, reinforce systems of injustice. Consider, for example, flavored products like menthol, little cigars, and cigarillos, which are significant drivers of unjust health disparities. Tobacco companies have systematically marketed these deadly products to communities of color, individuals with low income, and young people who identify as LGBTQ+. Yet the 2009 Family Smoking Prevention and Tobacco Control Act excluded menthol from its prohibition on flavored cigarettes. When the FDA issued proposed rules to prohibit the manufacture and sale of menthol cigarettes and all flavored cigars in April 2022, this was an important step toward health equity and putting an end to tobacco companies' decades-long efforts to push flavored tobacco products and entice certain social groups.

However, public health researchers indicate that bans at the state and local levels are more important than ever before, especially as the federal ban may take years before it's enacted. Equally important are addressing the unequal distribution of resources for tobacco cessation treatments and health care services and barriers to treatment for those who develop tobacco-related diseases. Cigarettes are highly addictive by design and require multifaceted and equity-focused efforts, including investments in accessible and culturally tailored cessation programs.

Slide 28

Shrinking the gaps in health outcomes differs from trying to improve public health overall. It's a complex objective that requires new thinking and new strategies for action. Rather than focusing on reducing the prevalence of any single disease, the challenge is finding ways to change the distribution of healthy environments, economic resources, and opportunities. Finding such solutions requires a fundamental shift in how law and policy are used to promote health.

To address inequity, we need to identify, understand, and address the fundamental drivers – or the root causes – of inequity. Drawn from a wide range of research, theories, and practice, five drivers are:

1. Structural discrimination: historical and structural harms in our systems that perpetuate racial or other forms of discrimination
2. Income inequality and poverty: who can access and afford basic resources and services that are needed to lead a healthy life
3. Disparities in opportunity: who has access to quality education and economic opportunities that support health and equity
4. Disparities in political power: who has access to what types of political and economic power
5. Governance that limits meaningful participation: how our governance structures are set up to listen to or ignore community voices

Slide 29

What exactly does this mean in practice? Let's take a closer look at each of these drivers and some law and policy examples to illustrate how we might address them. We've included some examples and encourage you to think of additional ones.

Slide 30

Starting with structural discrimination, which acts as a macrolevel driver that influences the other four fundamental drivers of health inequity. In Part 1 of this series, we discussed redlining as one historical example of how law and policy have perpetuated structural discrimination and contributed to the health inequity we see today.

As you may recall from Part 1, structural discrimination occurs when systems (rather than individuals) unjustly deny wealth, opportunity, power, or government representation on the basis of characteristics such as race, gender, sexual orientation, social class, and immigration status. It accounts for how multiple dimensions of identity and interlocking systems of oppression shape individual experience.

All levels of government can play a role in mitigating the effects of structural racism and other forms of structural discrimination. Let's pause for a multiple-choice question to reflect on what this might look like in practice.

Slide 31

Using redlining as an example, how could public health practitioners address structural discrimination through law and policy?

A. Conduct a legal epidemiology assessment evaluating connections between laws and policies that perpetuate structural discrimination and disparate health outcomes.

B. Examine the linkages between local policies that create more racially and economically mixed neighborhoods and health effects.

C. Identify indicators of racial disparities that could inform a racial equity analysis necessary for supporting equity-centered policies.

D. All of the above.

Slide 32

If you selected D, you are correct. These are all examples of how public health practitioners might address inequity created by structural discrimination embedded in housing policies (e.g., redlining).

Can you think of additional examples or ways in which your health department or community is addressing structural discrimination?

Slide 33

An example of how one health department is addressing structural discrimination – in this case, racism – is spearheaded by the Boston Public Health Commission (BPHC).

For over a decade, the commission has been working to address racism as a determinant of health inequity in its city. This initiative has included developing the Anti-Racism Advisory Committee, requiring all staff to participate in racial justice and health equity training, diversifying their staff, and creating accountability mechanisms.

In 2008, BPHC formally established the Anti-Racism Advisory Committee to build on the growing interest among staff to address racism through their work. The committee develops recommendations on internal policies, practices, structures, and systems using a racial justice and health equity framework.

In 2011, the commission introduced a mandatory two-day workshop for staff that introduces concepts of racial justice and health equity, explores data about health inequity and what shapes health in Boston, and identifies what all staff members can do – as employees and as city residents – to achieve health equity. Staff are also required to complete at least eight hours of follow-up practice workshops on topics such as community engagement, policy advocacy, evaluation of health equity efforts, quality improvement and accreditation, and promotion of equity in internal operations.

