

**Centers for Disease Control and Prevention (CDC)  
Advisory Committee to the Director  
Health Disparities Subcommittee  
April 29, 2009**

The Health Disparities Subcommittee (HDSC) to the Advisory Committee to the Director (ACD) met at CDC's headquarters campus in Atlanta, Georgia, on April 29, 2009. Subcommittee Chair Dr. Nisha Botchwey called the meeting to order at 2:10 p.m. Those in attendance over the course of the meeting were:

*ACD Committee members:*

Ms. Vivian Berryhill (by telephone), National Coalition of Pastors' Spouses  
Ms. Linda Blount, American Cancer Society (ACS)  
Dr. Phillip Bowman, University of Michigan  
Dr. Moon Chen, University of California at Davis  
Dr. Fleda Jackson (by telephone), Emory University  
Dr. James Rimmer, University of Illinois at Chicago  
Dr. Elena Rios, National Hispanic Medical Association  
Ms. Bobbie Ryder, National Center for Farmworker Health  
Dr. John Seffrin, ACS  
Dr. Walter Williams, HDSC Designated Federal Official (DFO)  
Dr. Adewale Troutman, University of Kentucky (by telephone)

*CDC staff:*

Drew Barrett, DFO, Ethics  
Darren Burton, ACD Health Equity Workgroup

*Others:*

Dr. Robert Hood, FL DOH, Co-Chair Ethics subcommittee, (by telephone)  
Ms. Kamari Jones: Health Equity Workgroup member  
Ms. Marion McDonald, Health Equity Workgroup member

## **PROCEEDINGS**

*Health Disparities Subcommittee Overview*

Dr. Williams outlined the context in which the HDSC works since its initial activity in 2006-2007; the dimensions of the health disparities it addresses; its member composition over time; its reconstitution this year and, recently, its new charge. The HDSC did not work in 2007-08, as its parent committee (ACD) was not reconstituted until 2008.

Major health disparities exist across many dimensions of measurement: health status (burden of illness/death); gaining access to healthcare and then maneuvering within it; insurance coverage; types of care (preventive, acute, chronic) and quality of care (effective, safe, timely); and diverse settings of care, such as dentists, doctors, emergency rooms, nursing homes, etc. Many of those

who encounter these disparities are in minority racial and ethnic populations, as well as those in disadvantaged socioeconomic groups, or who live in underserved urban or rural areas. Gender, age, disability and their related risk status are other factors contributing to health disparities.

The 2006-07 HDSC membership included three ACD members and ten non-ACD members, who were broadly representative.<sup>1</sup> The subcommittee's charge was to advise the CDC director's address of health disparities, in achieving CDC's health impact goals; to support development of objectives specific to these disparities; to advocate for corrective actions; and to provide guidance to CDC on opportunities to work with other relevant sectors in this regard. During 2006-07, the subcommittee conducted a detailed review of CDC's structure, core values, operational framework, strategic imperatives, and health protection goals/subgoals. It participated in public partner engagement processes across the country, where facilitated sessions reviewed proposed objectives and recommended on starter objectives, approaches and prioritization criteria, to address health disparities throughout the context of CDC's work.

The 2009 HDSC reconstitution was almost complete as of this meeting. Again, it has three ACD members, but also two additional non-ACD members who add expertise in policy analysis and strategic planning. The new charge was similar to the last, to address health disparities broadly, but added support to CDC's work on health equity and support to its work on health systems reform.

*Discussion* included clarification that the "advocacy" cited in the charge is not for policy change on Capitol Hill, for example, but to invite input on appropriate CDC action relevant to health disparities, based on the members' own work and expertise.

#### *ACD Ethics Subcommittee Overview*

Dr. Drue Barrett (ESC DFO) and Dr. Robert Hood (ESC Cochair) provided an overview of that subcommittee's work. Originally convened to address the influenza seasonal vaccine shortages in the 1990s, the ESC was reconvened in January 2005 to discuss the considerations relevant to terrorism response (e.g., vaccination prioritization). In May 2005, in response to the ESC's recommendation, an Internal Public Health Ethics Committee (PHEC) was formed under CDC's Chief Science Officer, Dr. Tanja Popovic. Dr. Barrett has been the PHE coordinator since June 2006.

The ESC counsels CDC on questions of public health ethics and issues arising from CDC programs, scientists and practitioners. It also supports the agency's

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<sup>1</sup> Health, cancer disparities and research relevant to Asian/Pacific Islanders, American Indians, Alaskan Natives, Asian Americans, Black/African Americans, Gays/Lesbians, Hispanics; as well as community interventions/professional training; disability/physical activity; public health practice/health disparities; rural and migrant worker health; and sociology/health disparities research.

development of internal capacity to identify, analyze and resolve ethical issues. Internal workgroups are key to developing ethics guidance and building capacity, and 3-4 trainings are provided annually at CDC. With Drs. Robert Levine (Yale) and Kathy Kinlaw (Emory), the subcommittee also developed ethical guidance for pandemic flu response, regarding the allocation of scarce resources and the use of liberty-restricting interventions. Specific guidance in development is expected by year's end, on pandemic ventilator distribution. The ACD also accepted the ESC's guidance for public health emergency preparedness and response ethics guidance. The lead authors of this white paper were Bruce Jennings (Center for Humans and Nature) and John Arras (University of Virginia), to be published in the *MMWR*. Release of five other completed focus papers<sup>2</sup>, based on this white paper's main points, is expected by year's end. The subcommittee is working on the ethics related to traveler restrictions for those with communicable diseases; related SOPs are being developed by CDC's Global Migration and Quarantine group.

