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Lessons Learned: Can a Principled Mechanism for Improving Health Equity be Integrated into a Budgetary Process?

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LESSONS LEARNED: CAN A PRINCIPLED MECHANISM FOR IMPROVING HEALTH EQUITY BE INTEGRATED INTO A BUDGETARY PROCESS?

An Analytical Paper Presented to the Faculty of the College of Arts and Sciences

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In Partial Fulfillment of the Requirements of the Degree of MASTER OF ARTS in the

PUBLIC AFFAIRS AND PRACTICAL POLITICS PROGRAM

By

María X Martínez

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MASTERS OF ARTS DEGREE in PUBLIC AFFAIRS

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Under the guidance and approval of the committee, and approval by all the members, this thesis has been accepted in partial fulfillment of the requirements for the degree.

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Executive Summary

Every individual, family, and community deserves an equal opportunity to achieve a healthy, long life. When the barriers to achieving health are determined by one's social and economic status, it becomes an issue of social injustice. Health equity is the social justice lens that public health institutions across the United States have increasingly embraced as a mandate, however there are few jurisdictions addressing how to prioritize funding toward that end.   The practical translation of a social justice concept necessitates the creation of a budgetary tool and an implementation process that identifies those with the highest levels of health disparity and social disadvantage.

Using the San Francisco Department of Public Health (SFDPH) as its central case, this paper argues that for health delivery systems to be socially just and to achieve health equity, these systems must not only establish the principle that health equity is important, they must prioritize their funding to achieve it. It is important to recognize that the broad public health mission to protect and promote the health of all will create ethical and methodological challenges when it comes to prioritizing one group's needs over others.

This paper addresses the first steps toward creating a budget prioritization method that is feasible for managers to administer while also being transparent to the public. Health equity is one domain within a multi-criteria decision analysis tool that the SFDPH will use to prioritize funding. This tool asks evaluators, "To what degree does the program impact the health status of recognized groups where there is a known health status gap or disparity?" To remove bias, SFDPH will need to identify the "recognized groups" who need to be prioritized and develop a more exacting methodology for evaluating each proposal's impact on health equity.

An expert panel of researchers, analysts and evaluators was chosen to assess the prioritization process and to identify questions that SFDPH would need to incorporate into the development of the health equity rating of the budget tool. The expert panel was led through a consensus process to identify San Francisco's five priority populations and then a facilitated brainstorming session to solve the methodology challenges.

Following the process, most panelists reported that they struggled with the process and their decisions. All participants agreed that the five groups identified were "worthy" priorities, though most qualified their response with concerns about who had been omitted from the list and the intent of the priority tool itself.   Their general conclusions are summarized in two points.

First, prior to identifying priority populations, there needs to be deliberation about the working definition of health equity, as the intersection of health disparities and social disadvantage noted in Figure 1

Figure 1: Health Inequity Quadrants
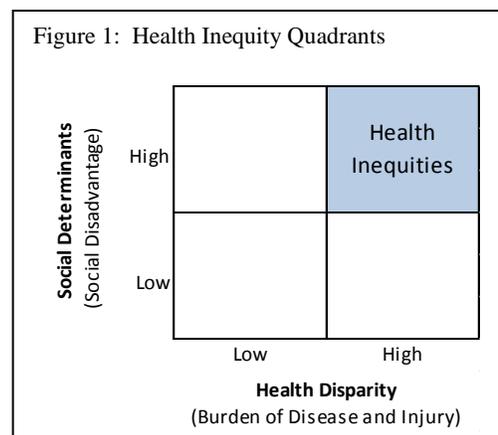
may not be the right paradigm. The concept is different depending upon the lens used; for example, HIV Health has a different priority population than does Maternal Child Health. Some participants believed the method omitted important populations who have much larger health risks, but because of their small numbers they were not prioritized, e.g., American Indians and Transgender individuals. Conversely, others believed it omitted important populations who have somewhat less health risks, but higher numbers of people who have very high social disadvantage; e.g., Latinos.   They also believed that mitigating social disadvantage and addressing the root causes of health inequities were outside the scope of public health departments.

Second, there needs to be clarity on how the identification of priority populations will influence redistribution of resources, e.g., would current programs be divested from so that new programs for the priority populations could be funded, or would the concept be applied only to new monies? There was significant reluctance to identify groups so that funds would be redistributed from one to another, albeit more disadvantaged, group.

The lessons learned during these initial steps will inform how the SFDPH moves forward. Deciding San Francisco's priority populations will need to utilize objective criteria and assure deliberations occur with all its stakeholders, including its scientists, those who legislate and fund healthcare services, and with those who stand to lose and gain from the redistribution of services. To achieve health equity, sister agencies and leadership in San Francisco will need to partner and share accountability and consider an equity and social justice ordinance similar to the one enacted in King County, Washington (2010) that requires the whole city to rate its funding priorities from an equity perspective.

Once done, however, redistributing funds from one group to another will stand to be the biggest challenge. It may be that San Francisco can identify ways to lift everyone up, while accelerating it for the most disadvantaged, without redistributing funds. If not, difficult decisions will need to be made. In choosing not to decide, public health officials must understand that maintaining the status quo is, in fact, a moral choice that has been made.

The steps outlined in this report to engineer Health Equity, a social justice perspective on health disparities, into a budgetary process are the first of many. The San Francisco Department of Public Health is committed to seeing this process through to implementation and will continue to share the lessons learned as they unfold.

Introduction

In the summer of 2012, the San Francisco Department of Public Health began what is expected to be a long, iterative, and deliberative process to develop a method employing health equity as one criterion for prioritizing funding during its budgetary process. Although the final mechanism is not yet formalized, key lessons for implementation have already emerged. This paper will discuss a) the background leading up to the creation of this process, b) the steps undertaken to develop a mechanism for use, c) lessons learned and questions raised, and d) challenges for the development of a feasible, transparent and actionable health equity budget tool. This summary of the process and dilemmas for implementing such a tool might prove useful for other public health departments who wish to operationalize the social justice concept of health equity through the funding lens.

Background

Every individual, family, and community deserves an equal opportunity to achieve a healthy, long life. When the barriers to achieving this goal are determined by the places wherein we live, work and play; by the exclusions entrenched in our institutions; by one's social status and the biases that accompany it; and by economic barriers; these factors culminate to an issue of social injustice. As the acclaimed documentary series *Unnatural Causes: Is Inequality Making Us Sick?* (California Newsreel, 2008) showed, the distribution of power, wealth, and resources shape our opportunities for health. While the debate over the value of universal health care continues, the proof stacks up that a heavier burden of disease and injury for some results in compromised health for all. Socio-economic barriers not only keep people from equal access to healthcare, they exacerbate health problems and create a widening health gap between groups, which in turn impacts the common good and the well-functioning of a society. This can be seen

clearly in the non-response to the early AIDS epidemic in the 1980s when it was considered a gay or injection drug user disease, and more recently, the slow response to communities in New Orleans following Hurricane Katrina. In both crises, individuals paid a high price for the lack of response by our nation's service systems, but the spread of infection and economic impact resulting from the displacement of whole communities continues to affect the common good.

Noted as early as 1988, the Institute of Medicine reported the need for health equity and social justice to be the direction of public health (Hofrichter & Bhatia, 2007) and, increasingly, health officials across the nation have embraced the directive to adopt a social justice perspective on health disparities. The San Francisco Department of Public Health, for example, has monitored the health status of its residents for many years and is acutely aware of the impact of social stratification on health. Yet over the years for the populations who bear the greatest burden of disease and injury, their health status has not improved.

Using the San Francisco Department of Public Health (SFDPH) as its central case, this paper argues that for health systems to be socially just and to achieve health equity, these systems must not only establish the principle that health equity is important, they must prioritize their funding to achieve it. While the public health side of SFDPH focuses on population and place-based (neighborhood) health status, categorical funding enables the delivery system side to overlook the fact that bias in its silo-funded services not only disproportionately impacts certain populations, it sometimes operates at cross purposes. Thus, focusing on population health and integrating that concept into a health department's budget of the delivery system is one important way to operationalize the social goals of health equity.

Although there is much research and literature addressing how to measure health disparities and how to promote and integrate health equity principles into the consciousness and

practice of an institution (Hofrichter & Bhatia, 2007), there are very few jurisdictions addressing how to prioritize funding toward that end. The practical translation of a social justice concept necessitates the creation of a budgetary tool and an implementation process. The broad public health mission to protect and promote the health of all creates ethical and methodological challenges when it comes to prioritizing one group's needs over others. Thus, any gains that the San Francisco Department of Public Health makes in developing such a mechanism may prove useful to other jurisdictions.

Working Definition of Health Equity

Achieving health equity is defined as reducing health disparities when these differences are patterned, preventable, and unjust. Over twenty years ago,

> SFDPH's Working Definition: Health Equity is reducing disparities in health status that are patterned, preventable, and unjust. Equity is achieved by prioritizing resources for those groups who experience high levels of social disadvantages in addition to poor health outcomes.

Margaret M. Whitehead, current Head of the World Health Organization (WHO) Collaborating Centre for Policy Research, further qualified this definition by suggesting the underlying causes of health disparities are imbalances in political power or privilege (Whitehead, 1992). Institutions such as the National Institute of Health (NIH) and WHO have since made the mitigation of the social determinants of health a high priority (Department of Health and Human Services, 2012). The term "inequity" is used differently than that which measures or reflects differences, disparity, or inequality. Inequity means injustice or unfairness and, in this paper, relates to the intersection of those bearing both the high burden of health disparities *and* social disadvantage. Thus, equity is achieved not only by reducing the unfair share of disease and injury that some groups experience, but also by prioritizing resources for interventions directed at those with the highest social disadvantage.

