



HEALTH EQUITY POLICY TOOLKIT

A Movement for Justice

A Letter from Dr. Wyche Etheridge

Jan. 2023

Dear State and Territorial Health Officials,

The summer of 2020 weighs heavy on the minds of many Americans. Marked by the global COVID-19 pandemic and the nationwide social unrest protesting police violence, it revealed many systemic inequities experienced by Black, Indigenous, People of Color (BIPOC), as well as other marginalized communities. This heightened national awareness presented an opportunity to educate the public about health inequities—long known to the public health community—and to cultivate resources and political will to address them.

In response to the outcry, more than 300 local and state governments, declared racism as a public health crisis. Many established new offices of health equity and invested in community-based organizations. As a result, there has been significant progress in many states and territories towards the advancement of health equity. The next challenge for public health leaders is to sustain the advancements made while continuing to champion policies that promote health equity. Health equity is a core tenet of ASTHO's strategic plan, and working to support and equip state and territorial health agencies to advance health equity is the first strategic priority.

ASTHO's Health Equity toolkit is part of this work, to help public health leaders navigate the policy process and address health inequities by building diverse and inclusive coalitions. Tools discussed in this guide are designed to support a wide range of policy changes that can promote health equity. Inside, you will find:

- Background information on health equity, intersectionality, and social determinants of health.
- An overview of several policy levers public health leaders can use to advance health equity.
- An overview of the policy development process, along with resources to support each step.

The ASTHO team is committed to supporting your journey to advance health equity in your jurisdiction.

Sincerely,



Kimberlee Wyche Etheridge, MD, MPH

Senior Vice President, Health Equity and Diversity Initiatives
Association of State and Territorial Health Officials

The essence of global health equity is the idea that something so precious as health might be viewed as a right.

– Paul Farmer, M.D., Ph.D.
Global Health Champion

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Introduction

ASTHO defines Health Equity as, *“when everyone has a fair and just opportunity to be as healthy as possible in a society that values each member equally through focused and ongoing efforts to address avoidable inequities, historical and contemporary injustices, and the elimination of disparities in health and healthcare.”*

The achievement of health equity reduces harm to people who have been marginalized and increases life expectancy and quality of life for everyone. Current health inequities can be traced to policy choices that negatively impact (or “disenfranchise”) communities, such as [racist redlining policies](#) and the [traumatic historical practice](#) of sending Native and Indigenous youth to boarding schools. Similarly, healthcare payment policies and a strained workforce result in geographic health disparities, with [more than 170 rural counties](#) lacking health system infrastructure such as a rural health clinic, Federally Qualified Health Center, or critical care hospital. Recognizing that past policy choices across all levels of government resulted in an inequitable system and structural discrimination allows strategic amplification across multi-sector partners to address these historical wrongs and the resulting inequities. Public health leaders have an opportunity to support policies that center the needs of historically marginalized, disenfranchised, and underinvested communities to achieve health equity.

This toolkit is designed to support public health leaders in leveraging the policy development process to achieve health equity in their jurisdiction. The toolkit includes an overview of core health equity concepts, such as defining the Social Determinants of Health (SDOH) and intersectionality, as well as descriptions and examples of common policy levers within public health leaders’ authority or influence. Key considerations for using the policy levers to advance health equity are also provided. Lastly, the toolkit includes resources for supporting health departments in the policy development process.



Defining The Issue

There are several terms and concepts public health leaders should understand in developing and implementing policies to advance health equity, including: levels of [oppression](#), levels of racism, and types of [inequity](#).

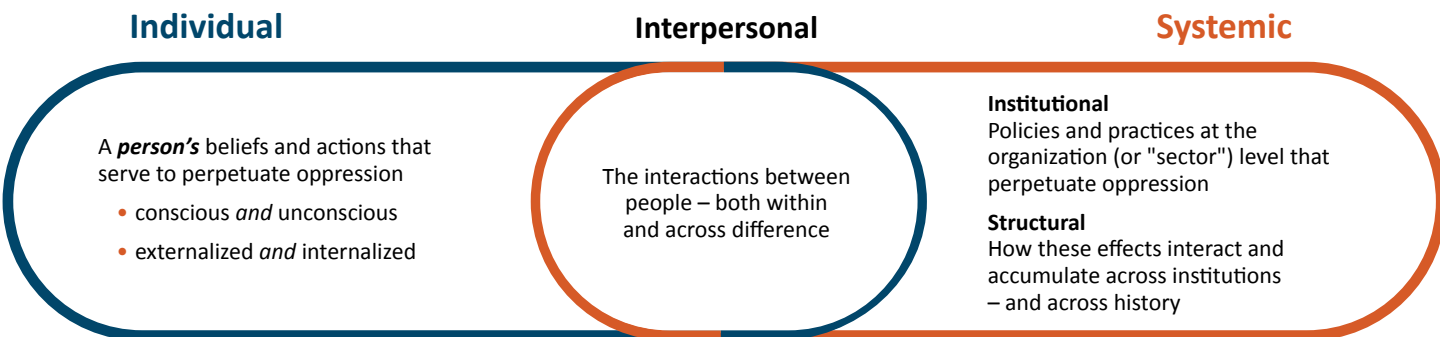
Levels of Oppression

There are [three defined levels of oppression](#): internalized, interpersonal, and institutional. Internalized oppression is a set of private beliefs, prejudices, and ideas that individuals have about the superiority of one group and the inferiority of another that can show up in conscious and unconscious behaviors and actions. [Interpersonal oppression](#) is expression and action between individuals, or from one individual toward another. [Institutional oppression](#) is discriminatory treatment, unfair policies and practices, as well as inequitable opportunities and impacts within organizations and institutions. Researchers describe the system of privilege and oppression as [structural oppression](#) or systemic exclusion, which is diffused and infused throughout all aspects of society, including history, culture, politics, economics, and the entire social fabric (behaviors, norms, values).

A person can experience multiple layers of oppression simultaneously. An example could be a health department employee looking for space to hold meetings within their community. When selecting a space, they choose an older building that does not have adequate accommodations for individuals with disabilities. If this venue is also the only meeting held in a historically divested community, lacking Americans with Disabilities Act (ADA) accessible spaces along with limited public transit a person with disabilities and lacking private transportation would experience several instances of institutional oppression. Further, if the person is from a racial or ethnic minority and treated differently based on their race when attending the meeting, they would be experiencing interpersonal oppression. These various levels of oppression together illustrate structural oppression.