A new charge for the ESC is in discussion, encapsulated in two goals. In addition to discussing the conceptual and normative issues that define the ethical aspects of public health and health reform, the ESC: 1) may particularly emphasize the role and importance of social determinants of health; and 2) examine the ethical imperatives and best approaches for integrating health considerations into societal policies across all sectors and levels of society. This was termed as "enacting' health in all policies".

Preliminary discussion of conceptual outcomes and related ESC work has begun, pending ACD response, including better collaboration with non-traditional partners vis-à-vis the nation's health reform efforts. The ESC also hoped to collaborate with the HDSC, as their work aligns. Dr. Barrett invited the HDSC's assistance to develop guidance documents with the planned ESC workgroups, which mostly work via conference call.

*Discussion* included Dr. Barrett's agreement to send the ESC's white paper submitted to the ACD for the HDSC members' review. Dr. Williams will distribute the paper. Mission overlap and how to maximize the two subcommittees' coordination was discussed. The major difference is that the ESC focuses on the ethical considerations/methods involved, while the HDSC focuses on defining specific choices to be made. The ESC's review of the HDSC's choices would be appreciated and interested HDSC members were invited to attend the next ESC meeting (June 17-18).

The ACD will review the ESC's guidance and the HDSC's planned policy brief. The two documents could be done jointly and released after ACD approval or, with contextual consensus between the two reports, each could each be endorsed by the other group and ensure aligned communications from CDC.

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<sup>2</sup> Addressing: research during public health emergencies; vulnerable populations; justice, resource allocation and stockpiling; professional, civic and personal obligations; and community consultation.

Dr. Hood will raise this at the ESC's June meeting, where there is disagreement on what people are "due." The HDSC could assist in clarifying "equality." Is it a question of equal opportunity to access healthcare, or equality of opportunities in terms of health outcomes? CDC's strategy or policy initiatives may turn on such conceptual approaches. Dr. Williams will participate in the June 17<sup>th</sup> afternoon ESC meeting and Ms. Berryhill also expressed her interest in attending. It was agreed that the work of the HDSC's Health Equity Workgroup had to be coordinated with the ESC's activities. A meeting by the Institute on Social Determinants of Health at the February 2009 Third National Leadership Conference prompted formation of an ad-hoc CDC Social Determinants of Health Workgroup. They have presented to the ESC, as has the National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP) on their consultation about determinants of health. The ad hoc SDH workgroup is developing a 2-page report for CDC Acting Director Richard Besser.

Development of a coauthored paper/policy brief by the HDSC and the ESC, or development of different but complementary papers will be discussed by Drs. Barrett and Williams, to coordinate the option to be followed. Dr. Williams will check with the ACD DFO to determine if the HDSC should be coordinating with any other ACD subcommittees. The ACD charter allows for 5-6 subcommittees.

That was appreciated, given the HDSC members' expressed wish for a better contextual understanding of the HDSC's work within CDC's activity. The members also requested a summary of CDC's work regarding health system reforms. That included a previous focus on the Healthiest Nation Alliance, a nonprofit that focuses on health systems reform. Dr. Williams will provide a link to the Healthiest Nation Initiative. Further work with that initiative awaits the decision of the new CDC director, but that will not affect the HDSC's charge.

*HDSC Coordination.* It was agreed that the ESC's focus on the ethical/normative dimensions of issues and the descriptive value of equity and social values is rarely found, and it could contribute as a foundation to the HDSC's work. The challenge is how to coordinate the two; the HDSC to develop recommendations for the ESC's response, or to do so based on ESC recommendations? This will be discussed.

*Healthy People 2020.* Ms. Ryder asked the HDSC's overall role in relationship to the Healthy People 2020 goals. Dr. Troutman, who is on the HP2020 advisory committee, reported their work to define "health equity," and their understanding that all those doing this defining need to coordinate with each other – particularly the agencies that will be largely responsible for implementing HP2020 over the next decade. A common understanding is essential, especially as regards the HP2020 objectives and health indicators. In the HEWG charter, the fourth bullet should add "and HP2020."

Dr. Williams reassured those present that CDC is a formal reviewer of the objectives, with the involvement of the Health Equity Workgroup members. Health disparities will be examined in context.

