Advancing Health Equity in Minnesota

Executive Summary

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For the full report, go to http://www.health.state.mn.us/divs/chs/healthequity/

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Executive Summary

Minnesota ranks, on average, among the healthiest states in the nation. But the averages do not tell the whole story. Too many people in Minnesota are not as healthy as they could and should be, and the health disparities that exist are significant, persistent and cannot be explained by bio-genetic factors. Minnesota has these disparities in health outcomes because the opportunity to be healthy is not equally available everywhere or for everyone in the state.

The 2013, Minnesota Legislature directed the Minnesota Department of Health (MDH) to prepare a report on Advancing Health Equity in Minnesota The purpose of this report is to provide an overview of Minnesota's health disparities and health inequities, to identify as far as possible the inequitable conditions that produce health disparities, and to make recommendations to advance health equity in Minnesota.

To develop this report, department staff engaged in discussions with a wide range of Minnesota communities. The goal of these discussions was to identify the sources of long-standing health disparities, and to gather diverse perspectives on what changes could be made in systems, policies, and processes to better protect, maintain, and improve the health of all people in Minnesota. Over 180 conversations were held with over 1,000 participants, and nearly 100 persons filled out an online survey, generating approximately 200 single-spaced pages of comments. This legislative report provides a summary of the methods, findings, and recommendations from this process.

Health and Health Inequities

Health is a state of complete physical, social, and mental well-being and not merely the absence of disease or infirmity. Health is created in the community through social, economic and environmental factors as well as individual behaviors and biology. When groups face serious social, economic and environmental disadvantages, such as structural racism and a widespread lack of economic and educational opportunities, health inequities are the result.

These inequities affect many populations in Minnesota:

- African American and American Indian babies die in the first year of life at twice the rate of white babies. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years.
- American Indian, Hispanic/Latino, and African American youth have the highest rates of obesity.
- Intimate partner violence affects 11 to 24 percent of high school seniors, with the highest rates among American Indian, African American and Hispanic/Latino students.
- African American and Hispanic/Latino women in Minnesota are more likely to be diagnosed with later-stage breast cancer.
- Gay, lesbian and bisexual university students are more likely than their heterosexual peers to have struggles with their mental health.
- Persons with serious and persistent mental illness die, on average, 25 years earlier than the general public.

These health disparities persist and are neither random nor unpredictable. The groups that experience the greatest disparities in health outcomes also have experienced the greatest inequities in the social and economic conditions that are such strong predictors of health:

- Poverty rates for children under 18 in Minnesota are twice as high for Asian children, three times as high for Hispanic/Latino children, four times as high for American Indian children, and nearly five times as high for African American children as for white children.
- Unemployment is highest among populations of color, American Indians, and people who live in rural Minnesota.
- While 75 percent of the white population in Minnesota owns their own home, only 21 percent of African Americans, 45 percent of Hispanic/Latinos, 47 percent of American Indians, and 54 percent of Asian Pacific Islanders own their own homes.
- African Americans and Hispanic/Latinos in Minnesota have less than half the per-capital income of the white population.
- Lesbian, gay, bisexual, and transgender youth are at increased risk for bullying, teasing, harassment, physical assault, and suicide-related behaviors compared to other students.
- Low-income students are more likely to experience residential instability, as indicated by the frequency of changing schools, than their higher-income peers in every racial and ethnic category.
- American Indian, Hispanic/Latino, and African American youth have the lowest rates of on-time high school graduation.
- African Americans and American Indians are incarcerated at nine times the rate of white persons.

Structural Racism

A key decision made in the Advancing Health Equity effort was to be explicit about race and structural racism, especially the relationship of race to the structural inequities that contribute to health disparities. Even when outcomes related to other factors such as income, gender, sexual orientation, and geography are analyzed by race/ethnicity, greater inequities are evident for American Indians, African Americans, and persons of Hispanic/Latino and Asian descent.

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. Structural racism is deeply embedded in American society and is a potent factor leading to inequities in all major indicators of success and wellness.

Structural racism is perpetuated when decisions are made without accounting for how they might benefit one population more than another, or when cultural knowledge, history and locally-generated approaches are excluded. When this happens, programs and policies can reinforce or compound existing race-based inequities.