Levels of Racism

There are also three identified [levels of racism](#). [Institutionalized racism](#) shows itself both in material conditions and in access to power. Some of the conditions impacted by institutions include quality education, housing, employment, and appropriate medical care. [Personally mediated racism](#) is when prejudices and discrimination are associated with a specific race at a personal level. [Internalized racism](#) is defined as acceptance of stereotypes and negative messages by members of stigmatized races about their worth. Prejudice includes a judgment or opinion, which is often but not always negative, formed on insufficient grounds before facts are known or that disregard contradictory facts. [Prejudices](#) are learned and can be unlearned.



Social Determinants of Health

Inequities manifest in different areas of public health and include racial, socioeconomic, geographic, sexual orientation, gender identity, and disability components, among many others. Life expectancy varies dramatically based on regions or zip codes. Additional examples include [higher rates of death](#) for pregnant persons of different races.

The first stage of policy development is to identify the problem. In the context of promoting health equity, public health leaders should understand how the environments where people live, work, learn, and play affect their overall health and quality of life. Fully identifying the problem recognizes oppression in conjunction with environmental factors, known as the social determinants of health (SDOH). SDOHs are commonly grouped into five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context.

- [Economic stability](#) is defined as having the resources needed to live a healthy life.
- [Education access](#) and quality means more educational opportunities and helping children and adolescents do well in school.
- [Medical care access and quality](#) means access to comprehensive, high-quality healthcare services.
- [Neighborhood](#) and built environment can promote health and safety.
- [Social and community context](#) is the relationship people have with the places they live, work, and play. Strong community connection—including enhanced civic engagement and employment—can reduce health disparities.



In island jurisdictions, additional [social determinants](#) include limited access to fresh produce and healthy foods because of high importation costs, limited public health infrastructure, and vulnerabilities to natural disasters such as typhoons and hurricanes.

Each of the identified determinants create opportunities for public health interventions. In general, public action and interventions and representation in systems of power have the greatest population impact. Practical application of the Health Impact Pyramid [framework](#) has great benefit when addressing potential public health outcomes (e.g., clean water, quality standard education, public safety).

SDOH exist in a complex societal and policy environment that can affect individuals, institutions, and broader communities. In 2021, scholars from the University of Illinois published a [conceptual model](#) describing how these forces contribute to health disparities within communities that experience health inequities.

Intersectionality and Health Equity Frameworks

[Intersectionality](#) is a lens working to show how social identities correlate on a human level while racism and oppression effects all. The wheel of [power and privilege](#) is a tool that highlights where intersections exist and how equity and inclusion helps marginalized groups can live healthier lives.

Within public health, officials and researchers have created several health equity frameworks as a basis for public action and intervention designed to address individual and systemic barriers. One [example developed in 2020](#), shows a Venn diagram of factors that influence health outcomes. The considerations include individual factors, relationships and networks, systems of power, and physiological pathways. Rooted in the social-ecological model theory, the complexities of social determinants are rooted in individual, relationship, community, and societal factors.

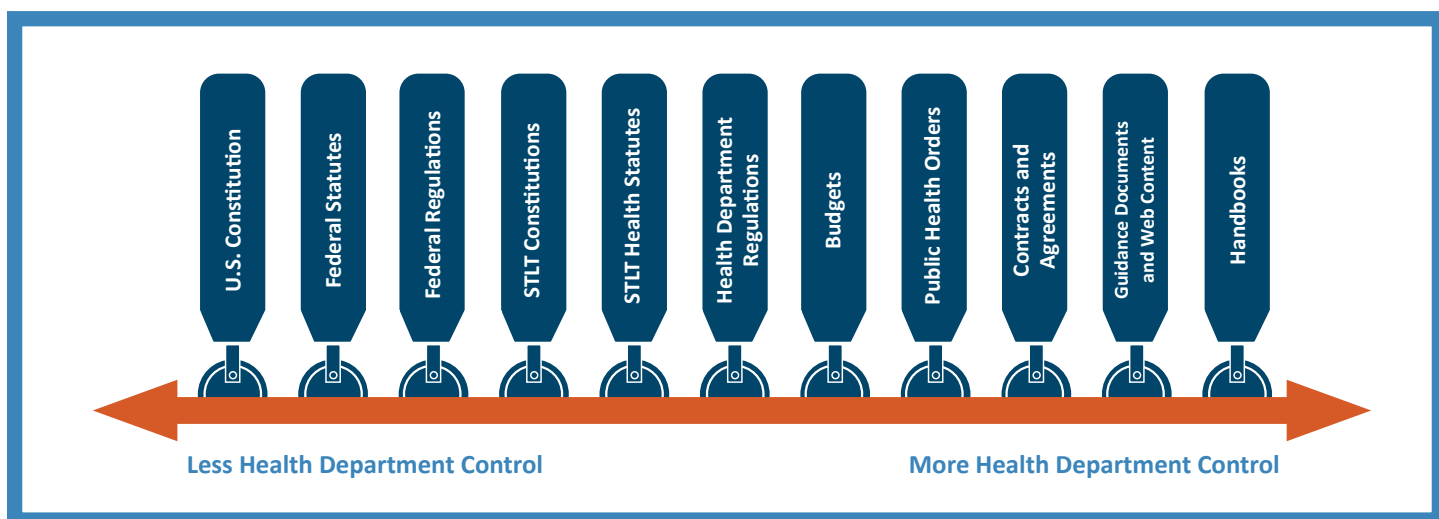
The idea of achieving [health equity](#) has moved to the forefront of [public health](#) with many states and local jurisdictions beginning with declaring racism a [public health crisis](#).

ASTHO is committed to health equity and created a [policy statement](#) to support its position. Leadership, members, and the board of directors along with staff developed a policy statement on advancing health equity committing to addressing structural racism and discrimination to help improve health outcomes for all.



Policy Levers

Public health policy can be defined as an authoritative decision or rule intended to direct or influence the actions of specified parties or influence systems development and organizational change to promote improvements to population health. These authoritative decisions can come in many forms, across all levels of government, with the collective body of decisions creating a specific policy landscape for an issue. These forms of decision-making operate as policy levers, which can range from unilateral action from a public official (e.g., a public health order) to a deliberative process involving multiple branches of government (e.g., legislation being enacted into law).