### **CDC's Role In Achieving Health Equity In A Healthier America**

Dr. Williams reported that the Health Equity Workgroup's charge arose from international discussions about this issue. This workgroup reviews the alignment of CDC's goal action plans and ensures that work on health system transformation includes health protection and health equity

In the context of CDC's mission toward the goal of a healthier American, health equity has been defined as the absence of health disparity; the presence of health equality among groups with more or less social advantage, and fairness in the opportunity to achieve optimal health status. The challenge to achieve this is exacerbated by the growing proportion of people immigrating from less developed countries. Health inequities linked to social disadvantage will reduce the overall health of the entire nation. With other countries and with U.S. states already proactively addressing this, CDC should lead, not follow.

A Health Equity Workgroup (HEWG) was formed to define health equity. Its 12 members listed criteria for and conducted a review of existing definitions and literature, and developed three proposed definitions for CDC's Executive Leadership Board. The latter selected a working definition: *"Health equity is the fair distribution of health determinants, outcomes and resources within and between segments of the population, regardless of social standing."* The HEWG was asked to circulate that for more input from CDC employees, as regarded three questions: the contribution (or limitation) of this definition to the staff's work; potential revisions to make the definition more useful to CDC; and what the individual and their organizational unit at CDC currently did to support work on health equity. In the end, the ELB's definition was chosen, but the conversation continues

WHO and others all have their own definitions but, while none are exactly alike, they all have two overarching concepts: health equity achieved through the absence of modifiable health disparities, and the absence of the conditions that frustrate enhanced longevity and health, particularly among disadvantaged groups (i.e., differences in the determinants of health).

### **HEWG Development Of A Health Equity Operational Definition**

Dr. Burton described CDC's move from the theoretical definition above to an operational platform. To do that, all the subsidiary concepts had to be identified and framed as measurable subunits. Then, to combine those subunits into a single overall measure, mathematical relationships were needed.

In this case, the subconcepts of the health equity are “fair,” “distribution,” “health determinants,” “outcomes and resources,” “population segments,” and “social standing.” Each of these were clearly defined, then arranged in a flow pertinent to operationalizing the definition. The order of concepts reflected logical dependencies; that is, health outcomes had to be specified to select appropriate distribution criteria to population segments, regardless of social standing, to be equitable.

The steps in operationalizing a useful working health equity definition were to: 1) select a health outcome/determinant or resource of interest; 2) select metrics to describe the distribution of that concept (e.g., mean, rate, prevalence, confounding factors not related to “fairness” such as age distribution); 3) select social standing parameters of interest (e.g., income, educational level, race, ethnicity, etc.); 4) use those social standing parameters to define population segments between and within which the metrics selected (step 2) will be compared; 5) define criteria to determine the presence/absence/degree of “fairness” when comparing distribution metrics between/within population segments (i.e., identify meaningful differences between these groups); and 6) apply the fairness criteria to the distribution metrics, and report the presence or lack of health equity.

This resulted in an operational restatement of the health equity definition: *“Health equity is operationally defined as the satisfaction of specified criteria for assessing fairness when comparing selected metrics of health outcomes, determinants, and resources between (and within) population segments, defined by selected attributes related to social standing.”* This provided each step in the process an operational aspect, proceeding from an *a priori* decision about the key (underlined) parameters of interest.

According to the steps above, the example of high blood pressure was shared, based on a monograph (on CDC’s Website<sup>3</sup>). 1) Data supported selection of this outcome of interest. 2) To allow for comparisons between population segments, the measurement metric selected was the percentage of adults (age adjusted, those  $\geq 20$  years) with hypertension or taking blood pressure-lowering medication. 3) To define the criteria for assessing fairness/equity, they selected a  $< 1.0\%$  difference between the population segment metrics, to the tenths decimal point. This percentage was selected because even a 1% difference in prevalence between population segments represents a substantial absolute difference in disease burden. 4) The fairness/equity criteria were applied to selected population segments to see whether those criteria were satisfied. Based on the data, they were not satisfied for gender (prevalence in all women or all men) or for poverty status levels, with very few exceptions (e.g., lower prevalence in white women).

This work is an ongoing process, and the HDSC’s input will be welcomed.

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<sup>3</sup> “Facts and Statistics on High Blood Pressure,” <http://www.cdc.gov/bloodpressure/facts.htm>

*Discussion.*

Ms. McDonald, who is the HEWG convener, clarified that there was a diversity of views within the workgroup. The vetting of the definition among CDC staff produced many good comments that were not used by the ELB, something she thought unfortunate. She expressed concern that the high focus on measurement would obscure the big picture. While this is a good process to go through, examining and measuring everything will not produce all the answers. As an example, she cited as the real concern the fact that black women die at higher rates of heart disease, not so much due to elevated blood pressure. The measurement approach also mistakenly assumes that everything relevant has been studied and measured, which involves aspects excluded from study/measurement. For example, outcomes are affected by societal inequities in the perception of aging, such as the rarity of blood pressure checks among the elderly.