And in 2015, the committee and the Human Resources Office formed the Hiring, Promotion, and Retention Workgroup. Outcomes of this group included incorporating the concept of health equity into the screening and interview process, as well as holding hiring managers accountable for recruiting a diverse pool of candidates. Boston also created a workforce dashboard showing the race, gender, salary, and tenure of city workers to illustrate how departments are moving toward the vision of becoming a city government reflective of the city.

Slide 34

The example of Boston also illustrates how public health solutions can address another fundamental driver of inequity: disparities in opportunity, which occur when some people or groups are denied quality education, jobs, and other economic opportunities that would support financial independence, wealth generation, and healthy living.

By establishing the Hiring, Promotion, and Retention Workgroup, Boston's Anti-Racism Advisory Committee addressed disparities in opportunity by taking steps to ensure that health equity was part of screening potential staff. It further implemented accountability measures to ensure managers recruit a diverse pool of candidates. Finally, the workforce dashboard fosters accountability in the city's progress toward becoming a city government reflective of the city.

Cities and localities like San Antonio, Texas (which we mentioned earlier), that have adopted universal pre-K policies are examples of how law and policy can be leveraged to address disparities in opportunity.

Slide 35

We've talked about structural discrimination and disparities in opportunity. Now we'll turn to the other three drivers:

- Income inequality and poverty
- Disparities in political power
- Governance that limits meaningful participation

Let's explore another hypothetical example to continue illustrating how local and state governments can implement equity-driven policies and programs to interrupt these drivers of health inequity.

Slide 36

Meet Jackie. Jackie works for the City of Innovation's Department of Health and has a degree in public health.

In light of evidence that a lack of access to affordable transportation can be a barrier to healthy food and gainful employment, Jackie's office has been asked by the city's Department of Transportation to help design a pilot project offering subsidized transit for one year. The city hopes to measure whether free or discounted public transit affects the lives of residents across sectors such as employment rates, transportation emissions, traffic congestion, pedestrian deaths, high school graduation rates, and rates of enrollment in higher education.

Slide 37

Jackie starts off with three options that the City Department of Transportation has proposed:

- The first option would eliminate the use of passes or tickets on all public transportation in the city.
- The second option would grant new free passes for all public transit. This option would require riders to submit an online application and verification that they fall below certain income limits.
- The third option is to give riders the opportunity to apply for a quarterly reimbursement of 50% of public transit-related costs.

To analyze which policy would best serve the communities most affected by a lack of affordable public transit, Jackie began to do some research.

Slide 38

During her research into data tracked by different agencies in her city, Jackie found that 75% of current riders are Black or Latino, 70% have an annual household income below $35,000, and 51% live below the federal poverty level.

These numbers were provided by the Los Angeles Metro. Los Angeles hosted the largest fareless transit initiative in the United States for 22 months during the COVID-19 pandemic and has continued fareless rides for certain K–12 and community college students.

Slide 39

Next, Jackie hosted informal community gatherings in the city's five neighborhoods with the lowest median household income to solicit input on the proposed policy options. Her conversations with community residents confirmed data she had found, and she followed up with her partners at the Department of Transportation with this final proposal:

- Jackie proposes that the city adopt a totally fareless system for its pilot. From her research into other jurisdictions and her conversations with community members, Jackie determined that requiring applications for free transit passes likely will decrease participation, hamper the program's potential positive impact, and increase administrative costs.
- Jackie recognizes the importance of accountability in government programs and proposes the establishment of a Transportation Equity Advisory Committee to oversee and make recommendations for this and other equitable transportation programs in the city.
- Finally, Jackie believes that at least half of the committee should be members from the communities that will be most affected by this program.

Slide 40

Let's pause for a quick knowledge check: Which drivers of inequity are addressed by Jackie's policy proposal?

A. Income inequality and poverty

B. Disparities in political power

C. Governance that limits participation

D. All of the above

Slide 41

If you answered D, you are correct. We'll explain why on the next several slides.

Slide 42

Jackie's proposal addresses income inequality and poverty because it reduces the cost of an essential good: transportation.