For any public health policy issue, there are often several [policy levers](#) operating simultaneously to create a broader policy landscape. This interaction can be illustrated by public health efforts to collect sexual orientation and gender identity (SOGI) data to identify health disparities experienced by the lesbian, gay, bisexual, and transgender communities. Clear data is the foundation of effective and equitable policies. Two common sources of SOGI data that public health officials may be able to access to identify LGBTQ+ health disparities are the [Behavioral Risk Factor Surveillance System](#) (BRFSS) and reports from Electronic Health Records (EHRs). Currently, all states, three of eight island jurisdictions and Washington D.C. participate in BRFSS to collect data on population health risks, chronic health conditions, and use of preventative services. While BRFSS is supported by the federal government, states, territories, and the District of Columbia determine what data to include in the BRFSS survey. Only [31 jurisdictions](#) included SOGI questions in 2016. Some jurisdictions enacted laws requiring the inclusion of SOGI questions in the BRFSS, such as the [Washington D.C.](#) in 2019.

In recent years, the federal government has used its rulemaking authority to encourage collecting SOGI data through EHRs. CMS issued a [final rule](#) in 2015 requiring certain EHRs to allow for the collection of SOGI data, however the rule does [not require](#) the collection of SOGI data. Some states are now enacting laws to require providers to submit SOGI data through EHRs. In 2021, Oregon enacted [HB 3159](#), which requires coordinated care organizations, healthcare providers, and insurers to annually submit sexual orientation and gender identity data in accordance with standards developed by the Oregon Health Authority.

This toolkit highlights several common policy levers that can advance health equity, organized below based on the level of authority or influence of state/territorial public health departments. Each lever has varying permanence and can be used in conjunction with other levers. For each policy lever described, there is an assessment of a health department's authority/influence, a brief description of the process to activate that policy lever, and an estimated timeframe it takes to use the policy lever. While these levers are generally applicable to most jurisdictions, there are some special considerations for [territories](#), [freely associated states](#), [Washington D.C.](#), and [tribal nations](#).

Health Department Handbooks/Guidance Documents

- **Authority/Influence:** S/THO Authority
- **Process:** Development and revision follows state procurement laws and executive branch guidance (if applicable)
- **Timeline:** Several months

Public health departments develop internal guidance documents on a wide range of topics, including employee handbooks, style guides, operations handbooks and more. These documents often include the organization's history, mission, values, policies, procedures, and benefits. They provide policy guidance to department staff by creating a written record of agency standards and norms. Through department handbooks and guidance documents public health agencies can promote inclusive and supportive workplace environments and encourage the advancement of health equity as a guiding principle in agency work.

Considerations for Health Equity

When focusing on health equity, handbooks and policy documents are examples of how agencies can address internal [policies and practices](#). Guidance can include more inclusive language that is representative of the many different identities and lived experiences of the impacted populations. As a workplace, agency policies and procedures can be changed to adjust with new [evidence-based practices](#). Additional considerations for handbook and guidance documents include policies that are carried out at the discretion of current leadership. Health equity language changes could include additional terms for gender identity or racial groups. Handbooks can integrate equity into job descriptions and provide peer-to-peer learning opportunities to enhance workplace cultures. [Evidence](#) shows culture changes over time when a commitment to equity is formalized.



Health Department Contracts and Agreements

- **Authority/Influence:** S/THO Authority
- **Process:** Development and revision follows state procurement laws and executive branch guidance (if applicable)
- **Timeline:** Several months

Like all governmental agencies, public health agencies enter into agreements with other governmental entities, non-governmental entities, and private entities to procure goods or services to meet the health department's mission. This process, known generally as procurement, is governed by state/territorial laws that establish the processes government agencies must follow to enter into contracts for goods and services. Procurement laws usually require competitive bidding processes for large contracts, factors agencies can consider when weighing competitive bids, and establishing clear guidelines for when and how agencies can engage in sole-source contracts.

Considerations for Health Equity

Establishing inclusive government procurement and contracting processes can support a jurisdiction's health equity goals by supporting businesses owned by people of color, women, veterans, or other groups underrepresented in traditional procurement processes. Although some state procurement laws make it very [difficult for agencies to operate procurement programs conscious of race or gender](#), many state laws allow governments to consider race, gender, or other factors in the procurement process as a way to account for structural discrimination or bias. For example, in 2022 Maryland enacted [HB 389](#) to revise how the state procurement process considers historically-excluded or BIPOC owned businesses. Under this new law agencies using competitive sealed bids must provide a summary of factors used in determining the expected

participation of minority business enterprises and authorizes the Governor's Office of Small, Minority, and Women Business Affairs to assess previous government contracts to determine whether the minority business enterprise goals set out in the contract were achieved.

In addition to statutory efforts to promote inclusive contracting, agencies can implement agency specific policies and strategies to account for structural barriers faced by businesses owned and operated by underrepresented groups. For example, instead of seeking a single large contract agencies can [choose to unbundle the request for services into multiple small contracts](#), increasing the number of opportunities for underrepresented businesses to bid for the contract and lowering potential administrative barriers for those companies to submit a bid. Additionally, agencies can participate in mentoring and education programs to inform diverse business leaders about the government contracting process.

The procurement process has the potential to be inclusive with targeted outreach, forecasting opportunities to include specific groups, and streamlining the process for equitable access. A [case study](#) of this research examines the city of Chicago, IL, and the effectiveness of the Request for Proposal (RFP) process by eliminating department repetitive disclosure forms. Additional strategies during the contracting process could be requiring diversity plans, or additional loan programs during the procurement process.



Public Health Orders

State Public Health Orders

- **Authority/Influence:** S/THO Authority
- **Process:** Outlined in state laws defining S/THO authority
- **Timeline:** Immediate to months

For state public health authorities, the agencies to issue orders must also be established under state law and is typically used to address a violation of public health law or to mitigate an emerging public health hazard, threat, or risk. For example, the Vermont Commissioner of Health is able to issue [health orders](#) and [emergency health orders](#) to “require any person responsible for contributing to the public health hazard or significant public health risk to take actions to protect the public health.” In other instances, health orders such as Public Health Standing Orders (or Standing Physician Protocols) may have more limited roles. These are frequently used by State Health Officials to increase and coordinate vaccination efforts. In Illinois, the Health Official can issue [standing orders](#) to clinics for “specified medical services” during a prescribed period of time.

Like state health orders, many public health orders are issued by municipal, county, or local health departments. In Michigan, local health officials issue [health orders](#) to limit gatherings or involuntarily detain and treat “individuals with hazardous communicable disease.” These types of orders are generally authorized under state law but issued and enforced at the local level.



Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in federal law
- **Timeline:** Immediate to months

Administrative agencies reside within the executive branches of federal, state, and territorial governments. On the federal level, these include agencies such as HHS, CDC, and FDA. On the state and territorial level, these also include health and human services agencies and departments of public health. While agencies are overseen by the Executive Branch, the powers and authorities of administrative agencies are established through legislation. Similar to rulemaking authority, when authorized by statute, some agencies may hold the authority to issue orders.

In federal agencies, some of these authorities are triggered by declarations of a public health emergency. For example, FDA can issue an [Emergency Use Authorization](#) to make medical countermeasure available during a public health emergency under Section 564 of the [Federal Food, Drug, and Cosmetic Act](#) (FD&C Act) (21 U.S.C. 360bbb-3). However, this is only possible when the HHS Secretary has determined the existence of a [Public Health Emergency](#) under [section 319 of the Public Health Service Act](#).

Considerations for Health Equity

Public health orders have been used to highlight the crisis of structural discrimination and demonstrate the need to show the importance of health equity. Dayton Ohio's Board of Health issued a resolution ([20-270](#)) declaring racism and discrimination a public health crisis. To declare racism and discrimination a public health crisis. As leadership begins to move forward on addressing health equity health orders and regulations although temporary can be a start to achieving health equity.

Budgets

Health Department Budget

- **Authority/Influence:** S/THO Authority
- **Process:** Development and revision follows executive branch guidance (if applicable)
- **Timeline:** Several months

The budget for a health department allows general funds to be used to promote work within the department. "Budget dollars come from state revenues, federal agencies, or grant dollars for specific programs. Health departments can allocate dollars to specific programs or overall health outcomes sought by the general strategic plan of the department."

State

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in state constitutions, involving the legislature and governor
- **Timeline:** Several months

Every year, legislators make choices about how to fund programs and services through state revenues. State budgets show priorities of the legislature and elected officials and provide measures to adequately fund them. A state's budget is passed every year, or every other year in states with a two-year or biennial budget. The [budget process](#) occurs during most states' legislative session. The process starts when the governor submits a proposed budget and, in some states, this can happen before the start of the legislative session. Then it proceeds to the legislature, which holds most of the authority over the final budget. Over a few months, legislators review and modify the governor's proposal and add additional spending measures as they see fit. All states allow the public to weigh in on the budget with their priorities along the way. Budget appropriations at the state level means funds are set aside for specific means or purposes.



Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Rooted in [Congressional taxing and appropriations](#) authority established in the United States Constitution, supported by the Executive Branch
- **Timeline:** Several months

The [federal budget](#) process begins with the President of the United States (POTUS) submitting a detailed document on October 1 to Congress. Included in the POTUS budget are priorities for federal policy, programs, and services, such as [improving public health](#) infrastructure. The POTUS must recommend funding levels for annually funded programs, but not propose legislative changes for ongoing parts of the budget already funded by prior laws. Next, Congress generally holds hearings to question administration officials about their requests and then develops its own budget plan, called a “budget resolution.” This work is done by the House and Senate Budget Committees whose primary function is to draft and enforce the budget resolution. Once the Budget Committees pass their budget resolutions, the resolutions go to the House and Senate floors, where they can be amended (by majority vote). A House-Senate conference then resolves any differences, and the budget resolution for the year is adopted when both houses pass the conference agreement. Once the legislature has adopted the budget resolution, Congress considers the annual appropriations bills, which fund discretionary programs for the coming fiscal year, and considers legislation to enact changes to mandatory spending or revenue laws within the dollar constraints specified in the budget resolution. The reconciliation process in the federal budget helps expedite mandatory spending.

Considerations for Health Equity

Allocating the appropriate resources to policy actions that support health equity provides these policies a better opportunity for success. The budgeting processes across all levels of government are best positioned to allocate those resources and influence public health priorities of a given budget year. For example, Oregon’s legislature enacted [HB 4052](#) in 2022 directing its Health Authority to convene an advisory committee to provide guidance on creating a pilot program aimed to improving health outcomes of residents impacted by racism. Following the guidance of the committee, the department is further directed to distribute grants to entities that serve the priority populations who have a demonstrated ability to conduct meaningful community engagement. To support these health equity priorities, the legislature also increased the department’s appropriation so that it can meet the goals established by the act. General funds can be used to work on health equity without a designated appropriated line item.



Regulations

State

- **Authority/Influence:** S/THO Authority for S/THA regulations, S/THO Influence for Non-S/THA regulations
- **Process:** Established in the state/territorial administrative procedures act
- **Timeline:** Several months to a year

State agencies adopt rules ([or regulations](#)) to fill in the details of legislation, implement, interpret, or set policy, or establish practice or procedural requirements of the agency. Legislation may also authorize state health agencies to adopt rules or explicitly direct health agencies to do so.

Most states and territories are empowered to address health equity through a rulemaking process. Each state or territory establishes its own procedures for promulgating regulations. All 50 states, Washington, D.C., and many of the territories have formally adopted an administrative procedure statute outlining the process for executive agency rulemaking. The rulemaking process typically requires the agency to publicize a proposed rule for a designated time period to receive comments. This feedback can be given in written comments to the agency or public hearings on the issue. Agency leaders should consult with their legal counsel to determine which methods of feedback are required under their state or territorial law and what is legally required during a public hearing. After public comment, the agency can approve the rule, terminate the process, or extend the rulemaking period (if state law allows). The final approval process varies by state, but typically the agency submits the rule to an independent commission or the legislature for review and approval. If approved, the rule is usually filed with a state entity (e.g., Secretary of State), published in a register, and placed in the state or territorial administrative code.



Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the federal law, primarily the Administrative Procedures Act
- **Timeline:** Several months to a year

Rulemaking is the term used when a federal government agency creates, modifies, or rescinds rules published in the Code of Federal Regulations. A regulation is created by a governmental agency, often to implement a given law, and does not have to go through the bill process. With regulations, an agency holds a public comment period and after that hearing decides on either adopting, changing, or rejecting the regulation.

Considerations for Health Equity

The regulatory process is transparent and informed, relying on the expertise of the agency issuing the rule. When considering regulatory action, agencies can and should consider how a change may affect different groups based on information gathered during the public comment period of a proposed rule. Additional considerations include how regulations can be [suspended](#) during times of crisis.



Courts are empowered to review agency regulations, often determining whether the agency is acting within the bounds established by the legislature.