Dr. Burton clarified that the process CDC is working through is not intended to be limiting; he simply used an existing dataset to demonstrate the process. This is not for programs investigating new areas or determinants, but to help them consider what data they might want to collect. Dr. Williams added that the cancelled ACD meeting of the following day was to discuss possible Health Equity Workgroup products, such as using this process to define and measure inequitable conditions and a program's impact.

CDC was commended for tackling this challenge. This was an impressive attempt to build on evidence, to submit a complex construct like health equity to a scientific construct and practical measurement. The notion of turning this into a operational exercise was commended, to define what needs to be measured and to produce a methodology to operationalize it into action, policy change, community organizing, etc., to eliminate the inequity and create a more equitable situation. Some of the same issues are being wrestled with for the Healthy People 2020 program.

Other comments included:

- Whether the HDSC should use this methodology as a policy framework is a question to be determined by CDC leadership, which awaits the new CDC director.
- Determinants are often examined at a societal level. A top down approach to examine the macro level of such social determinants as such as employment, poverty, education level, etc., should also be discussed by a specific group. Dr. Burton clarified that this example used health outcomes, but other determinants could be used. The HEWG hopes to expand on this process.
- The ACS offered to share their work on a statistical model to look at interdependencies of social determinants to cancer outcomes. They have found SES to be a huge contributor to health outcomes.

- Another perspective that could be explored is whether health equity has ever been achieved, such as in the military population. Dr. Williams added a potential historical example of the Cherokee nation before the Trail of Tears.
- Using a single method automatically eliminates other perspectives that may not undermine the point of the approach taken and could suggest other aspects, such as by adding ethnographic and qualitative approaches. For example, University of Illinois cultural anthropologist Susan Russell would suggest considering some of Ms. McDonald's points, which cannot be addressed by the traditional public health statistical and biological science approach. People need to be addressed in their context with multiple methodological approaches: quantitative, qualitative, cultural, etc., rather than being delimited to one consideration. It is particularly true that dealing with people in their organizational setting helps when the need is not only to understand, but to take action to reduce the problem. Ultimately, a multi-method approach could provide the richest results, and may help reduce some of the HEWG's conflict/tension.
- There was lingering discomfort with the definition's focus on the absence of something, rather than the more empowering approach of defining what should be present.

Dr. Botchwey **moved to issue a recommendation that the definition take on a positive framework; that is, health equity is the presence of certain things (to be specified by the Health Equity Workgroup) to be driven by social determinants. It should include language that this would take on a multi-method approach to evaluation, and clarify that the definition would lead to some operation or action. The goal is to be intentional, not just defining this, but implementing it to create change.**

The motion was seconded by Dr. Troutman. With no discussion, all voted in favor and none were opposed. The **motion passed.**

### **Review, HDSC Action Agenda**

To guide the HDSC's development of a policy brief on health equity and social determinants of health, with recommendations on appropriate public health practices for CDC and implications for CDC policy/program action, Dr. Williams discussed examples of such previous work by CDC advisory committees. In general, the formats included an introduction or executive summary, review of relevant published (and other sources of) information; a multi-disciplinary review, cost benefit analyses, resulting recommendations and a reference list.

The meeting book held sample recommendations by the Advisory Committee on Immunization Practices; recommendations to the NCHHSTP and the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), and other background materials:

- The NCHHSTP recommendations embodied CDC’s efforts to address the social determinants of health (SDH):
  - The external consultation, referenced earlier, to identify key priorities relevant to NCHHSTP program focus areas. The consultants reviewed social determinant models and case studies based on CDC programs, discussed and recommended action steps to identify social determinant issues relevant to that process.
  - A green paper addressing SDH among people disproportionately affected by HIV/AIDS, Viral Hepatitis, STDs and TB. This resulted from a meeting convened to identify common social determinants of health across diseases and discussion of integrated approaches – i.e., common drivers.
  - An abstract on addressing SDH in infectious and chronic diseases.
- National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP): report to the Excellence in Science Committee and report that of the National Expert Panel on the Social Determinants of Health Equity.
- Other background materials provided were:
  - “Promoting Health Equity Workbook: A Resource To Help Communities Address Social Determinants of Health” – this is CDC’s resource book for communities.
  - The “King County Equity and Social Justice Initiative, January 2008 Update Report” – examines underlying issues affecting health equity and designing interventions to address them.
  - “Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission To Build A Healthier America, February 2008.”
  - Other countries’ work to address SDH (e.g., U.K., Canada, WHO).

### *Discussion*

Given the amount of material, Dr. Botchwey suggested the subcommittee begin by brainstorming on focus areas for a policy brief, and then teleconferencing further. A subgroup and leadership structure will be developed to write the report, and to discuss a partnership structure to work with the Health Equity Workgroup and on the HP2020 recommendations.