Purpose of this Paper

This paper reports on San Francisco's efforts to date to engineer Health Equity, a social justice concept, into its health department's budgetary process. The goal is to create a prioritization method that is feasible for managers to administer while also being transparent to the public. Ultimately, it will need to be actionable. That is, the method must point to funding decisions that improve health equity for San Francisco's most vulnerable populations.

There are three important elements of health equity that are outside the scope of this paper: (1) Social disadvantage is promoted as one criterion for prioritizing populations, however this paper will not outline ways for improving the socio-economic status of San Franciscans. (2) Effective interventions are critical to reducing health disparities, however this report will not cover the array of evidence-based practices that a health department might wish to consider. (3) Inequality results from inequity in society and in our institutions. It cannot be overstated how important the role that prejudice and power play in health inequities, as manifested through institutional racism, sexism and homophobia, among others. However, it is beyond the scope of this paper to address the internal scrutiny that health departments should self-apply when attempting to make health equity operational.

This paper will focus solely on the identification of priority populations and the development of a rating tool. First, it will address the general challenges that public health departments face when distributing resources. Next, it will outline the approach that SFDPH has taken thus far in developing a Health Equity Rating Tool, a mechanism for prioritizing funding to those who experience the highest health inequities. Finally, it will offer lessons learned from the process to date and conclude with issues and recommendations for other county jurisdictions to consider.

Distribution Dilemmas for Health Departments

Public health officials face challenges when attempting to develop a social justice framework because their institutions "remain stymied by bureaucratic structures, statutory requirements, limited funding, and constrains on surpassing the seemingly traditional disciplinary boundaries" (Hofrichter & Bhatia, 2010, p. 5).

Public Health's role is to keep people healthy so that they can access opportunities and reach their goals; for example, health status impacts one's ability to get and keep jobs or to attend and learn in school. The essential functions of Public Health are to monitor differences in health status and to detect trends in health behaviors, environments, populations, and responsiveness from our systems of care (American Public Health Association, 2012).[1] Most public health departments do not operate healthcare delivery systems, thus the scope of their authority for affecting health disparity is limited. Their traditional role as it relates to delivery systems is to advocate and influence the private sector's response to the needs of the people.

Each public health jurisdiction is different, thus it is important to frame this case study in the context of the San Francisco Department of Public Health (SFDPH). With a $1.5 billion budget, SFDPH is San Francisco's largest city department.[2] It has a dual role for in addition to providing traditional public health services, a significant amount of the budget goes toward the provision of direct healthcare services through its large medical and trauma center, a long-term care facility, jail health services, and an array of community-based services, including primary care, behavioral health, and supportive housing.

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[1] Ten Essential Public Health Functions: (1) Monitor health status to identify community health problems, (2) Diagnose and investigate health problems and health hazards in the community, (3) Inform, educate, and empower people about health issues, (4) Mobilize community partnerships to identify and solve health problems, (5) Develop policies and plans that support individual and community health efforts, (6) Enforce laws and regulations that protect health and ensure safety, (7) Link people to needed personal health services and assure the provision of health care when otherwise unavailable, (8) Assure a competent public health and personal healthcare workforce, (9) Evaluate effectiveness, accessibility, and quality of personal and population-based health services, (10) Research for new insights and innovative solutions to health problems.

[2] The San Francisco Public Utilities Commission is the second largest city department, with half the SFDPH budget.

Thus, unlike most other jurisdictions, public health decisions in San Francisco can directly influence how health services are distributed. On the other hand, like many health care systems across the nation, SFDPH must identify how to do more with fewer resources. Over the next several years, SFDPH will confront several strategic challenges, including the need to prepare for changes in reimbursements and respond to new requirements resulting from federal and state health care reforms. It must continue to serve San Franciscans while facing a seismic rebuild of its hospital, significant investments in the modernization of its information technologies, and integration of its health care delivery services. No matter how favorable the economic climate is, each year due to labor agreements for cost of living increases, SFDPH starts with a $17.5 million deficit and then faces federal, state, and local level pressures to reduce its expenditures.

The prevention and intervention services that are provided by SFDPH can help mediate social disadvantages; however, there are never enough resources to address all disparities or to serve all in need, and the prioritization process for distributing these resources has always been a challenge. The budget process for bureaucracies as large as San Francisco's health department remains the same: there is never enough time, never enough data, and never enough resources to make optimal decisions. Priority setting frequently boils down to value judgments made by SFDPH management and San Francisco politicians. The criteria with which programs are cut, merged, or added are typically single-focused and inconsistently applied year-to-year, with reasoning that is not always evident to the public (Baltussen & Niessen, 2006). To create a fair and transparent process, it is important to construct more objective criteria within priority principles that are agreed to by all.

Budgeting Using Multiple Criteria Decision Analyses (MCDA)

This section outlines a priority setting framework that SFDPH is poised to implement in its budget process. The purpose of describing the tool is to situate the development of the Health Equity Rating Tool, which will inform one criterion of the larger tool.

To develop its five year budget and to evaluate all new initiatives with considerations that weigh multiple criteria at the same time, SFDPH will implement a multi-criteria decision analysis (MCDA) tool. The method, as outlined by health economists Baltussen and Niessen in the Netherlands (2006) and modified by the Vancouver Coastal Health Authority's (Mitton, Dionne, Damji, Campbell, & Bryan, 2011), met the SFDPH goals to have a transparent budget prioritization process that could be applied to all new initiatives in a consistent manner. The selection of this tool by SFDPH was influenced by an evaluation that found that the Vancouver managers believed the tool enabled them to make better decisions about what programs to invest in and divest from (Mitton et.al., 2011).

Figure 2: Distribution of MCDA Domains

SFDPH modified Vancouver's MCDA prioritization tool and prioritized each criterion under the following four domains with levels of weight as noted in Figure 2: Financial Impact, Strategic Alignment, Organizational Impact, and Health Impact (Aragon et.al., 2012).[3] (See Appendix 1.) The MCDA tool will be used by management to evaluate each budget proposal by assigning points to each criterion.
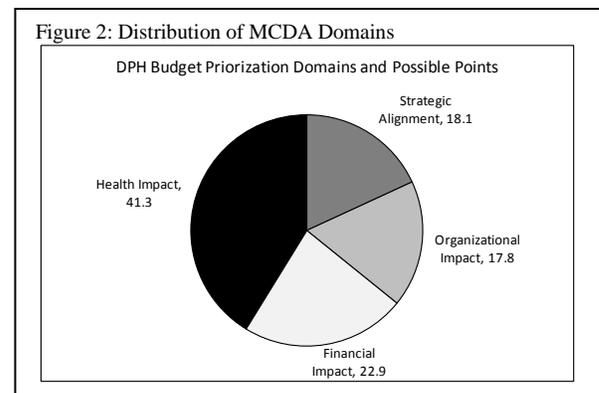
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[3]   Distribution of the 100 points: Financial Impact: impact on revenues and sustainability (7.6), cost avoidance (7.7), efficiency and appropriateness (7.6). Strategic Alignment: extent of alignment to Health Commission's 5-year budget priorities (9.8) and other external mandates (8.3). Organizational Impact: extent of feasibility in adoption and implementation (5.2), impact on the workplace environment (7.7), and impact on innovation and knowledge transfer (4.9). Health Impact: scope in numbers affected (5.0), significance of impact on health outcomes (6.8), extent of effectiveness (8.3), impact on well-being and disease/injury prevention (7.2), impact on client experience (6.3), and impact on health equity (7.7).

The Health Impact domain of the MCDA includes the following sub-domains: scope in numbers affected, significance of impact on health outcomes, extent of effectiveness, impact on well-being and disease/injury prevention, impact on client experience, and impact on health equity.

The Health Equity sub-domain asks evaluators, ***"To what degree does the program impact the health status of recognized groups where there is a known health status gap or disparity?"*** As noted in Figure 3, Health Equity in the San Francisco MCDA tool constitutes 7.7

points of the possible one hundred overall points for determining which programs and proposals are to be prioritized. It will be important that SFDPH minimize bias in the process. Reviewers will need to understand the complexities of the score and consistently rate programs based upon

Figure 3: Sub-domains under Health Impact

Health Impact Domain

Impact on health equity, 7.7
Numbers affected, 5
Impact on health outcomes, 6.8
Impact on client experience , 6.3
Extent of effectiveness, 8.3
Impact on well-being, 7.2
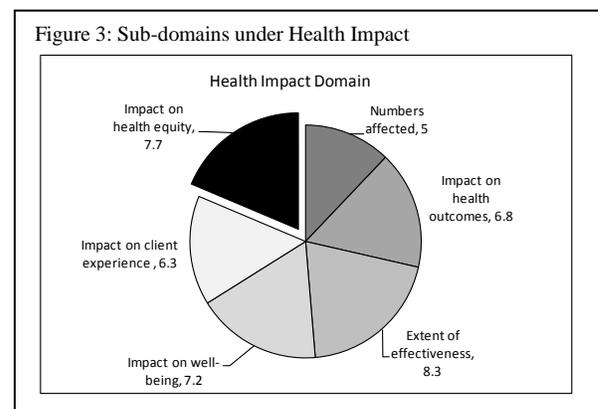
the program's ability to reach groups that experience the greatest health inequity.

Approach

For SFDPH to prioritize funds that increase health equity in a feasible, transparent and actionable manner, the MCDA tool alone does not suffice. SFDPH will need to identify the "recognized groups" who need to be prioritized and develop a more exacting methodology for evaluating each proposal's impact on health equity. Engineering a complex concept into a rating scale will need to be developed in an inclusive and iterative manner and be simple enough for non-expert managers to administer.