Laws and policies play a role in the concentration of wealth, which shapes community and individual opportunities to have access to or afford basic needs like housing, healthy food, transportation, health care, a living wage, and child care supports.

Let's pause and reflect on what other policies could reduce poverty and income inequality.

Some of you might have identified:

- Policies that improve working conditions and offer fair wages with benefits
- Policies that preserve, protect, and expand social protections and programs like paid family leave and paid sick leave policies, unemployment insurance, and social security
- Place-based investments that improve neighborhood settings

These are just a few examples.

Slide 43

Jackie's process of developing her policy proposal as well as the substance of the final proposal addresses disparities in political power that occur when some people or groups are denied the ability to make their needs visible to and a priority for government and institutional decision makers.

Jackie engaged with community members by hosting informal gatherings, which created space for community members to bring attention to their needs. Jackie's incorporation of community members' input into the final proposal prioritized the needs of the community most directly affected by the policy. She further ensured that the city will continue to prioritize community voices by reserving half of the membership on the resulting Transportation Equity Advisory Committee for community members. By requiring the city to compensate members for their time, Jackie seeks to mitigate any unintended perpetuation of poverty.

Slide 44

Finally, Jackie's proposal seeks to interrupt governance that limits meaningful participation. This occurs when governments and institutions make decisions that shape places and distribute resources and opportunities without working to get agreement across all of the stakeholders who will be affected by those decisions. It's important to remember that governance describes the structures and processes for making decisions. It can include but is not limited to government.

For instance, the rules and procedures of elections have become central issues in American politics. Some states have passed laws that make voting more challenging. While restrictions vary by state, some include limiting the use of ballot drop boxes and doing away with local laws that allow automatic registration for absentee voting. In these examples, government is making critical decisions without engaging those most affected by those decisions (voters) and then limiting the possibility of future voter participation.

Slide 45

We have covered a lot, so I want to take a moment to briefly recap the main takeaways from this framework. The important point to remember is that the five fundamental drivers of inequity presented here can be tools for addressing current and historic inequity by assessing the consequences, impacts, and distribution of resources and power through these five lenses:

1. Structural discrimination
2. Income inequality and poverty
3. Disparities in opportunity
4. Disparities in political power
5. Governance that limits meaningful participation

If you're interested in learning more about these five drivers of inequity and how administrative law can be used to address them, we encourage you to check out the Public Health Law Academy's training series on administrative law that addresses some of these concepts specifically for state and local health departments in greater detail.

Slide 46

This brings us to the next segment of today's training, which explores some of the concrete action steps that health departments can take to utilize the tools of law and policy to address the fundamental drivers of inequity.

Health departments can't do the work of using law and policy to advance health equity on their own. This section shares why cross-sector collaboration and community engagement and partnerships are critical for work on healthy equity and offers some guiding principles to help health departments work collaboratively with other stakeholders. We'll weave in examples highlighting the work of state, territorial, local, and tribal health departments.

Slide 47

To help ground this conversation, I'll refer back to the 10 Essential Public Health Services, which describe the public health activities that all communities should undertake. They provide a framework for describing and assessing the quality of public health practice in the United States. They expand on the three core functions of public health that were established in 1994 and strengthen their focus on equity:

- Assessment
- Policy development
- Assurance

Keep these in mind as we walk through the steps for supporting equity-centered policies.

Slide 48

A way to further distill supporting equitable policies into practice is through a framework that we'll spend the next few slides discussing. The framework centers on the importance of:

- **Engaging** community and cross-sector partners at every step in the process
- **Assessing the problem** and supporting data
- **Identifying** policy options and working with partners to develop a strong policy that expresses the vision
- **Educating** and meeting with decision makers
- Ensuring the policy is effectively and equitably **implemented**

Notably, these steps don't always happen in the same order, and some of the actions, like engaging communities and key partners, occur at multiple stages in the process.

There is also no one-size-fits-all approach. This information provides a framework, but you may have your own strategy.

Slide 49

We'll start with "engage." When it comes to equitable policy change, it is critical for the community that will be affected by a policy to be involved in its development. Community representatives can identify when a policy solution is not a good fit for their community, and they can foresee potential unintended consequences that a well-meaning policymaker or public health practitioner might miss.

Public health practitioners must work with both government and community partners and ensure that engagement is inclusive and representative through ongoing dialogue with members of communities and groups most affected, as well as allies inside and outside government.