### *Focus areas were discussed:*

- *Practicality.* Defining equity, focusing on determinants, outcomes and resources, and achieving equity in those.
  - Ensure that recommendations result.
  - Target CDC as the audience; CDC mission statement will be part of the context.
- *Organizational linkages.* Clarify the link between the HDSC, the Health Equity Workgroup and the Ethics Subcommittees

- Look for indicators as a starting point in the HP2020 work and the DHHS reports' address of health disparities, and put those in a broader context to advance the health disparities agenda.
- *Policy Paper.* Frame a policy paper to drive CDC's contribution to health equity, whether nationally or internationally, building on in what it already does well: research, analysis, approaches for intervention, tools for measurement, etc.
  - Internally, CDC could contribute the above relevant to SDH and health equity, using the public health research model, looking at risk predictors, etc., and applying those to an approach like this; i.e., recommendations on what should be done to deal with core health equity issues.
  - Take advantage of CDC as a catalyst for state/local health disparities work – an untapped resource.
  - Answer the “what; so what; then what” questions in the paper. Many of these determinants date back centuries. Perhaps develop minimum goals or standards to begin to turn that curve, projecting likely results with- and without action.
  - Research existing tools from other agencies (e.g., how the housing department finds out social determinants relevant to housing).
- The point is that real people have health disparities and there now is enough information to support a population-based rationale. In terms of the rationale for doing this work, perhaps think about a population-based health disparities focus, to weaving the issues back into the social fabric in which these populations live, work, etc. (i.e., the sub-population's SDH). A practical approach, building on minimum goals, will help to move from the theoretical/big picture aspect to a way of communicating this, so as to be easily embraced by the people in the community who can help achieve this. That is, translate this work to develop policy to an application in reality.
  - That will involve multiple aspects that emerge from an initial policy brief, perhaps compiled as a report, manual or other tool for community-based implementation. The document needs to “sing” to speak to the community leader, legislator, and/or funder, using easily comprehensible language to convey the heart of the recommendations.
- *Policy Linkages.* Recommendations will be needed to address the partnerships and collaborations needed across sectors and levels.
  - Sectors would include what public health controls versus aspects under other federal agencies' jurisdictions. That is a policy issue.
  - Partnerships and collaborations in joint action across levels from global to federal, state to local communities, and in a global context. CDC is already somewhat structured that way, but policy needs to consider alliances to help this devolve down or evolve up on multiple level and across sectors.

- Consider policy to engage/mobilize people to ensure the policy's implementation/effect. The complexity of social determinants of health cannot be addressed without thought about the boundaries.
- Remain cognizant of opportunities to:
  - inform future policy in other areas outside of the HDSC's jurisdiction. CDC is a world authority. An HDSC conclusion will have impact that "we need to inform policy makers that progress, unlike polio, can't be achieved by vaccines alone. Major improvements can only be achieved by systematic reductions in the social determinants of health related to disparities."
  - connect to this new paradigm, moving beyond the traditional approaches of the public health curriculum, health education, etc., to a social determinants model. Those leading the HDSC and ESC should be included in CDC's focus on a policy agenda so as to ensure inclusion of equity considerations.
  - build upon existing relevant community leadership (e.g., for disability issues) to include the social determinants context, curriculum development champions, and enhance current health disparities model programs (e.g., REACH, National Diabetes Education programs).

*Framing the paper.* Policy can be discussed in a linear way, but frame this with the high-stakes issues involved:

- Make health an issue in other disciplines such as education, bringing what is implicit to the fore. Deal with disparities by first acknowledging the difficulty to act with integrity without health in all sectors – a very different way of thinking about policy.
- *Use timing.* Wilbur Cohen commented that the social pendulum has "about a 40 year cycle," and always swings back. Capitalize on the new administration's forward motion, to raise consciousness that it's the right time to do the right thing and to develop and apply solutions to health disparities. "In another decade we'll be either a vibrant healthy nation with a lot of old people, or we'll be disabled." Given the knowledge about keeping people well, this is the time to act, and it's also important to know the consequences for failure to act. That is a compelling argument, an "offer you can't refuse."
- Factor in international partnerships, starting with close to home, as this pertains to immigrant issues. The U.S. is making an expensive mistake in wasting precious resources with a reliance on cheap labor (particularly Mexican immigrants) and with the incarceration and disparities of African Americans. Granted, CDC's ability to make such links abroad with Ministers of Health is not paralleled within this country. It will take courage to "get into the face of housing, education," etc., to say what needs to be done in policy to produce results in 30 years. Perhaps a focus could be on

shifting resources to the community (e.g., the private sector, housing, employment, etc.) to provide capital to those without it, or equitable employment to those with disparities. Consider shifting the paradigm to include all different groups in a community to build health – safety, transportation, etc. – starting with the lowest common denominator (barriers to persons with disabilities) and working up from that.

*Economic consequences.* There are strong national and international market drivers for what happens in the U.S., such as exploitation of cheap labor here and in other countries. Better health outcomes in other countries such as Canada, Japan, and Sweden, have been described in the media (e.g., January 2008 *Annals of Internal Medicine*; U.S. News and World Report article by Robert Kutner) as have the U.S.' differences and market drivers.