An expert panel of researchers, epidemiologists, and analysts were chosen to begin the system design. They were chosen because of their past group experience in taking concepts and

boiling them down to practical applications, their familiarity with data and with patient care services, and their minimal conflict of interest, i.e., they do not manage direct care areas of SFDPH that might be affected by budgetary decisions. For most, their roles in SFDPH focus on one disease, thus their bias was acknowledged from the beginning.

SFDPH began the 4-step process toward developing a health equity rating tool using the framework already established in the MCDA tool. The SFDPH Health Officer championed the project and assigned a senior staff member to manage the project, as follows:

Step 1: Research other jurisdictions that use an MCDA tool or other prioritization tools for health equity and evaluate their applicability to SFDPH's goal to prioritize in a fair, transparent, and actionable manner.

Step 2: Facilitate and test a consensus process with an expert panel to identify San Francisco's priority populations.

Step 3: Facilitate a brainstorming session with the expert panel to solve the methodology challenges to creating a health equity rating tool ensuring it analyzes the right criteria and is feasible for managers to administer during the budget prioritization process.

Figure 4: Steps Toward Developing the Framework

1. Investigate Prioritization Tools
   Fit with MCDA Tool?   Meet Goals?

2. Identify the Priority Populations
   Selection Criteria   Consensus Process

3. Establish Components of an Effective Rating Tool
   Measures   Methodology

4. Review Lessons Learned
   Identify questions   Improve process

Step 4: Utilize the expert panel's insights to reflect upon the definitions, methods, and process to identify improvements before redesigning and engaging other stakeholders in the process.

The next section of this report focuses on the efforts and progress that SFDPH has made to accomplish these steps.
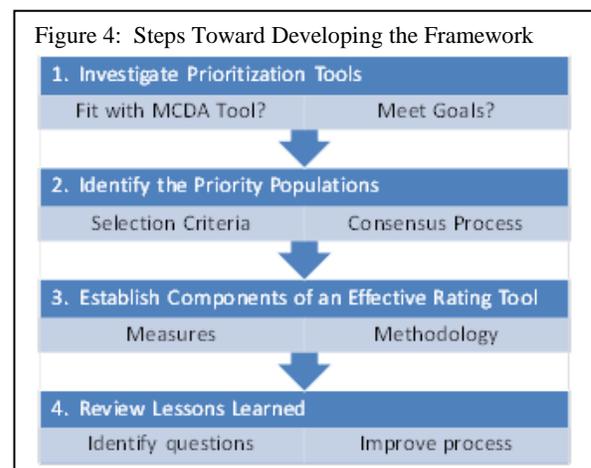
Step 1: Investigate Health Equity Budget Prioritization Tools

Health equity is generally not a criterion used in budget prioritization. Dominating the process includes fulfilling public health mandates, meeting funding requirements, and balancing the budget. The focus is primarily on financial information such as revenue, expenditures, and unit cost. When equity is addressed, it is often narrowly measured in terms of access to or utilization of services and does not address the interplay of health disparities, social disadvantage and structural marginalization (Mooney, 2009). Using access and utilization as criteria is insufficient, as they do not allow for the higher costs per individual that are needed for disadvantaged groups to achieve health equity (Ong, Kelaher, Anderson, & Carter, 2009).

Public Health's purpose is to assure the health of everyone, thus health department managers must not only consider the soundness of the business case, they must also consider the societal markers. Annie Michaelis, in the Journal of Public Health Policy (2002), refers to these priority setting markers as an "acknowledged set of ethical guidelines that give precedence to criteria that turns a blind eye to the social and political power of affected groups" (p. 401).

King County, Washington utilizes an Equity Impact Review Tool that helps assess county-wide initiatives and their impact on equity, only one component of which is health, but it does not point to any budget rating scale. Its lengthy narrative questionnaire asks general questions about the degree to which the initiative will improve "access to affordable and culturally appropriate health and human services" or affect the "built environment, climate, air, water, and exposure to toxic substances" (King County, 2012) but it does not distinguish health equity as a criterion. The California Assembly considered a bill in 2012 that would have the state monitor a Health Equity Index that profiles and measures the social, economic, and environmental conditions that affect population health, in order to have local jurisdictions

incorporate the findings into their strategic plans, however the legislation does not address how this index will affect its budget allocations (Health Equity Index A.B.2204, 2012).[4]

Other methodologies were found to consider multiple criteria and social justice, though without incorporating the concept of equity. In one example, by using the same ethical criteria established in 1995 by the American Medical Association to determine who goes to the top of an organ transplant list, Annie Michaelis (2002) suggests that public health officials prioritize populations and interventions using the same multiple criteria, by replacing the word "person" with "population": "(1) likelihood of benefit to the population (as evidenced by the intervention, not the population), (2) impact of treatment on the population's quality of life, (3) duration of the benefit, (4) urgency of the population's need, and (5) all else being equal, the amount of resources required for successful intervention" (p. 403). Health equity, as measured by high burden and high social disadvantage, is not one of the criteria.

In San Francisco, the Health Equity Rating Tool must fit within the multiple criteria decision analysis (MCDA) methodology that will be implemented during this fiscal year's budget process. MCDA has been employed by other industries as a management science and operations research method since the 1960s to help prioritize investments when multiple, often conflicting considerations are at stake (International Society of Multi Criteria Decision Making, 2012). A search for other health jurisdictions utilizing MCDA found health institutions in Australia, Canada, and the United Kingdom, but few in the United States.

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[4] California Assembly Member, Roger Hernandez, moved legislation forward to the Health Committee, then rescinded in April of 2012. AB2204 would have required the use of a health equity tool to enable the department to assess the needs of individuals (including metrics on quality of transportation, food, housing, healthcare, schools, physical activity), the quality and sustainability of the environment (quality of air, green spaces, toxin levels, energy levels), adequate levels of economic and social development (living wages, healthy jobs, child and youth development, education), health and social equity, and social relationships.

The Los Angeles County Department of Public Health (2010) utilizes MCDA when considering which issues to tackle as a health department. Both the Vancouver and Los Angeles models ask general questions about health equity and ask evaluators to rate the extent to which the program would have an "impact on the health status of recognized groups where there is a known health status gap" (Vancouver) or if "health inequity exists for the issue" (Los Angeles). Neither provides the methodology for rating the impact on health equity.

SFDPH modeled their MCDA tool on Vancouver's version and poses a similar general question about the impact of the program on disadvantaged groups and provides a rating scale between zero and 7.7 points with the higher being more likely to achieve the health equity criteria. Managers who are unfamiliar with specialty programs or certain populations are put in the position to assess and score multiple proposals, especially during the stress of the annual budget process, will need more guidance to rate proposals reliably and to minimize bias imposed by the writer of the proposal or by the evaluator.

SFDPH has made a commitment to improve health equity using the domain in the MCDA that measures its impact, but it cannot take action on that commitment until it knows the populations with the least health equity.

To identify the priority populations and to develop the rating tool's criteria will require a methodology that makes that rating transparent to all. These processes will be discussed in Step 2 and 3. To assure feasibility given the variability of managers who will take part in the evaluation process, it will require that the tool measures the right metric and that it be simple enough to administer. This process will be discussed in Step 4.

Step 2: Identify the Priority Populations

A two-hour consensus workshop was held with 14 members of an expert panel which included researchers, evaluators, and analysts of SFDPH, all of whom were familiar with data regarding the San Francisco population in part or in whole (see Appendix 2 for select examples and Appendix 3 for the power point presentation). The facilitator reviewed the SFDPH goal to identify populations most affected by health inequities and to develop a methodology to incorporate Health Equity into its health department's budget prioritization. The group was informed by the Health Officer that they would be the first of many who would have a say in which groups are prioritized, but their main role was to help develop the methodology for this decision-making process.

A secondary goal for this meeting was to raise awareness on how the definition of health equity differs in two ways from the health disparities each of them normally monitors: (1) Most members of the expert group have a deep yet narrow view of health disparities depending upon which SFDPH section they work in. Although familiar with groups who experience high rates of specific diseases (schizophrenia or HIV, for example), they would need to move to a wider view that defines health equity as population-, not disease-, based. (2) Considering the differences in social status and prioritizes those groups who experience higher social disadvantage would also be a new lens for them.

After reviewing an example for each (See Figures 5 and 6), members were asked as a group to identify examples of health disparity and then examples of social disadvantage.

Much discussion ensued about the difference between the two. Often the expert panel identified a population when it was actually a health status; e.g., schizophrenics, people with HIV/AIDS…mirroring the narrow health focus within which individuals at the table work.

The group identified examples of each:

Health Disparities. High prevalence and rates of premature mortality, chronic diseases (cancer, diabetes, asthma, HIV/AIDS, STDs), conditions (stress, mental illness, disabilities), high risk behaviors (poor nutrition, addi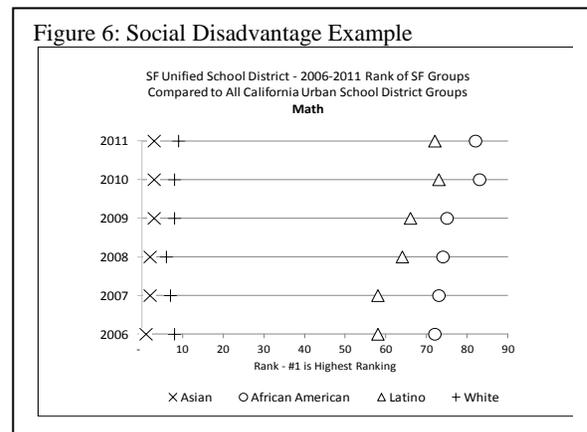ction, smoking), violence (intimate partners, family, community, suicides, homicides), utilization of urgent/emergent services (hospitalizations, emergency room use, ambulance use).