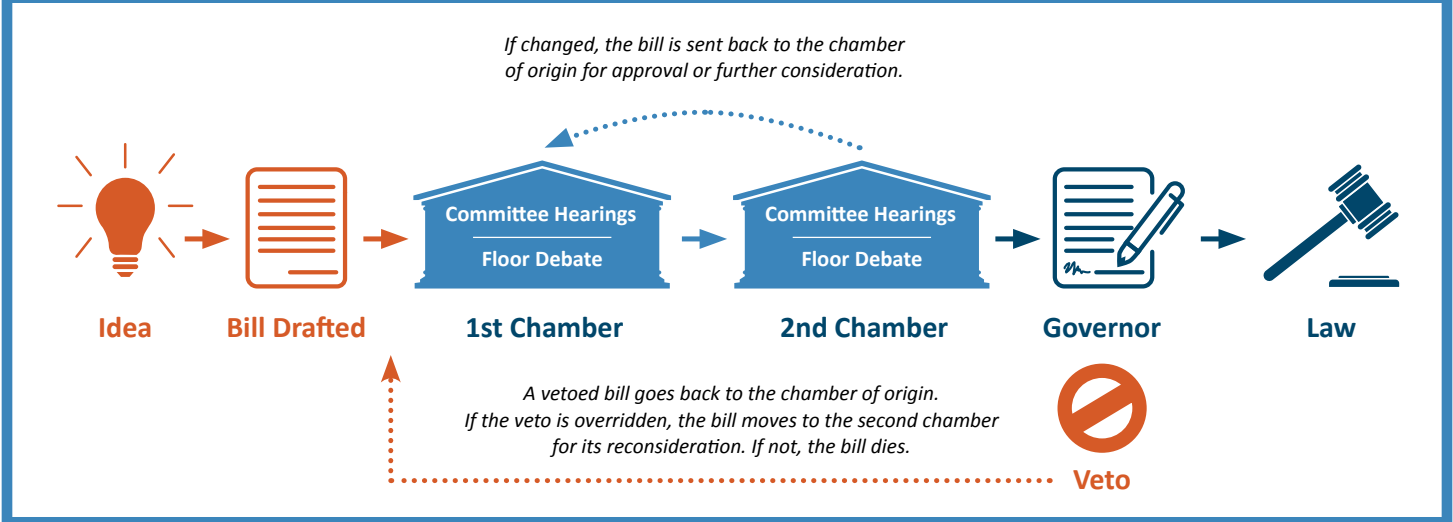
Statutes and Resolutions

The legislative body of a jurisdiction is comprised of elected officials empowered to pass laws and levy taxes. After the legislative body passes a bill (proposed law) it is usually signed into law by the chief executive. Once adopted, those laws are called statutes.

In addition to considering bills, legislative bodies can also adopt resolutions. A resolution, in most cases, represents the voice and view of the body that adopts it (i.e., the legislature as a whole or a single chamber of the legislature).



State Legislative Process



State

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the state/territorial constitution
- **Timeline:** Several months to two years

Similar to the federal government, 49 state legislatures are bicameral (have two chambers) with the state constitution defining how many members comprise each chamber. One state, Nebraska, has a unicameral legislature. The main legislative mechanism for a member of the legislature to introduce a bill into the legislative chamber. Once the bill is introduced, it is assigned to committee(s) for consideration. The committee(s) then hold public hearings, debate the bill, consider amendments, and ultimately vote on whether to send the bill out of committee to the floor. Once a bill is reported to the floor, the entire chamber will vote on the bill. If passed in a legislative chamber of a bicameral legislature the bill would then go to the second chamber, in a unicameral legislature passed bills would go to the Governor. The Governor then has the option to sign the bill into law or veto the bill. If a bill is vetoed, the legislature can usually override the veto by a two-thirds majority vote and the bill would become law.

Most state governments provide the legislature the power to levy taxes and appropriate funds to support government programs and operations. Unlike the federal government, which can operate with a deficit budget, the majority of states [require a balanced budget](#), which can limit the size and scale of some state programs.

State legislatures also consider resolutions (simple and joint); however, state resolutions typically express the viewpoint of the legislature or establish operational rules for the body and do not have the force of law. To enact a simple resolution a single chamber of the legislature must approve by a majority vote. In a bicameral legislature, a joint resolution must pass both chambers to be adopted.

Considerations for Health Equity

State statutes can be a powerful tool for advancing health equity by appropriating funds to programs that reduce health inequities, investing in long-term strategic efforts to reduce systemic barriers, and prohibiting or mitigating actions that perpetuate inequities. States have considered strategies for advancing health equity through legislation, including (1) enhancing data collection and analysis of several factors such as race, ethnicity, sexual orientation, and gender identity, (2) establishing health equity zones, and (3) allocating resources to support offices of health equity. Some recent examples include:

- [Colorado HB 22-1157 \(enacted in 2022\)](#): Requires the Department of Public Health and Environment to collect race, ethnicity, disability, sexual orientation, and gender identity data as practicable, in accordance with other state and federal laws.
- [Maryland HB 463 \(enacted in 2021\)](#): Creates a “Pathways to Health Equity Program” as part of the Community Health Resources Commission, which will provide two-year grants for projects that reduce health disparities and improve health outcomes. The commission is required to give special consideration to projects in areas previously designated as Health Enterprise Zones under the 2012 Maryland Health Improvement and Disparities Reduction Act that had been repealed in 2017.
- [Washington SB 5052 \(enacted in 2021\)](#): Authorizes the health department to designate areas as health equity zones based on relevant health data—such as hospital community health needs assessments and rates of maternal mortality and morbidity. Communities in the health equity zones are then encouraged to create an action plan and design projects to reduce health inequities, supported by state funding.

During the legislative process, some states include a structured assessment of the health equity impact of proposed legislation. These health equity assessments can be done by the health department as part of its legislative affairs efforts, the legislative services agency, the Governor’s office, or another structure. While some jurisdictions conduct health equity legislative assessments as part of the agency norms and internal policies, some states have introduced legislation to formalize health equity assessments in the legislative process.

For example, during the 2021 legislative session, at least five states (California, Massachusetts, Nevada, Oregon, and Vermont) considered bills to incorporate health equity assessments into the legislative process. Although these efforts were unsuccessful, Oregon was able to enact a law creating the Racial Justice Council to advise the Governor on issues related to racial justice and equity. Specifically, the council will assist state agencies in creating racial impact statements on programs included in the agency budget and track progress toward racial equity taken by the state legislature.



The majority of state [legislatures operate part-time](#), with some legislative sessions lasting only 35 legislative (working) days. Four states (Montana, Nevada, North Dakota, and Texas) only [convene legislative sessions every other year](#).