It is important to build a foundation of trust among policymakers, practitioners, and the community. The legacy of inequitable policies can be a source of inherent mistrust of government. Dismantling these dynamics and building trust takes time and requires demonstrating credibility, reliability, openness, and commitment to community-identified needs.

Equally important is seeking change that promotes community strengths, assets, and resilience. Recognize people as agents in the creation of their own well-being, not as victims of traumatic events. This strengths-based approach focuses on resilience and aims to use residents' experiences, knowledge, and skills to help drive positive change.

Slide 50

There is of course much more to consider when it comes to adopting equitable methods of community engagement to address the social determinants of health. Indeed, that could be an entire training in and of itself, if you are interested in learning more on this topic – particularly how state health departments can better understand the roles that equitable and inclusive community engagement play in their work and support local health departments toward addressing the social determinants of health.

Slide 51

I want to also mention cross-sector partnerships, especially within government institutions, which are necessary to remove deep-rooted structural discrimination from the complex and multifaceted systems that affect public health (whether it be health care, the criminal legal system, or other laws and policies at local, state, and federal levels). As the strategies for addressing drivers of health inequity from the previous segment illustrate, no single government agency has full authority over all of these factors.

Building partnerships with a broad spectrum of local stakeholders also builds community capacity. For example, the private sector can help ensure that strategies designed to reduce health disparities align with and leverage economic and other market forces as much as possible. Anchor organizations and institutions that represent the community may have resources that can be leveraged to drive change.

Slide 52

Related to engagement is assessment. This includes examining questions, such as:

- What's the problem?
- What data are there?
- What solutions are there?

It also includes assessing community, government, and institutional readiness to create change.

You may find that your community already has the will and awareness needed to take action. Or you may learn that you need to start spreading the word, sharing knowledge, and developing partnerships with allies.

Slide 53

A key piece is understanding the roots of the problem. It can be helpful to revisit the guiding questions we discussed in Part 1 when assessing an issue in your community:

- Who has been harmed or omitted?
- Who stands to benefit, and how?
- How can inequity be repaired?

It is important to develop a shared understanding of what problems exist locally, as well as the contemporary, historical, place-based, and systemic issues that are causing those problems. To do this, you can analyze where and how health equity issues originate.

Health departments can partner with communities to develop deep understanding of gaps in health outcomes and structural drivers behind them. This connects to the assessment function of public health. Data on health gaps and change over time, as well as policy analyses like health impact assessments, can be particularly helpful. These can be used to identify policy options that address the root causes on inequity.

Slide 54

Let's take a moment to explore a real-world example from Greenville, South Carolina, that brings to life these key components of working in partnership with communities to understand the root causes of public health issues in their community.

In Greenville County, Hispanic youth are overweight and obese at a higher rate (44%) than their white peers (32%). Local officials and community leaders were puzzled. Why were these rates higher than youth obesity rates in both the region and the rest of the state? Which factors were contributing to these higher rates of obesity, and how could their community disrupt this trend? Were there systemic or environmental conditions contributing to these trends?

To explore these questions, a large coalition of Greenville County partners – including LiveWell Greenville, the Hispanic Alliance, the Bon Secours St. Francis Health System, Prisma Health, the Institute for the Advancement of Community Health at Furman University, and the South Carolina Department of Health and Environmental Control – established the Build Trust, Build Health project (BTBH; Fomentar la Confianza y Salud).

BTBH sought to understand the root causes of higher obesity rates for Hispanic youth in the White Horse Road Corridor (WHRC) and to gain a deeper understanding of the factors that promote and hinder healthy eating and active living for WHRC Hispanic families. The BTBH team set out together to identify culturally appropriate and community-informed interventions to mitigate health disparities and disrupt key systems contributing to these conditions.

To gain this insight, the team used a data-driven approach, conducting community-based participatory research through parent/student and provider focus groups and mapping community systems influencing higher Hispanic youth obesity rates. This approach identified upstream solutions with the greatest potential for influence on community health in the WHRC, with a focus on Building Trust, Building Community, and Building Access. As a result of these findings, the project created a culturally appropriate healthy food program that served over 1,600 families in a 12-month period, with more than $157,000 invested in food access for families.