Figure 5: Health Disparity Example
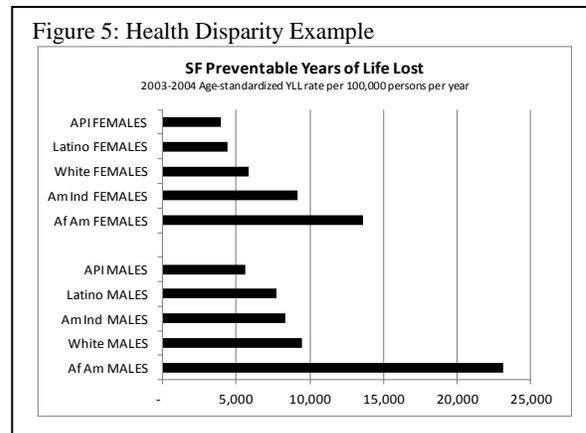
Social Disadvantages. Isolation, poverty, lower social class, poor attendance in school, low graduation rates, poor access (to health care, healthy foods, health insurance), undocumented immigration status, lack of provider cultural competence, no family support, low literacy (language barrier, health literacy), political poverty, institutionalization (foster care, criminal justice, involuntary holds), homelessness, disabilities, poor functioning status, unhealthy homes and environments. Root causes of these social disadvantages were discussed: stigma, discrimination, racism, sexism, homophobia and other types of marginalization.

Figure 6: Social Disadvantage Example

Using the quadrant graph in Figure 7, the group was asked to consider San Francisco populations using their knowledge of health disparities and social disadvantages and to identify up to 10 groups who would fall in the upper right hand quadrant of the Health Inequity graph. The facilitator used the example of women in Marin, a wealthy county, who were found to have

high rates of breast cancer (a health disparity) but because of their high socio-economic status,

they would not fall into the upper right quadrant.

To assist the process, participants were given a list of groups to choose from. This list (see Appendix 4) included groups typically noted in the health equity framework: age groups, social identity groups (ethnic, gender, and sexual orientation) and groups defined by where they live (neighborhoods, public housing sites,

Figure 7: Health Inequity Quadrant

and the homeless). Participants were instructed that they could ignore, mix and match, or add

populations to the list. Upon review, the group agreed that another social identity group,

"immigrants," should be added.

Participants worked individually to select ten populations who meet both the high health

disparity and high social disadvantage criteria. They were then given ten minutes to work with a

partner to discuss and write their top five populations on cards. Once completed, all cards were

posted on the white board and participants were asked to begin clustering the populations under

like categories. The following populations were prioritized through a consensus process (the

maximum vote possible was seven):

The top 5 priority populations included: African Americans (7 votes), Homeless (7

votes), Public Housing residents (4 votes), Bayview residents (4 votes), and Tenderloin residents

(4 votes).

The remaining populations that had more than one vote included: American Indians (3

votes), Immigrants (3 votes), Latino/a (2 votes), Transgender Male to Female (2 votes). The

populations with only one vote included: Gay, Children Aged 0-5, Visitacion Valley residents,
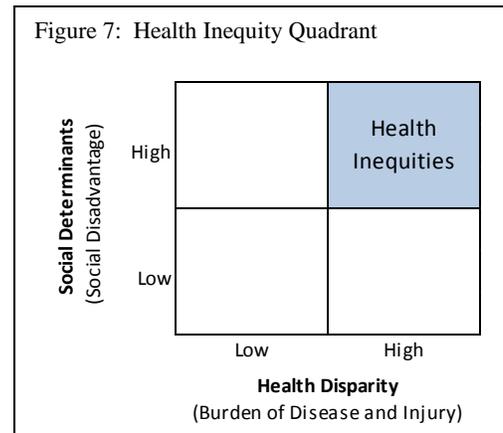
Youth, Immigrants, and Seniors. One vote went to a social disadvantage descriptor (low-income status).

The expert panel deliberated about the process and the outcomes of this exercise and this will be covered Step 4 section of this report.

Step 3: Establish Components of an Effective Prioritization Tool

The purpose of the Health Equity Rating Tool is to guide evaluators in their scoring of programs and proposals when using the Multiple Criteria Decision Analysis (MCDA) budget method. Each proposal has the potential to score a maximum of 7.7 points for Health Equity.

At the second session (See Appendix 5 for the power point presentation), the expert panel was presented a mocked-up evaluation tool (see Appendix 6) that assigned points based upon the program's relative reach into a prioritized group in order to stimulate further discussion about the concepts and methodology for operationalizing health equity into the budget prioritization process. The expert panel addressed whether or not priority groups should be equal or weighted and how to handle groups that are mutually exclusive (e.g., people cannot live in Bayview Hunters Point and the Tenderloin at the same time, and they cannot be homeless and live in public housing simultaneously). A review of the tool evoked further discussion on the challenge of making a concept such as health equity operational.

Step 4: Review Lessons Learned

As other jurisdictions, SFDPH is making a commitment to the health equity principle and is taking the steps necessary to incorporate it into policy and practice. Moving from a commitment to actually prioritizing and allocating funds toward that end is expected to be an ongoing and evolving process. The following summarizes the findings of the process thus far.

What Worked. Expert panelists expressed appreciation for being included in the starting point of the process and acknowledged that it was a challenging, but not impossible, task to take a social justice concept such as health equity and make it operational. Their collective experience as analysts, epidemiologists and researchers proved to be the right place to start the process for distilling a conceptual idea down to a practical application.

Because the brainstorming was limited to utilizing the health equity line of the MCDA budget prioritization tool (i.e., the MCDA method was the only option), ideas were more focused than if the challenge to be solved was improving health equity, in general. Having examples of other jurisdiction's health equity tools to consider was helpful and focused the discussion on what would or would not work in San Francisco.

Although the panel was informed that their five priority populations would not necessarily become the top five SFDPH priority populations, their choices illustrated the issues and the challenges of the prioritization process. The exercise enabled discussion, deliberation, and constructive feedback on the purpose and methods, which will contribute greatly to SFDPH's revised strategy.

What Did Not Work. Most panelists struggled with the process and their decisions, expressed concerns about the intent of the priority tool itself, and offered constructive criticisms about the prioritization methodology. In addition to what follows, they asked for a review of empirical data, more time for deliberations, and more perspectives and voices to be at the table.

Definitions. According to the panelists, before identifying priority populations, there first needs to be deliberation about the working definition of health equity, i.e., the intersection of health disparities and social disadvantage may not be the right paradigm. Criteria for identifying priority populations should be derived from this agreed-upon definition. All

participants agreed that the five groups identified were "worthy" priorities, though most qualified their response with concerns about who had been omitted.

Many felt that mixing populations that overlap (e.g., social identity and place-based groupings) was confusing and that more precise definitions of certain populations are needed; for example, homelessness. The concept of health inequity being the intersection between health disparity and social disadvantage is different depending upon the lens used and health disparities are multi-faceted. For example, HIV Health has a different priority population than does Maternal Child Health.

Homeless people were identified as one of the priority populations because of their high status in both health disparities and social disadvantage, but the category itself defines a social status. For all other populations, it is possible for them to achieve health equity; that is, their identity or association does not in and of itself define health inequity. For example, African Americans can achieve health equity and remain African American, Baview residents can achieve health equity and remain Bayview residents, and so on. Individuals can move out of being homeless, but as a population they will forever be considered to have health inequities. This conundrum blurs the delineation and definition of populations.

Intent. Participants wanted clarity on how the identification of priority populations will influence redistribution of resources, e.g., would current programs be divested from so that new programs for the priority populations could be funded, or would the concept be applied only to new monies? There was significant reluctance to identify groups so that funds would be redistributed from one to another, albeit more disadvantaged, group.

Measures. Are there more effective ways to measure, promote and incentivize positive impact on health equity than identifying socially disadvantaged groups? For example,

the County Health Rankings and Roadmaps Program produced by the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin methodology (2012) attributes 40% of the impact on health disparities to social determinants, and also considers the impact of health behaviors (30%), access to clinical care (20%), and the physical environment (10%). The other subcategories of Health Impact on the MCDA tool (see Appendix 1) might be infused with health equity language to bolster the importance of weighing the various attributes that address health equity.

How far upstream should prioritization take place? Should the timeframe be an immediate impact for a few or a distant future impact for many? Funds might better be spent on prioritizing younger people with the goal of helping future generations achieve their health potential.

Some panelists believe that economic status alone is a single biggest predictor of all social disadvantages, thus as the county's safety net provider, SFDPH already serves the most disadvantaged. Others suggested that a disabling health condition (e.g., schizophrenia) creates a condition of health inequity, no matter what the economic status of the individual.

When identifying priority populations, do numbers matter? Some participants believed the method omitted important populations who have much larger health risks, but because of their small numbers they were not prioritized, e.g., American Indians and Transgender individuals. Conversely, others believed it omitted important populations who have less health risks, but higher numbers of people who have very high social disadvantage; e.g., Latinos.

Course Correction. As SFDPH attempts to operationalize health equity into its budget prioritization process, it will need to resolve many questions about the right framework to use to address health equity, which criteria to use for selecting priority populations, and the

methodology for incorporating both into its Multiple Criteria Decision Analysis (MCDA) budget tool. San Francisco, in general, may have priority populations that differ from its health department's disease-specific or population-specific programs. The methodology of a health equity rating tool should be developed at a general city-wide level, while being universal enough to apply to priority-setting by divisions of SFDPH.

Moving forward, SFDPH will create a Health Equity Workgroup to create a strategy, clarify the goals and criteria, and help identify the questions and the stakeholders who should be engaged to answer those questions. The role of this workgroup might also be to review other components of Health Impact domain of the MCDA tool (for example, effectiveness and significance of impact) to provide managers with a more refined tool to effectively rate the budget initiatives before them.