Many legislatures establish limits on how many days bills can be considered. Some states establish a crossover deadline, meaning that if a bill does not pass the chamber it originates in by that date the legislation dies. Additionally, in many states if a bill does not pass by the time the legislative session ends the bill dies.

Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the United States Constitution
- **Timeline:** Several months to two years

The U.S. Congress is the federal legislative body comprised of two chambers: the House of Representatives and the Senate. The House of Representatives has [435 voting members](#) representing the 50 states and six [non-voting members](#) representing the U.S. Territories (American Samoa, Guam, the Commonwealth of the Northern Mariana Islands (CNMI), Puerto Rico, and the U.S. Virgin Islands) and Washington D.C. The Senate has [100 voting members](#) representing the 50 states. Members of both bodies are elected by citizens of the jurisdiction they represent.

The work of both chambers usually takes the form of a bill or a resolution (joint, concurrent, or simple). As a practical matter, there is little difference between a congressional bill and a joint resolution. Both forms must pass each chamber and then be signed by the President of the United States to become law. In both cases, a legislator in one chamber will develop the idea for a new law and introduce that bill or joint resolution to the chamber. Once introduced, the legislation is referred to a committee for public hearings, debate, and mark up (process of amending the proposal). If the committee approves the legislation, it will report the legislation to the chamber as a whole for a vote. Bills and joint resolutions approved by a majority of one chamber are then submitted to the second chamber for consideration. If the second chamber made alterations to the original bill before passing it, the bill goes to a conference committee between the chambers to reconcile the two versions. The final reconciliation bill is then presented to the President to sign into law. If the President does not sign it (veto) the bill goes back to Congress, which can override a Presidential veto by a two-thirds majority vote in both chambers.

The U.S. Congress also considers concurrent resolutions and simple resolutions, which are not legislation with force of law. A concurrent resolution typically addresses a matter related to the operation of the two houses, is adopted by both chambers, and is used to express “[facts, principles, opinions, and purposes of the two Houses](#).” A simple resolution is limited to one of the houses (H.Res for House of Representatives or S. Res for the Senate) and governs the rules or operations of the chamber or expresses an opinion of that chamber.

Considerations for Health Equity

Under the U.S. Constitution, the federal government is granted specific powers and areas where it can act, reserving substantial powers to the states. Two common powers exercised by the U.S. Congress are the “power of the purse” (authority to levy taxes and appropriate funds) and its power to regulate interstate commerce (commercial activity across state lines). As such, federal legislation to address health equity often designates resources to study or address a particular issue.

In recent years, Congress has considered bills directly related to addressing health equity. For example, [H.R. 666, the Anti-Racism in Public Health Act of 2021](#) was introduced in early 2021, which would create a National Center on Anti-racism and Health within CDC. The proposed center would collect and analyze data related to the impact of racism on health and well-being of Americans as well as the intersectionality of race with gender identity, sexual orientation, disability status, and age.

Under current Senate Rules, individual Senators—or a minority group of Senators—who oppose a bill or bill amendment can delay floor action through [extended debate \(filibuster\), amendments, motions, roll call votes, or other devices](#). The only formal procedure for breaking a Senate filibuster is to invoke cloture (i.e., closing debate), which, by rule, requires a minimum of 60 Senator votes.

Non-voting members of the House of Representatives may serve on committees, speak from the Floor, introduce bills, and offer amendments. However, they are not able to vote on final passage of legislation or during business conducted as the Committee of the Whole.

Under the U.S. Constitution, Article 1, Section 7, all bills which raise revenue (e.g., levy taxes) must originate from the House of Representatives. By tradition, all [appropriations bills](#) (bills that designate funding for federal policies and programs) also originate from the House of Representatives.



Executive Orders

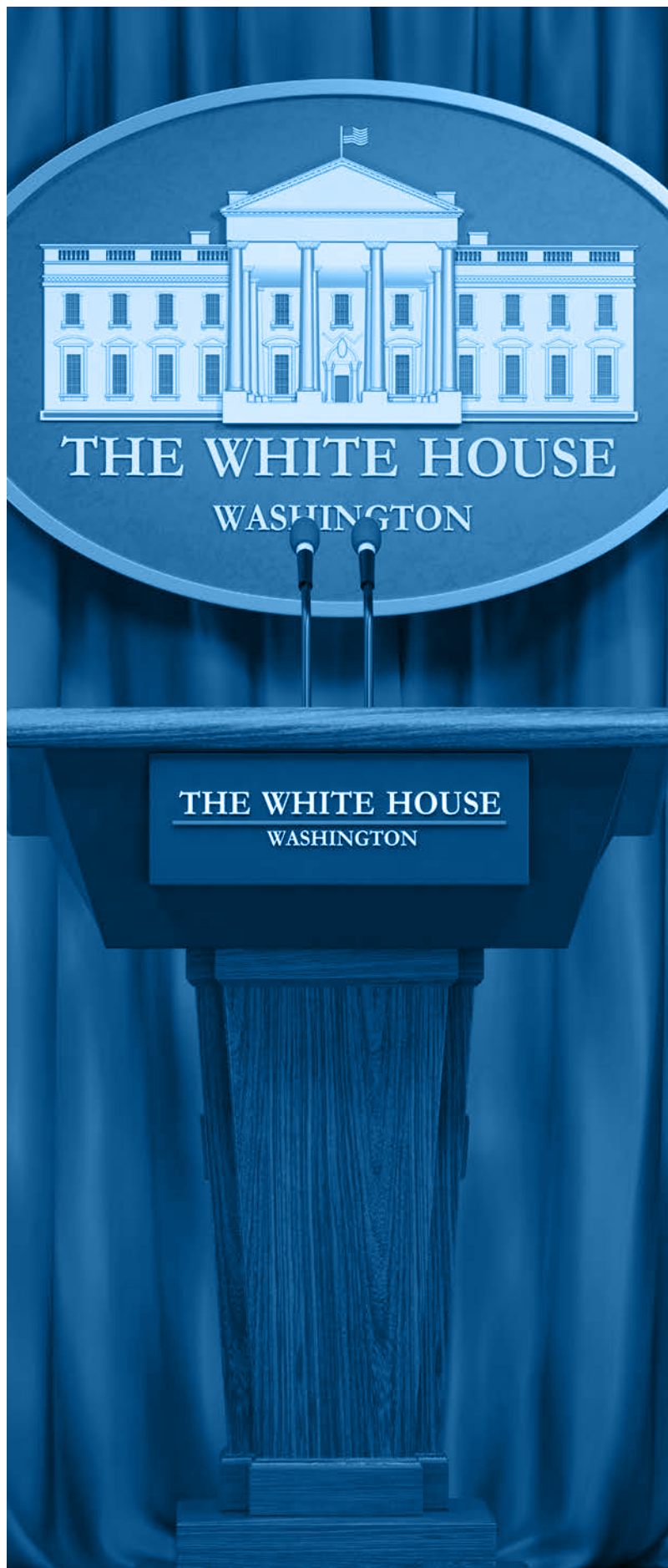
State and Territorial

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the state/territorial constitution
- **Timeline:** Immediate to several months