The project represents a systems-level shift in how the Greenville Community addresses health equity by improving language and cultural capacity and increasing community representation to build out advocacy efforts for the Hispanic community. Using a collective impact approach, the BTBH team engaged community members in collecting data and partnered with them to create a community action plan to address social determinants of health leading to these inequitable health outcomes for Hispanic youth.

Slide 55

Related to understanding the root causes of a problem is identifying possible policy options to address those causes. In the previous example, we explored how the Build Trust, Build Health project in Greenville engaged community to assess the root causes of health disparities among Hispanic youth, leading to a culturally appropriate healthy food program.

For purposes of this module, we focus primarily on the legal and policy approaches that health departments can adopt to address the social determinants of health and advance health equity. We also encourage you to think about some of the other activities, like the 10 Essential Public Health Services, that you could integrate into your current or future practice.

Slide 56

When it comes to identifying possible policy options, it is important to understand the parameters of one's legal authority to address the social determinants of health through law and policy, in addition to assessing a prospective policy's impact. Be mindful of these issues:

- The scope of your legal authority: whether you have the power to implement the policies you have identified
- The need to balance the common good with individual rights as guaranteed by the federal and state constitutions
- Preemption – whether a higher level of government limits or eliminates the power of a lower level of government to pass a law or policy on a particular issue
- Political feasibility

We won't go into depth on each of these but encourage you to check resources that discuss these issues in more detail. All of them are part of the Public Health Law Academy, including trainings on Public Health Law: Past & Present, Preemption & Public Health, and our three-part administrative law series. In addition, our resource *Understanding Legal Authority to Address Social Determinants of Health* walks health departments through the process of determining whether it has the legal authority to address the social determinants of health.

Slide 57

Before moving to the next stage in the policymaking process we wanted to uplift legal epidemiology as a public health law approach that applies to nearly every step of the policymaking process (and also aligns with the activities in the 10 Essential Public Health Services). Legal epidemiology is the scientific study of how laws affect public health.

Legal epidemiology enables research on the potential impact and effectiveness of laws and policies on health and health equity. By employing legal epidemiology methods, public health practitioners can assess whether and how laws and policies affect health outcomes or create, perpetuate, or exacerbate health inequity. It can also help practitioners assess whether there are gaps in laws and policies in their own jurisdictions.

This can in turn inform the development of the practical solutions or policy options.

Legal epidemiology also enables health departments and organizations to create valid, reliable, and replicable data sets that can help educate community partners, residents, policymakers, leaders of public agencies, and other decision makers to inform policy agendas, strategic plans, regulatory changes, and future research to promote health equity.

Finally, it can be used to ensure that the policy and its implementation are achieving its intended results and can be refined as needed.

For more information, including how to design and conduct legal epidemiology projects, we encourage you to view our three-part series that is available through the Public Health Law Academy.

Slide 58

Another important step in the policymaking process is educating and meeting with decision makers as well as strengthening support for people most affected by the relevant policies by providing materials, educational outreach, and training. Developing partnerships with community organizations through consistent outreach and engagement opens avenues for sharing the most up-to-date evidence around important public health issues.

This is again where legal epidemiology can be a helpful tool. By creating results and advancing research, legal epidemiology can help make the case for – or against – laws and policies depending on whether they have a positive or negative effect on health equity. Legal epidemiology findings can also show how the law has evolved over time, providing context for some of the health disparities we see today and their historical roots. By sharing these findings directly with policymakers or with community organizations helps support equitable policies supported by legal epidemiology findings.

Slide 59

Finally, health departments have an important role to play in ensuring that the enacted law is implemented and enforced in such a way that it is equitable and achieves its intended goals: translating policy to effective practice on the ground. Furthermore, governments not only have the authority to do the actual enforcement action but also the authority to implement equitable practices and policies guiding how that enforcement is done.

Slide 60

Equitable enforcement requires recognition of its effects across different populations and minimization of the disparate harms to people affected by health inequity. Designing equity-centered policies includes thinking about the repercussions of their enforcement. Working in partnership with communities is critical to equitable enforcement. Without the former, we cannot achieve the latter.

Enforcement actions taken in the name of public health can sometimes harm, discriminate against, or otherwise undermine the health of the very people the laws are meant to protect. In fact, when enforcement is carried out inequitably, it can often create, maintain, or exacerbate existing health inequity.