What is Not Resolvable. The MCDA tool for prioritizing budget initiatives will move forward before SFDPH is able to resolve the methodology questions on how to identify priority populations and how to rate the options based upon their impact on health equity. Asking reviewers to rate a program's or project's ability to "impact the health status of recognized groups where there is a known health status gap/disparities" without more criteria is bound to be confounding for the evaluators, but it is at least a start and the feasibility questions that arise from that managerial process will add further issues for the Health Equity Workgroup to consider.

Discussion

As expected, San Francisco's first steps to identify priority populations and develop a Health Equity Rating Tool have created more questions than answers, but those questions are informing its next steps.

Michaelis (2002) emphasizes that "it is critical that public health institutions collaborate to establish an explicit and public consensus about theoretical priority setting standards for the delivery of public health services" (p. 402). Thus the ruling faculty for making decisions about who are San Francisco's priority populations would be to utilize objective criteria and assure deliberations occur with all its stakeholders, including its scientists, those who legislate and fund healthcare services, and those who stand to lose and gain from the redistribution of services. Before reaching out to stakeholders, SFDPH will need to consider if communities can comprehend complex data and weigh them fairly if their friends and families stand to lose, or if its experts can comprehend the experience and weigh the implications if they do not live it. These are questions that SFDPH must address when it develops its working group.

Although they strive for it, health departments that also deliver healthcare may not be ready and nimble enough to enact social justice goals within the scope of their work or make difficult ethical decisions. Once priority populations are identified and agreed to, what happens when they discover that they have no programs that effectively address these groups, or that there are no new monies to be had? It may mean that some programs need to be divested from in order to invest in others, and when everyone that SFDPH cares for is in need, this will be a difficult decision to make. Reaction from the expert panel showed that it was one thing to identify priority populations and yet another to conceive that funds would be redistributed in accord with those priorities. As well, legislative bodies may not accept the application of a

social justice principle when the political dollars do not add up and portions of their constituents are on the losing side of that equation.

Public health institutions traditionally believe that to achieve equal health, it is sufficient to assure equal access to preventative and healthcare services, yet in fact, only a small percent of mortality is attributable to lack of healthcare services (McGinness & Foege, 1993). The County Health Rankings model attributes 20% of the impact on health outcomes to clinical care and 50% to social disadvantage and environmental factors (Robert Wood Johnson Foundation & University of Wisconsin, 2012).[5]

Thus, while distributive problems exist in the delivery of healthcare, the field of public health must embrace what Iris Marion Young refers to as the injustice of the "two forms of disabling constraints: oppression and domination" (Young, 2010, p. 39) where institutions indirectly and directly exclude some groups from the opportunities and resources needed to achieve their health potential. The approaches to increasing the benefits of shared community life were designed by already entitled members of our society. Historically, the health disparities for people of color, lesbian and gay people, and women have been framed as an issue of merits, deficits, and scarcity which places the responsibility, priority, and potential for reform in the laps of the communities most disenfranchised and most impacted…one person at a time. The answers to these issues can no longer be decided by the legislative bodies and bureaucracies in isolation, as however accountable we would like to believe we are, public servants remain far removed from those who personally stand to lose.

Yet for agencies struggling to meet their core responsibilities, solving the underlying causes for social disadvantage seems daunting as it remains outside the immediate purview of a

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[5] County Health Rankings Model (2012): Factors affecting health: Physical Environment (10%), Social and Economic Factors (40%), Clinical Care (20%), Health Behaviors (30%)

health department. Addressing root causes will require a lengthy and inclusive process. Iris Marion Young posits that community involvement to "analyze and evaluate social structures and practice" (Young, 2010. p. 39) is needed to mitigate institutional oppression and domination that are inherent to bureaucracies. SFDPH will need to assess the services it offers to assure that admission requirements do not exclude certain groups, that its services engage and promote health in culturally relevant ways, and that groups are represented at the table when designing and evaluating programs.

As has been noted a number of times in this paper, health inequity is the interplay between social disadvantage and health disparities. SFDPH has limited purview and ability to impact social disadvantages. To achieve health equity, sister agencies and leadership in San Francisco will need to partner and share accountability to address the underlying social determinants of health disparities, including housing, jobs, and education. Toward that end, an equity and social justice ordinance similar to the one enacted in King County, Washington (2010) would require the whole city to rate its funding priorities from an equity perspective. The Equity and Social Justice Ordinance in King County establishes definitions and identifies specific approaches necessary to implement and achieve their "fair and just" principle of equity. It asks department heads and legislators to "consider equity and social justice impacts in all decision-making so that decisions increase fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency or, when decisions that have a negative impact on fairness and opportunity are unavoidable, steps are implemented that mitigate the negative impact" (King County, 2010, p. 4). If San Francisco adopted such a policy, the burden of improving social advantage and reducing health disparities would be shared by all city departments.

Conclusion

Achieving health equity for all is not just a question of public financing; it poses moral questions as well. As a bureaucracy, the San Francisco Department of Public Health is not adept at asking itself moral questions. Funding is not limitless, nor can its distribution be redrawn based solely upon the advocacy and bargaining of those who will directly benefit. To improve health equity for those groups most affected, SFDPH will need more funds and/or it will need to re-ration existing care, and thus the reasoning posed would need to become more universal with fair reasons that are justifiable to all. To do otherwise would result in moral arguments about Public Health's commitment to protecting the health of all San Franciscans. The ethical purpose of health equity will need to move away from the narrow view of providing retribution to a few groups for its past harms to the wider view that achieving health equity will be a shared benefit for all. Once Health Equity is reframed with public reasons that are aimed at the common good, SFDPH will need to gain consensus on which criteria should be weighed to determine those groups that have the least health equity. A public process should be developed to identify the criteria, so that is agreed upon, and applicable in a consistent and transparent manner.

Though this distributive methodology will not solve the root issues of oppression and domination that is no doubt in public health systems, it is at least a principled mechanism for prioritizing public funds. By codifying the priority populations and prioritizing funding with a health equity lens, SFDPH will effectively communicate its priorities to the people who live in San Francisco and to the people who serve them. Developing criteria for identifying priority populations and engineering it into the budget process are feasible goals. Redistributing funds from one group to another, on the other hand, will stand to be the biggest challenge for the San Francisco Department of Public Health. It may be that SFDPH can identify ways to lift everyone

up, while accelerating it for the most disadvantaged, without redistributing funds.   If not, difficult decisions will need to be made. In choosing not to decide, public health officials must understand that maintaining the status quo is a moral choice that has been made.

The steps outlined in this report to engineer Health Equity, a social justice principle, into a budgetary process are the first of many. It is hoped that health departments with the similar dual role of providing traditional public health and direct healthcare services will find the analysis of these preliminary steps helpful. Other jurisdictions who do not directly oversee the allocation of healthcare services might also find these lessons helpful when advocating for support from the private sector. The San Francisco Department of Public Health is committed to seeing this process through to implementation and will continue to share the lessons learned as they unfold.

References

American Public Health Association. (2012). Retrieved from

http://www.apha.org/programs/standards/performancestandardsprogram/resexxentialservi ces.htm

Aragon, T. J., Dalnoki-Veress, F., Shiu, K., Chawla, C., Louie, J., Wagner, G., & Garcia, B. (2012). Deriving Criteria Weights for Health Decision Making: A Brief Tutorial. *Medepi.com*. Retrieved from http://medepi.com/2012/05/06/deriving-criteria-weights-tutorial/

Baltussen, R. & Niessen, L. (2006). Priority Setting of Health Interventions: The Need for Multi-Criteria Decision Analysis. *BioMed Central. Cost Effectiveness and Resource Allocation, 4:14.* doi:10.1186/1478-7547-4-14

California Newsreel & Vital Pictures, Inc. (Producers). (2008). *Unnatural Causes: Is Inequality Making Us Sick?* [Television series]. Washington D.C.: Corporation for Public Broadcasting. Retrieved from http://www.unnaturalcauses.org/amazing_facts.php

Department of Health and Human Services. (2012). *Healthy People 2020*. U.S. Department of Health and Human Services, Washington, D.C. Retrieved from http://www.healthypeople.gov/2020/

Health Equity Index, A.B. 2204. (2012). *California Legislature.* Introduced by Assembly Member Roger Hernandez (Coauthors: Assembly Members Bonilla and Fong) February 23, 2012. Retrieved from http://www.leginfo.ca.gov/cgi-bin/postquery?bill_number=ab_2204&sess=CUR

Hofrichter, R. & Bhatia, R. (Eds.). (2007). *Tackling health inequities through public health practice.* Oxford, NY: Oxford University Press, Inc.

International Society on Multiple Criteria Decision Making. (2012). Retrieved from http://www.mcdmsociety.org/facts.html

King County. (2010). *Washington State Ordinance 16948 to Achieve the Fair and Just Principles.* Seattle, WA. Retrieved from http://www.kingcounty.gov/exec/equity/~/media/exec/equity/documents/Ordinance16948.ashx

King County. (2012). *King County Equity Impact Review Tool.* Seattle, WA. Retrieved from http://www.kingcounty.gov/exec/equity/toolsandresources.aspx

Los Angeles County Department of Public Health. (2010). *Quality Improvement Brief: Priority-Setting in Public Health.* Quality Improvement Division, Los Angeles, CA. Retrieved from http://publichealth.lacounty.gov/qi/index.htm

McGinnis, J. M. & Foege, W. H. (1993). Actual Causes of Death in the United States. 270 *Journal of the American Medical Association*, pp. 2207-2212.

Michaelis, A. P. (2002). Priority-setting Ethics in Public Health. *Journal of Public Health Policy*, 3, 399-412.