States and territories have their own legal framework for the power of their executive, which [may be set out through their individual constitutions, statutes or case or common law](#). However, state and territorial executives generally have their own powers to issue orders or other directives to shape policy. These powers may also be, like the power of the President, [implied, or subject to further review by the legislative branch](#). For example, state constitutions may note that the power of the executive [is vested in the governor](#) and require that the governor take care that the laws of the state [are faithfully executed](#).

These broad constitutional powers are sometimes cited as the authority for executive orders issued by governors. Aside from executive orders, state executives may [take additional actions](#) with respect to the executive branch generally. Together, these powers might allow a governor to create a [council](#) or [task force](#), or [direct executive agencies](#) to work in furtherance of a policy goal.

State executive authority is also limited by the other branches of government. For example, states may have laws that [limit the power](#) of the executive to issue orders on certain topics, or require [legislative approval](#) of certain actions. State courts may also weigh in on the scope of the governor's executive power.



Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the United States Constitution and federal laws
- **Timeline:** Immediate to several months

The executive branch also has power to take actions, such as executive orders and other initiatives, that incorporate health equity principles at both the state and federal levels.

Federal Authorities

The POTUS is the head of the Executive Branch and has powers granted by both the Constitution and Congress. While the Constitution does not mention executive orders specifically, it is generally acknowledged that the POTUS has the authority to issue these and other directives to achieve policy goals. Executive orders generally have the force and effect of law, but still are limited in many ways.

First, the executive action or order must be grounded in a power delegated by Congress or provided for in the Constitution. Generally, orders affecting domestic issues, like public health, are derived from either the inherent powers of the Executive Branch or authorities granted by Congress in statute. For example, during the COVID-19 pandemic, the POTUS referenced the powers contained in the Defense Production Act and the Public Health Services Act to [issue an executive order](#) aimed at supporting the public health supply chain. Conversely, the President [issued another executive order](#) on advancing racial equity citing his general powers under the constitution and the laws of the United States more generally.

The POTUS does not have the final say with respect to the scope of this executive power. The courts are often asked to opine on the validity of an executive order and may determine that it exceeds the POTUS authority. [Past court precedents](#) may also limit the reach of the executive. Congress may act to limit the reach of an executive order, either through [its action or inaction \(e.g., passing a specific law or limiting funding\)](#).

Finally, executive orders are time limited as presidents [are free to modify or revoke](#) their own orders or those of a past president. The beginning of each new presidential administration often results in both new and rescinded executive orders, which are generally published in the [federal register](#). The process for their preparation is also codified in [federal regulation](#).

Considerations for Health Equity

Although executive orders can be adopted quickly, they lack permanence. As a consideration, an [executive order](#) can be repealed during transitions of leaders at state and federal levels. At the federal level during the COVID-19 pandemic POTUS issued an executive order on ensuring an equitable pandemic response and recovery. At its highest levels Presidential executive orders can provide guidance and show importance on addressing health equity. An example of a state [executive order](#) is one issued by Michigan's Governor in 2020 (No. 2020-9) addressing racism as a public health crisis.

Constitutions

State and Territorial

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the state/territorial constitution
- **Timeline:** Months to years

A state constitution is the statement of basic principles and highest laws of a state. Every state constitution reflects the diverse elements of its constituency, representing its people, traditions, and political cultures. It is the document in which the citizens of the state set forth their basic rights, and the structure and operation of their government. Some states have had multiple constitutions and methods of amendment.

Federal

- **Authority/Influence:** S/THO Influence
- **Process:** Outlined in the United States Constitution
- **Timeline:** Years

Written in 1787, ratified in 1788, and in operation since every second year by 1789, the United States Constitution is the world's longest surviving written charter of government. The Constitution assigned to Congress responsibility for organizing the executive and judicial branches, raising revenue, declaring war, and making all laws necessary for executing these powers. The president is permitted to veto specific legislative acts, but Congress has the authority to override presidential vetoes by two-thirds majorities of both houses. The Constitution also provides that the Senate advise and consent on key executive and judicial appointments and on the approval for ratification of treaties. To amend the U.S. Constitution, proposed changes can be submitted by either the Congress, through a joint resolution passed by a two-thirds vote, or by a convention called by Congress in response to applications from two-thirds of the state legislatures.



Considerations for Territories and Washington D.C.

The federal government has a [unique relationship](#) with six jurisdictions—Washington D.C., five territories (American Samoa, the Commonwealth of the Northern Mariana Islands (CNMI), Guam, Puerto Rico, and the U.S. Virgin Islands). The specific relationship each jurisdiction has with the federal government determines whether the residents of the jurisdiction are U.S. Citizens and whether the U.S. Constitution applies in whole or in select parts to the residents. People born in Washington D.C., Puerto Rico, Guam, USVI, and CNMI [are considered U.S. citizens](#), while people born in American Samoa are non-citizen nationals. None of these jurisdictions have voting members of Congress.

These jurisdictions operate similarly to states, with three branches of government, with most outlining their organization of government in a constitution. While most territories have their own constitution, the Territory of Guam operates under the Guam Organic Act of 1950 and other federal statutes. The Constitution of CNMI was drafted by thirty-nine elected delegates meeting in a constitutional convention on Saipan in 1976. The Constitution of the Territory of American Samoa was signed by 68 members of the 1960 constitutional convention and was approved by United States Secretary of the Interior. Additionally, Washington D.C.'s form of government is established by federal law in the [Home Rule Act](#).

Each of these jurisdictions has a legislature, three of which are bicameral (Puerto Rico, CNMI, and American Samoa) and three of which are unicameral (Washington D.C., Guam, and USVI). In most territories, the scope of powers granted to the legislature are limited and subject to parameters established by the U.S. Congress.