The Practice of Health Equity

In addition to identifying health inequities, this report shares many ways in which health equity can be advanced, based on research, the experience of other states, analysis of the nearly 200 pages of inquiry responses and a review of existing program resources. The practical ways of advancing health equity are directed toward a broad set of partners including the Minnesota Department of Health as well as toward state and local governments, community partners, other state agencies, the health care sector, and organizations across Minnesota.

Recommendations

The recommendations emerging through this report process provide a new approach to addressing health disparities and health inequities in Minnesota. These recommendations expand the understanding and response to differences in health status from a wholly individual or programmatic response to include a broad focus on social factors and conditions (e.g., historical, social, and economic).

1: Advance health equity through a health in all policies approach across all sectors.

Moving to a policy approach to advance health equity requires thinking more broadly and working across sectors to develop healthy public policy. Policies should be examined and resources targeted where efforts will have the greatest effect on populations with the greatest need, from housing to transportation to education and more.

2: Continue investments in efforts that currently are working to advance health equity.

While it is necessary to address the social and economic factors that drive health disparities, this approach must be paired with a commitment to continue the exemplary practices that are already making a difference for the people currently experiencing the impact of these inequities and health disparities.

3: Provide statewide leadership for advancing health equity.

MDH must build statewide capacity to implement a health in all policies approach, convene leaders and include health equity as a key component of policy discussions, and engage new and existing partnerships across all sectors in a shared sense of responsibility for the health of all people in Minnesota.

4: Strengthen community relationships and partnerships to advance health equity.

MDH must expand the range and depth of relationships with multiple communities and create avenues for meaningful participation of Minnesota's diverse communities in project governance and oversight.

5: Redesign the Minnesota Department of Health grant-making to advance health equity.

MDH must adapt grant-making procedures and practices to support a wider range of organizational capacity among MDH grantees, improving training and evaluation methods to advance health equity, and engage a diverse range of stakeholders in the grant development process.

6: Make health equity an emphasis throughout the Minnesota Department of Health.

MDH must assure that health equity and the analysis of structural inequities, including structural racism, become integral aspects of all MDH divisions and programs, and address changes needed in the MDH workforce to advance health equity.

7: Strengthen the collection, analysis and use of data to advance health equity.

MDH must strengthen coordination of data activities related to health equity across all divisions and programs, and develop a long-term plan for improving the collection, analysis, reporting, dissemination and use of health equity data.

Next Steps

Preparation of this report was part of a broader process to strengthen the efforts of the Minnesota Department of Health to advance health equity. Next steps to carry this effort forward include:

Establish the Minnesota Center for Health Equity

The Commissioner of Health established the Minnesota Center for Health Equity in December 2013 with the intent of bringing an overt and explicit focus to the efforts of the Minnesota Department of Health to advance health equity in Minnesota. It is envisioned that the Center will support both existing health department and partner efforts to advance health equity. The Center will serve as a technical resource for the agency and its state and community partners and create a solid, data-driven footing for health equity efforts. It will focus on building the capacity to collect and analyze data and community experience on health and health inequities as well as the pathways to opportunity, and will support and encourage the collection and analysis of race, ethnicity, preferred language, social and economic determinants, and LGBTQ data in relevant data sets. In addition the Center will work to increase cultural understanding and deepen working relationships across program areas and will assist in identifying promising practices with communities experiencing the greatest health disadvantage.

Convene and coordinate a cabinet-level health equity effort

The Commissioner of Health will invite state agency commissioners together in the spring of 2014 to consider how to include health equity as a key component of policy discussions. The cabinet members will consider ways to routinely incorporate health considerations and embed health equity in state government structures, processes and decision making.

Implement the Advancing Health Equity recommendations

The Minnesota Department of Health will determine where policy decisions are needed, both internal and external; develop policy recommendations in partnership with the community, tribes, and state agencies for the 2015 Minnesota legislative session; identify resource needs and develop training and communications plans for MDH; and maintain attention on operational areas noted in the recommendations, such as grant-making, data systems, and work force development.

As this work continues, the health department will be challenged to play an increasing leadership role across state agencies, community partnerships and with business and industry relationships. The department also needs to continue to educate more people and organizations about health equity, and to encourage specific and visible steps to advance health equity across all sectors of Minnesota.

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