Mitton, C., Dionne, F., Damji, R., Campbell, D., & Bryan, S. (2011). Difficult Decisions in Times of Constraint: Criteria Based Resource Allocation in the Vancouver Coastal Health Authority. Centre for Clinical Epidemiology and Evaluation, Vancouver Coastal Health Research Institute, Vancouver, Canada. *BMC Health Services Research*, 11:169. Retrieved from http://biomedcentral.com/1472-6963/11/169.

Mooney, G. 2009. Is it Not Time for Health Economists to Rethink Equity and Access? *Health Economics, Policy and Law*, 4, pp 209-221. doi:10.1017/S1744133109004848

Ong, K. S., Kelaher, M., Anderson, I., & Carter, R. (2009). A Cost-Based Equity Weight for Use in the Economic Evaluation of Primary Health Care Interventions: Case Study of the Australian Indigenous Population. *International Journal for Equity in Health*, 8:34. doi: 10.1186/1475-9276-8-34. Retrieved from http://www.equityhealthj.com/content/8/1/34

Robert Wood Johnson & University of Michigan. (2012). County health rankings and roadmaps: what works for health. Retrieved from http://www.countyhealthrankings.org/what-works-for-health

Whitehead, M. W. (1992). The Concepts and Principles of Equity and Health. *International Journal of Health Services*, 22(3), pp. 429-445.   Retrieved from http://salud.ciee.flacso.org.ar/flacso/optativas/equity_and_health.pdf

Young, I. M. (1990). *Justice and the politics of difference*. (1st ed., Vol. 1). Princeton, New Jersey: Princeton University Press.

APPENDICES

Appendix 1

DPH Multi-Criteria Decision Analysis Tool - Budget Prioritization

| Domain	Criteria	Definition	Weight
Health Impact	Numbers affected	Number of individuals affected by the proposed change	5.00
	Equity	Impact on the health status of recognized groups where there is a known health status gap/disparities	7.67
	Significance of impact	Impact on health outcomes for the patient/client (e.g., risk of adverse events, improved health status) as compared to current practice/service	6.83
	Effectiveness	1. Intervention is meeting a demonstrated need; 2. Intervention is known to achieve intended outcomes; 3. Intervention is evidence-based	8.33
	Health promotion and disease prevention	Impact on illness and/or injury prevention, wellbeing and harm reduction as measured by projected longer term improvements in health	7.22
	Client experience	Impact on safety, effectiveness, cultural competence, timely access, self-efficacy, and client experience of service(s) provided	6.28
Strategic Alignment	Alignment to Health Commission's 5-year budget priorities	1. Service directly supports IDS goals (i.e., provide medical homes responsible for coordinating preventive, primary, and specialty care; reduce misuse, overuse, and underuse of services; increase the number of insured patients served; enhance information technology to improve quality of care and decision making; manage resources responsibly for the maximum benefit of clients; ensure service excellence); 2. Service directly supports public health accreditation; 3. Service directly promotes financial and operational efficiency	9.78
	Mandates	1. The service is mandated by local, state or federal law, including the mandate to have a balanced budget; 2. The extent to which the level of service provided is below, at or beyond the mandated level	8.33
Organizational Impact	Adoption/ implementation	1. Political/legal challenges to the adoption of proposed initiative or reduction; 2. Internal operational challenges to the implementation of the proposed initiative or reduction	5.22
	Workplace environment	Impact on workplace environment including morale, workload, tools and equipment, safety and wellness, professional growth and teamwork	7.67
	Innovation and knowledge transfer	Impact on the generation and/or application of new knowledge/practice	4.89
Financial Impact	Associated revenue	1. The extent to which the program affects non-General Fun revenue (e.g., Medicaid match, grant funding); 2. The extent to which a project is sustainable beyond the expiration of time-limited funding.	7.56
	Downstream impact on service utilization	Impact on cost on future use of services elsewhere in the system (e.g., preventing unnecessary hospitalizations, preventing future illness, extent to which a service could be scaled up or down under different financial circumstances)	7.67
	Efficiency and appropriateness	1. Optimal use of resources to yield maximum benefits and results; 2. Appropriate level of service is provided; 3. Extent to which other organizations are also providing this service (e.g., duplication of service or sole provider)	7.56

Appendix 2: Select San Francisco Data

   Social Disadvantage in San Francisco

San Francisco is a world class tourist destination known for its beauty, tolerance for different lifestyles, and culturally rich and diverse neighborhoods.   However, over the years, there has been a flight of predominantly middle income families and low-income workers to other parts of the Bay Area where housing is relatively more affordable. As a result, as noted in Figure 9, the gap between the "haves" and the "have nots" in San Francisco is growing: while the affluent percent of population equaled 28% in 1980, it rose to 46% in 2010 (Kelly, 2012). Economic disparity between ethnic groups has
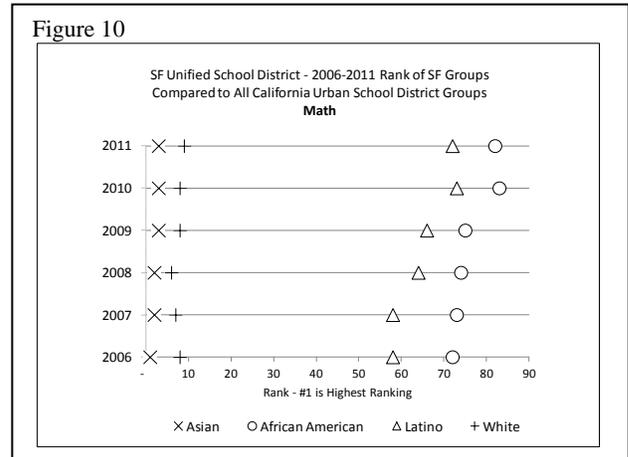

Figure 9

Affluent as a Proportion of San Francisco's Families
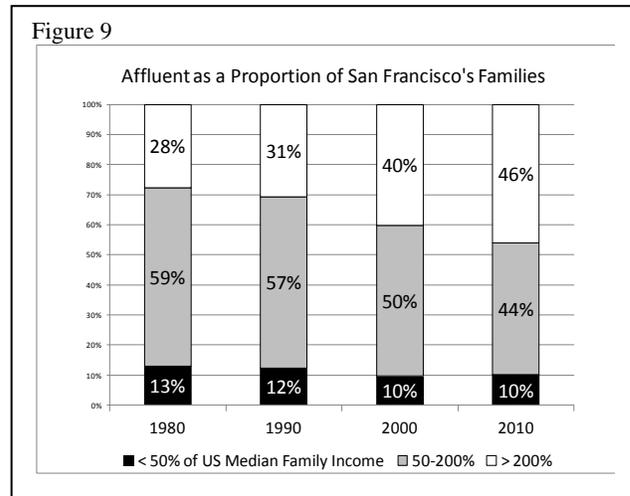
grown and there are now more wealthy white residents earning more than $200,000 a year than all African Americans residents combined (US Census Bureau, 2010). San Francisco rents are the highest of all American cities, requiring the equivalent of 4.6 full-time jobs for a family of four to afford a two-bedroom apartment (National Low Income Housing Coalition, 2012).

Socio-economic inequality exists depending upon your social group or where you live. Political wealth is disproportionately spread to whites, who are less than 50% of the city population, but more than two-thirds of the city's voters (Cook & Latterman, 2012). Of the 1,192 children engaged in the Foster Care system during April 2012, 62% were African American while representing only 5.8% of San Francisco residents (City and County of San Francisco, 2012). A recent large national survey of transgender people produced by the National Center for Transgender Equality showed high rates of postponed health care, refused care, inappropriate provider knowledge, and harassment and violence in care settings (Grant, Mottet,

& Tanis, 2010).   As shown in Figure 10, consistently since 1996, Latinos and African American students tested lower than other San Francisco groups, as well as all other urban groups throughout California, with African Americans test scores ranking below almost all other county's developmentally disabled and

Figure 10

SF Unified School District - 2006-2011 Rank of SF Groups
Compared to All California Urban School District Groups
Math

Rank - #1 is Highest Ranking

✕ Asian   ○ African American   △ Latino   + White

English Language Learner students (San Francisco Unified School District, 2012).   Decreased physical activity as a result of limited access to safe recreational places has been cited extensively in studies about public housing sites, but neighborhood violence also affects health by leading to isolation and decreased social supports (Stocksdale, Wells, Tan, Belin, & Zhang, 2007).

Health Disparity in San Francisco

Although San Francisco as a whole fares about average in health status when compared to other California counties,[6] there are deep pockets of health disparity within it (Robert Wood Johnson & University of Michigan, 2012).   A recent summary of health status reported that certain social groups and geographical areas in San Francisco fare far worse than others: African Americans experience a higher rate of violence, peri-natal and infant mortality rates, and higher preventable years of life lost (Harder and Company, 2012).   Latinos bear a greater burden of obesity, which results in diabetes and heart conditions.   Foreign-born Asians bear the largest TB

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[6]   The County Health Ranking is a project of the Robert Wood Johnson Foundation in collaboration with the University of Wisconsin Population Health Section. San Francisco ranks 24th in the 56 California counties. The tool bases the comparisons on each county's reported health outcomes such as mortality and morbidity rates, health behaviors such as smoking and injury rates, access to clinical care, social and economic factors, and physical environmental factors. This tool can be accessed at
http://www.countyhealthrankings.org/app/california/2012/rankings/outcomes/overall

burden and TB rates among Latinos have increased significantly. Certain San Francisco neighborhoods experience higher rates of pedestrian injury and deaths, preventable emergency room visits, and maternal/child health outcomes.

When comparing rates of disease and injury, almost every category shows a higher burden of both for the African American community than any other ethnic group (see Appendices 7 and 8). Figure 11 shows the number of age-adjusted preventable years of life lost by gender for each ethnic group in San Francisco. African American men and women far exceed the rate of preventable years of life lost than any other group, with American Indian females a close second to White men.