Additionally, many residents residing in territories are not eligible for some federal programs or do not qualify for the same level of support as states receive. Medicaid is a significant example of this disparity, with territories receiving lower funding than states due to a statutorily [lower Federal Medical Assistance Percentage \(FMAP\) rate](#) of 55% and an annual cap of federal funding while the states rate is based on per capita income without an annual cap. While the federal government has provided a patchwork of temporary solutions to this disparity—including [an extension](#) of a 76% FMAP rate for Puerto Rico and 83% for the other territories until December 16, 2022—[a sustainable funding solution is still needed](#).



In a series of decisions known as the [Insular Cases](#), the United States Supreme Court defined certain territories as “incorporated” and “unincorporated.” Under this determination, “unincorporated territories”—defined as territories not clearly on a path to statehood—are not entitled to full protections and rights under the U.S. Constitution.

Considerations for Freely Associated States

The three Freely Associated States—Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI), and the Republic of Palau (RP)—are [sovereign nations](#) that have entered into a compact with the federal government. Each of these countries has their own system of government. The federal government provides these nations financial assistance under the [Compacts of Free Association](#).



Considerations for Tribal Nations

The federal government has a complex relationship with tribal nations. The U.S. Supreme Court has acknowledged tribal governments as the [oldest form of government](#) on the continent, with tribal nations operating as sovereign jurisdictions. The federal government has a special obligation to protect tribal lands and resources. Generally, members of tribal nations are U.S. Citizens who are registered with a [federally recognized or state recognized tribe](#).



The relationship between federal and state governments and tribes is unique to each tribe. To help public health professionals navigate this relationship the Network for Public Health Law has created this [resource](#).

Policy Development Process

In investigating inequities, teams are encouraged to “start with asking why” an inequity exists before determining which policy lever, or series of levers, are needed to advance a policy goal. To guide this development, state/territorial policy teams should follow the general policy development process. While there are several models describing the policy development process, ASTHO’s Policy Academy uses the [CDC policy development process](#) as a guide.

Using the example from CDC, steps in the policy process include:

1. Problem Identification
2. Policy Analysis
3. Strategy and Policy Development
4. Policy Enactment
5. Policy Implementation
6. Interested Party Engagement and Education
7. Evaluation

This section includes an overview of each step of the policy development process as well as resources to help teams complete each step of the process.

Problem Identification

Clearly identify the problem or issue you are trying to address, synthesizing existing data and frame an issue in a way that lends itself to a policy solution. Tools for problem identification:

- **Root Cause Analysis (RCA)** is the analysis of systems, processes, and outcomes that require change to reduce the risk of harm. There are several ways to conduct RCA, including the “[5 Whys](#)” and [fishbone diagramming](#).
- **Knot Chart** - This is tool to help classify data collected during the problem identification process. This chart categorizes information into:
 - » **Know:** Available and credible data
 - » **Need to Know:** Required data, but unavailable
 - » **Opinion:** Possibly credible, but need more information to support opinion
 - » **Think We Know:** Possibly credible but need to verify data.
- **Behavior Over Time Graph** - [A behavior-over-time graph](#) shows a pattern of change over time.

Policy Analysis

Once the problem is identified, the next step is to identify potential policy solutions. These solutions can span the various policy levers described in the previous section. After several potential solutions are identified, the group assessing options should determine what criteria are necessary for the final policy solution. Based on those criteria, the team should prioritize which policy option is best to address the problem identified for that jurisdiction. There are several tools available to analyze policy options with an equity lens, a few include:

- [Washington State Health Care Authority Health Equity Toolkit](#).
- [Transdisciplinary Collaborative Center for Health Disparities Research and Morehouse College Resource](#).

Strategy and Policy Development

Once a policy option has been selected, the team should plan to gain support for the policy proposal to be adopted. This includes determining the route for adopting the policy, drafting the proposal, engaging with interested parties on the proposal, garnering support and anticipating roadblocks in making the policy change.

Policy Enactment

Following the strategy identified, including following the appropriate procedures for what type of policy is selected (e.g., agency rulemaking, legislation) the policy team should continue to engage with decision-makers and interested parties to formally adopt the proposed policy change. This is also an opportunity to request resources (e.g., personnel, fiscal) that will be needed to implement the policy. Communication approaches may vary depending on the audience and the political environment. The Network for Public Health Law's [Becoming Better Messengers](#) workshop provides resources on how to improve communication with decision makers by using [Moral Foundations Theory](#).

Another consideration for policy enactment is identifying sufficient funding for the policy, with many programs working to braid and layer funding to achieve a policy goal. Some examples of this can be found here:

- [Braiding and Layering Funding to Address Housing: Overview and Executive Summary](#)
- [Braiding and Layering Funding to Address Food Insecurity: Proximity to Food Retailers Braiding and Layering Funding for Adverse Childhood Experiences Prevention](#)
- [Braiding and Layering Funding for Adverse Childhood Experiences Prevention](#)

Policy Implementation

The policy development plan developed during the strategy phase should outline the implementation approach once the policy is enacted. This includes identifying who will implement the policy, who will enforce the policy, and how will implementation be monitored and evaluated. This resource from ChangeLabSolutions discusses [policy enforcement considerations](#) to achieve health equity.

Interested Party Engagement and Education

Interested parties—the people, communities, organizations, and others that may be impacted positively or negatively from a proposed policy—are crucial to the policy development process. Throughout the process, the team considering a policy change should assess who the interested parties are and ensure that they are authentically engaged with during each phase.

- Strategies from [Boundary Spanning Leadership](#), which provides tools to help facilitate stronger connections among and between groups, can be very effective in interested party engagement.
- Interested Party Outreach Guide: [Inclusive Outreach and Public Engagement Guide \(seattle.gov\)](#)
- [National Academy of Medicine: Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health](#)
- [The Spectrum of Community Engagement to Ownership](#)
- [Human Impact Partners: Resources for Collaboration and Power Sharing Between Government Agencies and Community Power-Building Organizations](#)

Evaluation

Throughout the development process, the planning team should consider and define evaluation needs, purpose, and intended use and users. There should both be an evaluation of the implementation of a policy (e.g., was it implemented as intended) and the effect of the policy (did the policy achieve its intended goal).

- [Defining Legal Epidemiology](#)



Additional Resources

In addition to this toolkit, there are other toolkits available to support different facets of health equity policy development. Below are a few of these resources, but is not an exhaustive list:

- [Rural Health Equity Toolkit](#)
- [Contracting for Equity](#)
- [Community Engagement Assessment Tool](#)
- [Health Equity Assessment](#)
- [Human Impact Partners](#)



HEALTH EQUITY POLICY TOOLKIT

A Movement for Justice

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