Fortunately, state and local health departments, and other key community partners and policymakers, can take steps to minimize or counteract inequity that may result from unjust enforcement (or lack of enforcement) of public health laws. When thinking through what an equitable enforcement approach to policymaking would look like, you should ask: "How do we ensure compliance with laws and policies while minimizing harms to communities?" This is yet another reason that it's so critical for the community that will be affected by a policy to be involved in its development. Community representatives can identify when a policy solution is not a good fit for a community, and they can foresee potential unintended consequences that a well-meaning policymaker or public health practitioner might miss.

There is much more we could say about this important topic and encourage you to review ChangeLab Solutions' guide to using equitable enforcement to achieve health equity for more information and best practices in the design and development of enforcement provisions.

Slide 61

Before moving on, let's pause to review what we've learned so far with a quick question: Which of the following is not a reason to engage community members in developing strategies to advance health equity?

A. Address the root causes on inequity

B. Prevent resources from being spread too thin

C. Develop local leadership, knowledge, and skills

D. Align actions across sectors

E. None of the above

Slide 62

The answer is E, "none of the above." All of the factors listed in items A through D are reasons that it IS important to engage community member in developing strategies to advance health equity.

Slide 63

Before we close and to help bring some of the concepts that we discussed today to life, let's walk through a hypothetical example of a public health practitioner applying the concepts introduced today to promote children's health and well-being.

Slide 64

Meet Elena, a registered dietician and public health educator who works in the local health department in the City of Innovation.

Slide 65

One day, Elena receives a phone call from a local city council member who asks her to develop testimony for a hearing on a proposed healthy kids' meal ordinance. The proposed ordinance would establish nutrition standards for all meals marketed as kids' meals that include a toy.

Elena asks if the council member knows what the community thought about the policy. She learns that there hasn't been any community engagement on the issue, but some national public health organizations think that this approach is worth pursuing.

Slide 66

Elena is familiar with statistics related to healthy nutrition for children. However, to prepare her testimony, she has to do some additional research looking for peer-reviewed literature on the impact of healthy kids' meal policies. She also looks for case studies about how the policy has been implemented in other jurisdictions. Based on the information she collects, a healthy kids' meal ordinance does seem to be a promising approach for promoting healthier choices among children and youth who eat at fast food restaurants.

Elena wants to be sure she is on the right track, so she goes to community meetings in neighborhoods where rates of unhealthy weight among children are highest.

When she shares the policy proposal, she is surprised to learn that community members are very frustrated with her. There is not a lot of trust between the health department and the community.

Some people express anger about the proposal because they feel it punishes them and their kids by taking away some of the only treats they can afford. Several community members comment that if the city was really interested in the health of their kids, it would fix the playgrounds and make sure the parks are safe. A member of a local youth group shares that she and other young people are afraid to use the parks and playground because they are often sites of community violence.

Elena recognizes that deeper issues than kids' meal toys are driving the childhood health disparities in the City of Innovation. She wants to find a better policy solution to propose to the council member.

As a follow-up to the community meeting, she reaches out to the nonprofit supporting the local youth group that attended the community meeting, as well as a professor at the local university about developing a partnership to identify policy solutions to the problems raised at the community meeting.

Slide 67

Elena is excited to hear that some of the members of the youth group are interested in speaking with her about their experiences growing up in the City of Innovation. The nonprofit and university are also willing to partner in an effort to find policy solutions to the issues that residents raised in the community meeting.

Together, the group develops a participatory action research collaborative that centers the experiences of youth from the districts with the worst child health outcomes.

The university researchers train the youth on how to conduct environmental audits, interviews, and surveys.

Together with health department staff, the youth and university researchers explore health data comparing outcomes across neighborhoods, the history of the city, and the social determinants of health.

They gather data from youth, families, teachers, and local business owners to help them understand what is behind the high rates of unhealthy weight among children in their neighborhoods.

Slide 68

Through their research, they learn that:

- Young people aren't actually eating very many kids' meals. Rather, many families with children are struggling to get enough to eat overall.
- Because of the rising cost of rent, many families have to make difficult choices between fundamental needs like paying for rent or for food.
- There aren't enough after-school programs and jobs in their neighborhoods.
- Children and families feel unsafe using parks and playgrounds because of frequent reports of violence in those places.
- Parents' concerns about police presence and violence are another reason they don't let their children play outside.