Figure 11

SF Preventable Years of Life Lost
2003-2004 Age-standardized YLL rate per 100,000 persons per year
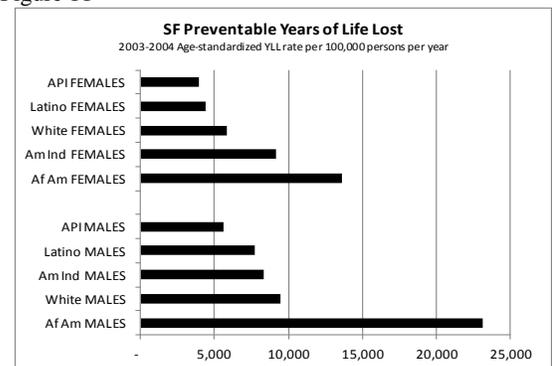
Residents living in five of the most distressed public housing sites in San Francisco report poor health (Cloutier, Fogarty, Jarrett, Martinez, & Wunsch, 2012).

References for Select San Francisco Data

City and County of San Francisco. (2012). *SF Foster Care: Demographics and Outcomes*.

>Human Service Agency, San Francisco, CA. Retrieved from

>http://www.sfhsa.org/asset/ReportsDataResources/FCS2012Q1QuarterlyReport.pdf

Cloutier, M., Fogarty, J., Jarrett, S., Martinez, M. X., Wunsch, B. (2012). Campaign for HOPE

>SF Health Task Force: Recommendations to the Campaign for HOPE SF Steering

>Committee. Retrieved from

>http://www.pachealth.org/docs/HOPE_SF_Health_Task_Force_Report_February2012.pd

>f

Cook, C. & Latterman, D. (2012). Ranked Choice Voting in the 2011 San Francisco Municipal

>Election Final Report, University of San Francisco. Retrieved from

>http://www.sfusualsuspects.com/wp-content/uploads/cook-and-latterman-final-rcv-

>analysis-3-27-12.pdf

Digenis-Bury, E. C., Brooks, D. R., Chen, L., Ostrem, M., and Horsburgh, C. R. (2008). Use of

>a Population-Based Survey to Describe the Health of Boston Public Housing Residents.

>*American Journal of Public Health*, *98:1,* 85-91. Retrieved from

>http://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.2006.094912

Grant, J. M., Mottet, L. A., & Tanis, J. (2010). National Transgender Discrimination Survey

>Report on Health and Health care. *National Center for Transgender Equality*. Retrieved

>from http://www.thetaskforce.org/reports_and_research/ntds

Harder and Company. (2012). Community Health Status Assessment: City and County of San

    Francisco. Retrieved from

    http://www.sfdph.org/dph/files/reports/PolicyProcOfc/CHSA_10162012.pdf

Kelly, D. (2012). Trends in Poverty Among San Francisco Families. *Department of Human*

    Services. May 23, 2012 Presentation to the Department of Public Health.

National Low Income Housing Coalition. (2012). Out of Reach – America's Forgotten Housing

    Crisis. Retrieved from http://nlihc.org/oor/2012 and

    http://nlihc.org/sites/default/files/oor/2012-OOR.pdf

Robert Wood Johnson & University of Michigan. (2012). County health rankings and roadmaps:

    what works for health. Retrieved from http://www.countyhealthrankings.org/what-works-

    for-health

San Francisco Unified School District. (2012). *2006-2011 Adequate Yearly Progress Reports*.

    San Francisco, CA.

Stocksdale, S. E., Wells, K. B., Tang, L., Belin, T. R., Zhang, L., Sherbourne, C. D. (2007). The

    importance of social context: neighborhood stressors, stress-buffering mechanisms, and

    alcohol, drug, and mental health disorders. *Soc Sci Med*.;65, pp 1867–1881.

U. S. Census Bureau. (2010). *Age of Householder by Household Income in the Past 12 Months*

    (in 2010 Inflation-adjusted dollars): San Francisco County, CA. Retrieved April 21,

    2012, from 2006-2010 American Community Survey 5-Year Estimates; B19037 series.

Appendix 3: Session 1: September 28, 2012: Identifying Priority Groups

See attached power point.

Appendix 4

092712 San Francisco Department of Public Health - Populations

Population by Social Identity		High Social Disadvantage?	High Burden of Disease and Injury?
		OVERALL CCSF	
Ethnicity	African American	❏	❏
	American Indian	❏	❏
	Asian	❏	❏
	Latino/a	❏	❏
	Pacific Islander	❏	❏
	White	❏	❏
	MultiEthnic	❏	❏
Gender	Male	❏	❏
	Female	❏	❏
	Transgender Male (F to M)	❏	❏
	Transgender Female (M to F)	❏	❏
Sexual Orient.	Heterosexual	❏	❏
	Lesbian	❏	❏
	Gay	❏	❏
	Bisexual	❏	❏
Age	Prenatal	❏	❏
	Age 0 to 5 – Young Children	❏	❏
	> 6 and ≤ 12 – Children	❏	❏
	> 12 and ≤ 17 – Teens	❏	❏
	> 18 and ≤ 23 – Transit. Age Youth	❏	❏
	> 24 and 60 – Adults	❏	❏
	> 60 – Seniors	❏	❏
Other	Immigrants (added)	❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏
		❏	❏

Population by Living Situation / Region	High Social Disadvantage?	High Burden of Disease and Injury?
	OVERALL CCSF	
D1 - Inner/Outer Richmond	❏	❏
D1/2 - Seacliff	❏	❏
D2 - Marina	❏	❏
D2 - Pacific Heights/Presidio Heights	❏	❏
D2/3 - Russian Hill	❏	❏
D2/5 - Western Addition	❏	❏
D3 - Chinatown	❏	❏
D3 - Financial District	❏	❏
D3 - Nob Hill	❏	❏
D3 - North Beach	❏	❏
D3/5/6 - Downtown/Civic Center	❏	❏
D4/5/7 - Inner/Outer Sunset	❏	❏
D4 - Parkside	❏	❏
D5 - Haight Ashbury	❏	❏
D6 - Mission Bay	❏	❏
D6 - South of Market	❏	❏
D6 - Tenderloin	❏	❏
D6/8/9/10 - Mission	❏	❏
D7 - Lakeshore	❏	❏
D7/11 - Ocean View	❏	❏
D7/11 - Outer Mission	❏	❏
D7/8 - Twin Peaks/West Twin Peaks	❏	❏
D8 - Castro/Upper Market	❏	❏
D8 - Diamond Heights/Glen Park	❏	❏
D8 - Noe Valley	❏	❏
D9 - Bernal Heights	❏	❏
D9/11 - Excelsior	❏	❏
D10 - Bayview	❏	❏
D10 - Potrero Hill	❏	❏
D10 - Treasure Island YBI	❏	❏
D10 - Visitacion Valley	❏	❏
D11 - Crocker Amazon	❏	❏
Public Housing Developments	❏	❏
Homeless	❏	❏

Appendix 5: Session 2: October 26, 2012: Making Health Equity Operational and Transparent

See attached power point.

Appendix 6

DPH Budget Prioritization: HEALTH IMPACT - Health Equity   (Weight 7.67 Points)

Example: African American (100%), Public Housing residents (76%), Homeless (5%), BVHP (15%), Tenderloin (76…

Example 2 - Keeping each population separate

Weight	Health Equity Prioritized Populations EXAMPLE: 5 CATEGORIES	Percent of UDC served that fall into the prioritized population category (% = # of prioritized individuals reached / # of total individuals served by the program)				Points	Weight	Weighted Points (Points x Weight)	Score (Total Weighted Points / 2.8 Possible Points)	Health Equity Score (7.67 x Score)
		1 Point	2 Points	3 Points	4 Points					
	Reach	10% to 25%	26% to 50%	51% to 75%	Over 75%					
20%	African Americans					4	4	0.20	0.80	
20%	Homeless	1					1	0.20	0.20	
20%	Public Housing Residents					4	4	0.20	0.80	
20%	BVHP Residents	1					1	0.20	0.20	
20%	Tenderloin Residents					4	4	0.20	0.80	
100%							**Total**	**2.80**	**1.00**	**7.67**

Total of these 2 cannot > 100% (Homeless / Public Housing Residents)
Total of these 2 cannot > 100% (BVHP Residents / Tenderloin Residents)

Example 1 - Combining Mutually Exclusive Categories

Weight	Health Equity Prioritized Populations EXAMPLE 3 CATEGORIES	Percent of UDC served that fall into the prioritized population category (% = # of prioritized individuals reached / # of total individuals served by the program)				Points	Weight	Weighted Points (Points x Weight)	Score (Total Weighted Points / 4 Possible Points)	Health Equity Score (7.67 x Score)
		1 Point	2 Points	3 Points	4 Points					
	Reach	10% to 25%	26% to 50%	51% to 75%	Over 75%					
33%	African Americans					4	4	0.33	1.33	
33%	Homeless &/or Public Housing Residents					4	4	0.33	1.33	
33%	BVHP &/or Tenderloin Residents					4	4	0.33	1.33	
100%							**Total**	**4.00**	**1.00**	**7.67**