- The percentage spent on healthcare enriches people, resulting in strong pressure to keep it that way despite strong evidence to the contrary.
- Many health economists say there is enough in the system; the problem is how the capitol is distributed. At some point, someone has to raise the issue of wealth distribution. Some countries' citizens are willing to pay a 50% income tax to ensure lifelong care. The point is that, at the bottom social rung, people are suffering, and that investment is going to go there anyway. Medicare, Medicaid, the Vaccines for Children Program, in effect already are income distribution. Other factors involve social, financial and educational capital (e.g., having a neighbor to take you to the doctor, etc.) that, when used, can reduce costs.
- CDC is most well known for addressing epidemics, but less so for prevention. Most Americans' focus is on access to care and getting health problems 'fixed' rather than avoided. The HDSC should draw attention to the value of reducing the destructive SDH to optimize disease/disability prevention and cost reduction.
- The ultimate goal is changing behavior at the community and individual level, and communication is important to that. One aspect to this is the likelihood that, by the year 2040, the majority of U.S. citizens will be Hispanic – something relevant to “turning the curve” in direction.

The workgroup to develop the paper will be led by Dr. Botchwey assisted by Ms. Blount and Dr. Bowman. They will confer by phone and report to the subcommittee in the HDSC teleconference.

Partnerships to be pursued by the HDSC will be with the CDC HEWG; ACD ESC; the Social Determinants of Health Workgroup; those developing the HP2020 program. The HDSC also will seek to participate in CDC's health reform activity.

The next in-person meeting will be in October. An August teleconference will be held beforehand to discuss the members' review of the draft policy paper. The subcommittee leadership will confer by phone before that.

Information on the June 17 Health Ethics Subcommittee meeting will be shared, for HDSC members who wish to call in to help them create their agenda.

### **Concluding Comments**

Dr. Williams noted that the Executive Summary of the report by the National Expert Panel on the Social Determinants of Health Equity presented eight recommendations. He congratulated the group on framing at least four or five of these in this meeting as aspects on which the policy paper should focus: public engagement, trans-disciplinary and multisectoral partnerships, internal aspects and CDC's role in data collection, monitoring analysis, etc.

Dr. Botchwey **moved to adjourn the health disparities subcommittee meeting.** With no discussion and all in favor, the meeting then adjourned.

The action items from this meeting are attached.

### **CERTIFICATION**

**I hereby certify that, to the best of my knowledge, the foregoing is an accurate representation of the conduct of this meeting.**

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**Marie Josette Murray, SoWrite, Inc.**

Atlanta, Georgia

404-522-6560

sowrite@bellsouth.net

**Centers for Disease Control and Prevention (CDC)  
Advisory Committee to the Director, Health Disparities Subcommittee  
Summary of the April 29, 2009 Meeting**

A quorum of the Health Disparities Subcommittee (HDSC) to the Advisory Committee to the Director (ACD) met at CDC's headquarters campus in Atlanta, Georgia, on April 29, 2009. Several presentations were provided. Action items from this meeting are attached.

*An overview of **the character of major health disparities** in the U.S. was provided, by burden of illness/death; access to and use of healthcare; insurance coverage; types and of care and the quality of that accessed in diverse healthcare settings. Disparities affect minority racial and ethnic populations, groups disadvantaged by socioeconomic status or residence in underserved urban or rural areas. Health risks related to gender, age, and disability also are factors.*

*An overview of the **HDSC** was provided, with its charge is to address health disparities broadly and its activity since its initial activity in 2006-2007; its member composition, this year's reconstitution with two additional non-ACD members with expertise in policy analysis and strategic planning; and its new charge to support CDC's work on health equity and on health systems reform.*

*An overview of the **ACD Ethics Subcommittee (ESC)** was provided. The ESC counsels CDC on questions of public health ethics and related issues arising from CDC programs, scientists and practitioners. It also supports the agency's development of internal capacity to identify, analyze and resolve ethical issues. The ESC has issued and is developing white papers on the ethics of public health emergency preparedness and response (these will be shared with the HDSC members) and it conducts internal CDC ethics workgroups and trainings. Its charge now includes discussion of the conceptual and normative issues that define the ethical aspects of public health and health reform, involving 1) the social determinants of health (SDH) and 2) the ethical imperatives and best approaches for integrating health considerations into societal policies across all sectors and levels of society (i.e., "enacting health in all policies").*

*Collaboration between the ESC and the HDSC was invited and welcomed by both, as their work aligns. The major difference is that the ESC focuses on the ethical considerations/methods involved, while the HDSC focuses on defining specific choices to be made. It was agreed that the ESC's focus on the ethical/normative dimensions of issues and the descriptive value of equity and social values is rarely found, and it could contribute as a foundation to the HDSC's work. But, how to coordinate?*

The ESC's review of the HDSC's choices would be appreciated and the HDSC could assist in clarifying "equality," a debate in the ESC. That is, does this involve equal opportunity to access healthcare, or equality of opportunities in terms of health outcomes? Interested HDSC members will attend the next ESC meeting (June 17-18). The subcommittees' DFOs also will discuss two collaborative approaches: 1) joint development of papers/policy briefs to be approved by the ACD, or 2) arranging contextual consensus between the two's reports, each endorsed by the other group and ensuring aligned CDC communications.