Recognizing that these issues have historic connections to five drivers of health inequity, including disparities in political power and governance that supported meaningful participation, the group developed these policy recommendations:

- Provide universal free school meals.
- Create a summer youth employment program.
- Create a new community policing initiative.

Elena then set up a meeting between the council member and the youth researchers so that they could share their findings and recommendations.

Slide 69

After meeting, the council member calls Elena to thank her for her work supporting the development of the policy recommendations the youth shared. The council member is impressed by the group and especially impressed by the depth of the community engagement that informed their proposal.

The problems and solutions identified all made sense – but there was one problem: the council member had no way to fund these new initiatives.

Elena is disheartened by this news. But then she has an idea: what if instead of introducing a healthy kids' meal policy in response to child obesity, the council member introduces a sugary drink tax to support healthy lives for all children and youth in the City of Innovation?

First, she determines whether this idea is legally feasible and confirms that there is no federal or state law that preempts a sugary drink tax in the City of Innovation.

She then meets with community members to discuss this policy option. It is a tough sell at first, but once community members understand that the tax would support the broad policy and program recommendations developed by the youth researchers, their support for the proposal grows.

Eventually the city council passes the tax, and a youth advisory board is established to periodically review the tax allocations and ensure they continue to align with the community's needs.

Slide 70

So, what does this case study illustrate?

Slide 71

In other words, what are some important lessons from Elena's example about advancing health equity?

A. Having data on an issue is enough to advance health equity

B. Identifying champions within the community and in leadership is important

C. Conducting a preemption analysis can inform solutions

D. B & C

E. None of the above

Slide 72

If you picked D, you are correct. Although having statistics about a health issue may help identify potential policy solutions B and C were important lessons Elena learned to arrive at an appropriate policy solution to advance health equity in the community.

Slide 73

Today, in Part 2 of this series, we have explored how public health practitioners can use law and policy to address the social determinants of health equity. Specifically:

- At the outset of the training, we reviewed how laws and policies have played a key role in creating conditions that have led to inequity and continue to reinforce them.
- We then explored five drivers of the health inequity framework and some evidence-based strategies for addressing those drivers.
- Finally, we discussed concrete actions that public health practitioners can take to advance equity through policy change that centers on cross-sector collaboration and community engagement.
- The training concluded with a hypothetical example illustrating how applying five drivers of the health inequity framework and principles of community engagement can lead to new responses to entrenched health inequity.

Slide 74

Before we conclude, here's some brief background information about the content providers.

ChangeLab Solutions is a nonpartisan nonprofit organization that uses the tools of law and policy to advance health equity. They partner with communities across the nation to improve health and opportunity by changing harmful laws, policies, and systems. Their interdisciplinary team works with public health lawyers; state, tribal, local, and territorial health departments; other government agencies; community organizations; and local institutions to design and implement equitable and practical policy solutions to complex health challenges.

Slide 75

The mission of CDC's Public Health Law Program (PHLP) is to advance the use of law as a public health tool. The program does this by creating tools that can be used to influence public health outcomes. For example, through:

- Training and workforce development
- Communication and partnerships
- Legal epidemiology
- Research innovation and translation

PHLP does all of this to serve CDC programs, as well as state, tribal, local, and territorial communities.

To submit a request or to learn more about public health law, you can visit the program's website at www.cdc.gov/PHLP.

Slide 76

Individuals who work as public health practitioners, lawyers, and policy experts in state, tribal, local, and territorial (STLT) health departments need measurable skills to move their careers forward. The CDC's Public Health Law Program developed the Public Health Law Competency Model to help guide practitioners in career trajectories. This module of the Public Health Law Academy covers the four competencies listed on this slide, to build skills for public health practitioners in public health law. We want to note that these are not the objectives for this course but are general public health law competencies suitable for the workforce and public health students.

The four competencies are:

1. Defining basic constitutional concepts that frame the everyday practice of public health.
2. Describing public health agency authority and limits on that authority.
3. Identifying legal tools and enforcement procedures available to address day-to-day (non-emergency) public health issues.
4. Distinguishing public health agency powers from those of other agencies, legislatures, and the courts.

This training is intended for public health professionals at all levels of their career, from students to entry-level staff to supervisors and executive-level managers.

Slide 77

This slide acknowledges that this training was made possible in part by a cooperative agreement with the CDC and that the views expressed in the training do not represent HHS official policies.

Slide 78

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Slide 79

Thank you for attending our training!