1 Are the priority populations equal? Should they be ranked? If so, how would you go about it?

2 Should we collapse mutually exclusive categories? What are the pros and cons?

3 Is the % of those served the right %, or is it % of the total population, or…?

4 Do the ranges weighing the "% distribution of individuals served" make sense?

5 Is this methodology feasible for a manager to complete?

Appendix 7

Overview of Health in San Francisco 2003: Ethnic Differences in Population Health Data								Randy Reiter, SFDPH, CHEDC				
		MEASURE VALUE BY ETHNICITY							**RELATIVE MEASURE BY ETHNCITY**				
Indicator	Sex	White	Asian/ Chinese		Latino	African American	Year	Unit	White	Asian/ Chinese	Latino	African American	Measure
HEALTH													
Burden of Disease													
Life Expectancy	M	73.6	80.0	C	75.8	62.5	2000	years	-10.70	-4.30	-8.50	-21.80	years difference
(Potential is 84.3)	F	80.6	84.3	C	84.1	74.3	2000	years	-3.70	0.00	-0.20	-10.00	years difference
Age-Adjusted Death Rate	M	1,084.1	728.1	C	865.0	1,617.7	2000	10^5	1.49	1.00	1.19	2.22	rate ratio
	F	699.4	495.9	C	514.9	956.0	2000	10^5	1.41	1.00	1.04	1.93	rate ratio
Age-Specific Death Rates	M						2000	10^5					
	F						2000	10^5					
Fair/poor health (Self rate)	All	8.5	20.0	A	23.6	17.3	2001	%	1.00	2.35	2.78	2.04	rate ratio
Non-Communicable Disease							2000						
Obese or Overweight	M	49.6	39.4	A	49.1	67.0	2001	%	1.26	1.00	1.25	1.70	proportion ratio
	F	29.0	17.1	A	53.4	59.4	2001	%	1.70	1.00	3.12	3.47	proportion ratio
Ischemic Heart Disease m	M	238.7	147.0	C	164.3	255.0	2000	10^5	1.62	1.00	1.12	1.73	rate ratio
(death rate)	F	134.5	81.1	C	83.2	185.0	2001	10^5	1.66	1.00	1.03	2.28	rate ratio
Stroke mortality	M	67.9	83.5	C	66.4	100.0	2001	10^5	1.02	1.26	1.00	1.51	rate ratio
(death rate)	F	61.5	74.6	C	56.4	92.2	2001	10^5	1.09	1.32	1.00	1.63	rate ratio
Diabetes diagnosis	All	3.5	3.4	A	3.3	13.6	2001	%	1.06	1.03	1.00	4.12	proportion ratio
High blood pressure (dx)	All	19.5	22.1	A	11.2	47.5	2001	%	1.74	1.97	1.00	4.24	proportion ratio
Cancer mortality--Overall	M	233.1	172.3	A	157.2	348.4	'96-'00	10^5	1.48	1.10	1.00	2.22	rate ratio
(death rate)	F	161.8	101.5	A	92.0	193.1	'96-'00	10^5	1.76	1.10	1.00	2.10	rate ratio
Lung cancer	M	56.9	50.3	A	33.7	98.4	'96-'00	10^5	1.69	1.49	1.00	2.92	rate ratio
(death rate)	F	36.2	21.3	A	14.2	45.3	'96-'00	10^5	2.55	1.50	1.00	3.19	rate ratio
Colorectal cancer	M	25.3	18.5	A	13.8	36.6	'96-'00	10^5	1.83	1.34	1.00	2.65	rate ratio
(death rate)	F	16.8	13.7	A	7.0	19.9	'96-'00	10^5	2.40	1.96	1.00	2.84	rate ratio
Cancer incidence--Overall	M	645.4	380.8	A	362.5	768.2	'96-'00	10^5	1.78	1.05	1.00	2.12	rate ratio
(incidence rate)	F	464.6	290.8	A	266.2	364.8	'96-'00	10^5	1.75	1.09	1.00	1.37	rate ratio
Lung cancer	M	76.1	70.4	A	36.5	131.3	'96-'00	10^5	2.08	1.93	1.00	3.60	rate ratio
(incidence rate)	F	51.6	31.0	A	23.4	53.7	'96-'00	10^5	2.21	1.32	1.00	2.29	rate ratio
Colorectal cancer	M	65.9	55.4	A	34.5	45.3	'96-'00	10^5	1.91	1.61	1.00	1.31	rate ratio
(incidence rate)	F	48.8	42.2	A	28.4	44.3	'96-'00	10^5	1.72	1.49	1.00	1.56	rate ratio
Ever told had Asthma	All	11.2	9.5	A	11.9	18.4	2001	%	1.18	1.00	1.25	1.94	proportion ratio
Ever toldhad Arthritis	All	17.6	13.2	A	10.5	31.8	2001	%	1.68	1.26	1.00	3.03	proportion ratio
Communicable Disease													
AIDS Deaths	All	803.0	48.0	A	124.0	265.0	'99-'02	N	1.42	0.12	0.68	2.71	PMR
AIDS cases	M	10,631.0	675.0	A	2,596.0	2,639.0	'80-'02	10^5	11.08	1.00	8.37	15.84	rate ratio
(cumulative rates)	F	328.0	54.0	A	127.0	451.0	'80-'02	10^5	4.27	1.00	5.12	33.83	rate ratio
Tuberculosis cases	All	19.0	81.0	A	20.0	25.0	2002	N	0.29	1.75	0.94	2.18	PIR
Injuries (deaths)													
Poisoning	M	55.0	2.0	A	4.0	25.0	2001	N	1.41	0.07	0.32	3.68	PMR
	F	10.0	1.0	A	1.0	5.0	2001	N	1.29	0.18	0.40	3.72	PMR
Motor vehicle accident	All	29.0	16.0	A	11.0	2.0	2001	N	1.10	0.86	1.29	0.44	PMR
Homicide	M	7.0	7.0	A	5.0	21.0	2001	N	0.38	0.55	0.85	6.65	PMR
	F	-	3.0	A	2.0	3.0	2001	N	0.00	1.17	1.70	4.75	PMR
Mental Health													
Suicide	M	44.0	10.0	A	10.0	6.0	2001	N	1.38	0.45	0.97	1.08	PMR
	F	10.0	8.0	A	-	1.0	2001	N	1.16	1.32	0.00	0.67	PMR
Did less-emotional probler	All	14.8	14.3	A	20.7	19.5	2001	%	1.03	1.00	1.45	1.36	proportion ratio
Needed help-emotional/MI	All	24.2	13.2	A	24.1	16.5	2001	%	1.83	1.00	1.83	1.25	proportion ratio
Not usual work--emotional	All	18.9	17.8	A	30.1	25.9	2001	%	1.06	1.00	1.69	1.46	proportion ratio
Maternal & Child Health													
Infant Mortality: SF	All	2.7	3.4	A	3.7	15.1	97,'99,	10^3	1.00	1.26	1.37	5.59	rate ratio (unstable)
Ca.	All	4.9	5.3	A	5.4	12.6	2000	10^3	1.00	1.08	1.10	2.57	rate ratio
Low birthweight	All	6.2	6.2	C	6.5	16.3	2001	%	1.00	1.00	1.05	2.63	proportion ratio
CONDITIONS													
Socio-Economic							2000						
Median Income	M	$ 42,978	$ 23,673	A	$ 21,847	$ 20,507	2000	$	$ -	$ (19,305)	$ (21,131)	$ (22,471)	difference
$42,978 SF Avg	F	$ 33,833	$ 16,933	A	$ 15,786	$ 15,276	2000	$	$ (9,145)	$ (26,045)	$ (27,192)	$ (27,702)	difference
Unemployment	M	3.3%	4.4%	A	7.3%	12.7%	2000	%	1.00	1.33	2.21	3.85	proportion ratio
Number	M	4,366	2,655	A	2,319	1,560	2000	N					
Unemployment	F	3.1%	4.2%	A	7.0%	11.3%	2000	%	1.00	1.35	2.26	3.65	proportion ratio
Number	F	3,099	2,579	A	1,653	1,309	2000	N					
Not in Labor Force	M	21.7%	36.0%	A	30.5%	46.5%	2000	%	1.00	1.66	1.41	2.14	proportion ratio
Number	M	36,181	33,750	A	14,043	10,686	2000	N					
Not in Labor Force	F	31.9%	43.9%	A	43.5%	50.8%	2000	%	1.00	1.38	1.36	1.59	proportion ratio
Number	F	47,213	47,703	A	18,122	11,958	2000	N					
Risk Behavior													
Smoking	All	21.3	15.2	A	16.1	19.3	2001	%	-6.1	0.0	-0.9	-4.1	difference
Physical inactivity	All	16.6	39.3	A	35.2	36.5	2001	%	0.00	-22.70	-18.60	-19.90	difference
Adequate fruits/vegetables	All	61.4	40.1	A	51.0	46.6	2001	%	0.00	-21.30	-10.40	-14.80	difference
Insured prior 12 months	All	86.0	77.1	A	63.1	86.1	2001	%	0.00	-8.90	-22.90	0.10	difference
Dental visit within past year	All	78.9	67.2	A	69.1	67.5	2001	%	0.00	-11.70	-9.80	-11.40	proportion ratio
Population proportion	All	45.5%	32.0%	A	14.7%	7.9%	2000	%	5.76	4.05	1.86	1.00	proportion ratio
			(20.5%: Chinese)										
									Best	Worst			

Asian/Chinese:	C = Chinese; A = Asian
Unit:	N = number of events; 10^5 = rate per 100,000 population; 10^3 = rate per 1,000 live births
Relative measures:	For relative measures, groups are generally compared to the one with the best measure, with the group doing worst highlighted in **bold**.
	For *differences* measures, the best group has a difference of 0. For most *ratio* measures, the best group is set to 1 and the others
	compared to it (except for *PMR*, *proportional mortality ratios*, and *PIR*, *proportional incidence ratios*, which are based on very small numbers.
	For these, numbers above 1.0 are greater than expected, and those below 1.0 are less than expected).

Appendix 8

Ethnic Differences in Population Health - CCSF

Difference from the Ethnic Group with the Best Marker (1.00)