The HDSC members asked for clarification of their coordination with any other ACD subcommittees and with Healthy People 2020 work. They also requested a summary of CDC's work regarding health system reforms.

*A presentation on CDC's Health Equity Workgroup (HEWG) was provided. Its members review the alignment of CDC's goal action plans and ensure that work on health system transformation includes health protection and health equity. The workgroup developed three working definitions of "health equity" for CDC's Executive Leadership Board, which selected the following: "Health equity is the fair distribution of health determinants, outcomes and resources within and between segments of the population, regardless of social standing." CDC's internal conversation about this continues. While the many definitions of health equity worldwide vary, they all have two overarching concepts: health equity achieved through the absence of modifiable health disparities, and the absence of the conditions that frustrate enhanced longevity and health, particularly among disadvantaged groups (i.e., differences in the determinants of health).*

The HEWG's development of an operational definition for health equity was described. They took all the definition's subsidiary concepts ("fair," "distribution," "health determinants," "outcomes and resources," "population segments," and "social standing") and framed them as measureable subunits that, when combined in mathematical relationships, could produce a single overall measure. The order of concepts reflected logical dependencies; that is, health outcomes had to be specified to select appropriate distribution criteria to population segments, regardless of social standing, to be equitable.

The steps in operationalizing a useful working health equity definition were to: 1) select a health outcome/determinant or resource of interest; 2) select metrics to describe the distribution of that concept (e.g., mean, rate, prevalence, confounding factors not related to "fairness" such as age distribution); 3) select social standing parameters of interest (e.g., income, educational level, race, ethnicity, etc.); 4) use those social standing parameters to define population segments between and within which the metrics selected in Step 2 will be compared; 5) define criteria to determine the presence/absence/degree of "fairness" when comparing distribution metrics between/within population segments (i.e., identify meaningful differences between these groups); and 6) apply the fairness criteria to the distribution metrics, and report the presence or lack of health equity.

This resulted in an operational restatement of the health equity definition: *"Health equity is operationally defined as the satisfaction of specified criteria for assessing fairness when comparing selected metrics of health outcomes, determinants, and resources between (and within) population segments, defined by selected attributes related to social standing."* This provided each step in the process an operational aspect, proceeding from an *a priori* decision about the key (underlined) parameters of interest. This method was demonstrated for the subcommittee by its application to determining the health equity issues relating to high blood pressure.

#### *Discussion*

The overall HEWG debate was clarified, centering on concern that a focus on scientific measurement risked obscuring the big picture. In the given example, the real concern is the fact that black women die at higher rates of heart disease, rather than elevated blood

pressure. Additionally, the measurement approach is mistaken to assume that everything relevant has been studied and measured (e.g., it cannot factor societal inequities in the perception of aging, such as few blood pressure checks of the elderly).

CDC clarified that the process underway is not intended to be limiting; this dataset was just used to demonstrate the process and indicate how it could help programs consider helpful data collection. Other HEWG products are to be discussed, such as using this process to define and measure inequitable conditions and a program's impact.

CDC was commended for tackling this challenge and particularly for working to operationalize it into action, policy change, community organizing, etc., to eliminate the inequities. HP2020 is wrestling with similar issues. Comments included:

- One suggestion was to form a workgroup to use a top-down approach to discuss the macro level of social determinants (e.g., employment, poverty, education level). Another perspective that could be explored is whether health equity has ever been achieved, such as in the military population.
- The ACS offered to share their work on a statistical model to look at the interdependencies of social determinants (particularly SES) to cancer outcomes.
- To avoid the tendency of a single method to automatically eliminate other perspectives that may, in fact, be helpful to suggest other aspects (e.g., adding ethnographic and qualitative approaches), consider expanding the traditional public health statistical and biological science approach. Use a multi-method approach to address people in their context; that is quantitatively, qualitatively, culturally, etc., to provide the richest results.
- Rather than the definition's focus on the absence of something, a preference was voiced for a more empowering approach of defining what should be present.

**Dr. Botchwey moved to recommend that the definition take on a positive framework; that is, health equity is the presence of certain things (to be specified by the Health Equity Workgroup) to be driven by social determinants. It should include language that this would take on a multi-method approach to evaluation, and clarify that the definition would lead to some operation or action. The goal is to be intentional, not just defining this, but implementing it to create change.** The motion was seconded. Without discussion, all were in favor and none opposed. The motion passed.

### ***Review, HDSC Action Agenda***

To guide the HDSC's development of a policy brief on health equity and the social determinants of health, with recommendations on appropriate public health practices for CDC and implications for CDC policy/program action, the members had been provided with extensive reference materials: sample recommendations by the Advisory Committee on Immunization Practices; recommendations and consultations to CDC's Centers, and background materials from abroad. Generally, these materials had in common an introduction or executive summary, review of relevant published (and other sources of) information, a multi-disciplinary review, cost benefit analyses, recommendations, and a reference list.

Given the amount of material, the subcommittee began by brainstorming on focus areas for a policy brief; further work will be done by teleconference. A subgroup and leadership

structure were developed to write the report, and to discuss a partnership structure for work with the HEWG and on the HP2020 recommendations.

Focus areas discussed for the policy paper included practicality (defining the audience as CDC and discussing the components of health equity), addressing beneficial organizational linkages to address/achieve health equity; developing the policy paper's framework to drive CDC's contribution to health equity, building on in its own expertise and that of other agencies. To establish the rationale for this work, CDC should consider a focus on population-based health disparities, to weave the issues back into the social fabric in which these populations live, work, etc. (i.e., the sub-population's SDH) and indicating how to translate this to develop policy applicable in reality. The resulting multiple aspects emerging from the policy brief could be compiled as a report, manual or other tool for community-based implementation.

*Framing the paper* should be done in such a way as to incorporate health in other disciplines such as education. The new administration offers advantageous timing for this fresh perspective and approach. The compelling argument is that "In another decade we'll be either a vibrant healthy nation with a lot of old people, or we'll be disabled." Given the knowledge about keeping people well, this is the time to act, and it's also important to know the consequences for failure to act.

In other areas, policy linkages should be addressed with recommendations on the needed partnerships and collaborations across sectors and levels, domestic and globally.

Consider shifting the paradigm to include all different groups in a community to build health – safety, transportation, etc. – perhaps starting with the lowest common denominator (barriers to persons with disabilities) and working up from that.

CDC should remain cognizant of opportunities to use its reputation as a world authority to inform future policy in other areas outside of the HDSC's jurisdiction, to advance the address of health equity issues with a social determinants model (e.g., participating in CDC's policy agenda formation to ensure inclusion of equity considerations). Existing relevant community leadership (e.g., again, disability) should be enlisted to include the social determinants context. International partnerships should be addressed, as this includes immigration issues. The perspective should be voiced that health disparities waste precious national resources, such as reliance on cheap Mexican labor, African American disparities in health and incarceration. Granted, that CDC's ability to make such links abroad with Ministers of Health is not paralleled within this country. It will take courage to "get into the face of housing, education," etc., to say what needs to be done in policy to produce results in 30 years.

Significantly, there are strong national and international market drivers to support keeping the U.S. healthcare system and status as it is, despite strong evidence to the contrary. Many health economists say there is enough in the system; the problem is how the capitol is distributed. Essentially, that investment will be spent anyway. Such programs as Medicare, Medicaid, and the Vaccines for Children Program, in effect already are income distribution. At some point, someone has to raise the issue of wealth distribution and note the other factors involved of social, financial and educational capital (e.g., having a neighbor to take you to the doctor, etc.). All can reduce costs. CDC's mission of prevention should be highlighted by the HDSC to draw attention to the value

of reducing the destructive social determinants of health to optimize disease/disability prevention and cost reduction.

The workgroup to develop the paper will be led by Dr. Botchwey assisted by Ms. Blount and Dr. Bowman. They will confer by phone and report to the subcommittee in the HDSC teleconference.

**Closing comments.** Partnerships to be pursued by the HDSC will be with the CDC HEWG; ACD ESC; the Social Determinants of Health Workgroup; and those developing the HP2020 program. The HDSC also will seek to participate in CDC's health reform activity.

The next in-person meeting will be in October. An August teleconference will be held beforehand to discuss the members' review of the draft policy paper, and the workgroup leadership will confer by phone before that.

Information on the June 17 Health Ethics Subcommittee meeting will be shared, for HDSC members who wish to call in to help them create their agenda.

Dr. Botchwey **moved to adjourn the health disparities subcommittee meeting.** With no discussion and all in favor, the meeting then adjourned.

### **CERTIFICATION**

**I hereby certify that, to the best of my knowledge, the foregoing is an accurate representation of the conduct of this meeting.**

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**Marie Josette Murray, SoWrite, Inc.**

Atlanta, Georgia

404-522-6560

sowrite@bellsouth.net

## **ACTION ITEMS**

- Dr. Barrett will send to the ESC's white paper to Dr. Williams for distribution to the HDSC members.
- Dr. Williams will attend in the ESC June 17 meeting (as may Ms. Berryhill).
- The HDSC policy paper workgroup will confer by phone to discuss and send out to HDSC members for discussion in an August teleconference.
- Dr. Williams and Dr. Barrett will confer on how the two subcommittees can coordinate their work.