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What is Health and Health Equity?

Health

The World Health Organization defines health as "…a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] The drivers of health are multi-dimensional and inter-related. Health outcomes are impacted by many factors; clinical care is an important driver of health but overall has less impact on overall health compared to health behaviors, socioeconomic factors, and the physical environment.

For decades, public health scholars have focused on the importance of community conditions as drivers of health. In the wake of the COVID-19 pandemic, health care systems have increasingly engaged in discussions about the role of the health system to influence drivers of health outside the delivery of health care services.

Improving health care service delivery is necessary but not sufficient to improve health outcomes. As a society we must also improve the policies, regulations, payment models and socio-economic-behavioral and environmental factors that impact our health.

Health Equity

Health equity means everyone has the opportunity to be as healthy as possible. Improving health equity requires an understanding of the root causes of disparities including poverty, discrimination, education, structural racism, political determinants, and more. Without changing the conditions that lead to health inequities, we cannot make sustainable improvements. Tackling these conditions will take collective action, bringing together partners who do not often work together and challenging the way we do work.

[1] https://www.who.int/about/governance/constitution

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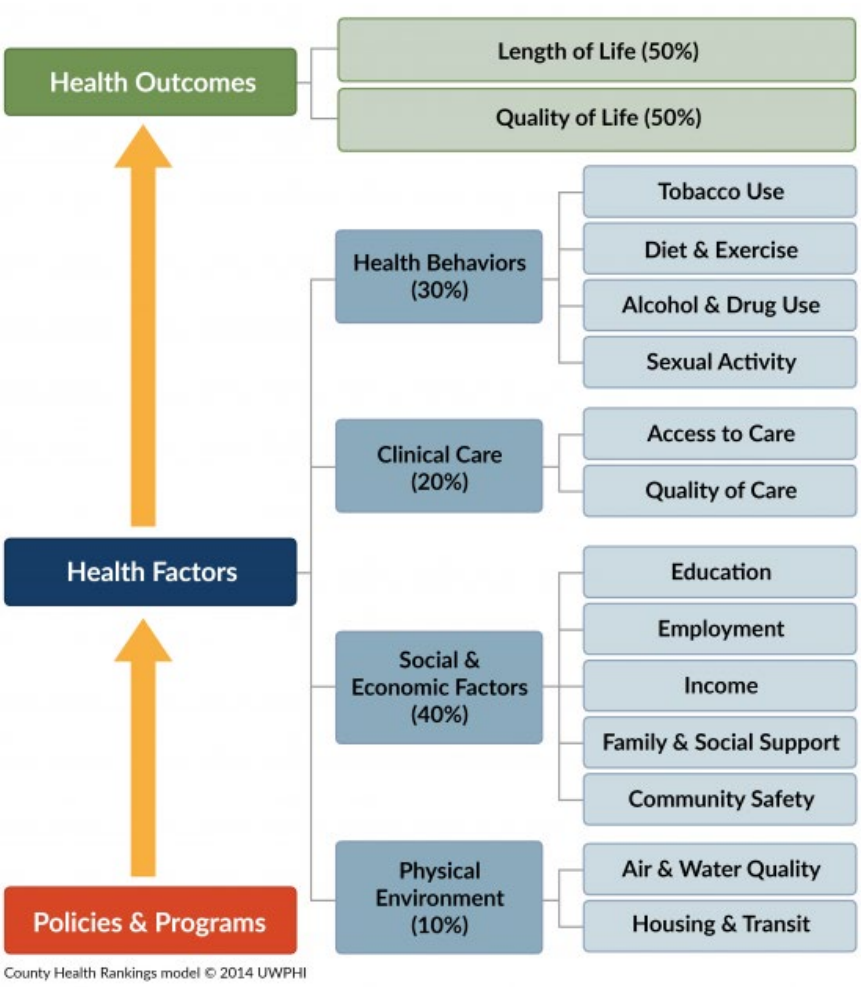
County Health Rankings model for Health Factors and Health Outcomes[2]



What is Rural Health Equity?

Rural Northern New England

Vermont, Maine, and New Hampshire are predominantly rural states with large percentages of land mass designated as rural and a large percent of the

[2] https://www.countyhealthrankings.org/health-data/methodology-and-sources/methods

population living in rural areas. There are numerous ways to define rural and federal agencies use different definitions. The US Census defines the rural populations as people who do not live within urban areas.

Rural is not a monolithic description of place or people. For example, rural in Alaska is different that rural in Vermont, with health barriers and facilitators that differ between those geographies.[3] However, scholars agree that rural populations share common characteristics[4][5]:

- Rural populations are older, sicker, and die younger.
- Rural populations are poorer, less educated, and less likely to be employed.
- Rural populations have higher rates of chronic disease and risk factors for chronic diseases.
- Rural populations have more challenges accessing health care services.

Rural Health Equity

Large—and increasing—disparities exist between populations living in rural and urban areas. In the US, approximately 14% of the total population lives in rural areas. However, according to the Rural Urban Community Area categories, in 47% of the population in Northern New England (VT, ME, and NH) lives in a rural area.[6] Rural populations have worse health outcomes on most health indicators. The disparities in life expectancy between rural urban populations in the US has tripled from 1999 through 2019. Crude mortality rates have increased for the working-age population in rural areas and, within rural populations, age-adjusted, all-cause mortality rates are highest in the Black population.[7]

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[3] https://www.commonwealthfund.org/publications/2017/mar/focus-reimagining-rural-health-care
[4] https://www.ruralhealthinfo.org/

[5] https://www.cdc.gov/rural-health/php/index.html

[6] https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/
[7] Thomas, K. L., Dobis, E. A., & McGranahan, D. (2024). The nature of the rural-urban mortality gap (Report No. EIB-265). U.S. Department of Agriculture, Economic Research Service. https://dx.doi.org/10.32747/2024.8321813.ers

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Finding solutions to rural health inequities requires multiple experts coming together, especially rural community members who have experienced—and discovered solutions to—local barriers. In 2022, the Center for Advancing Rural Health Equity (CARHE) was created at Dartmouth Health. Acknowledging the need to bring the knowledge and skills of many people together, CARHE supports collaborative learning and skill building so community members, researchers, educators, and clinicians may work together to make changes in our rural communities to help make everyone healthy as possible. Visit the CARHE website to learn about opportunities to get involved (https://www.dartmouth-health.org/carhe).

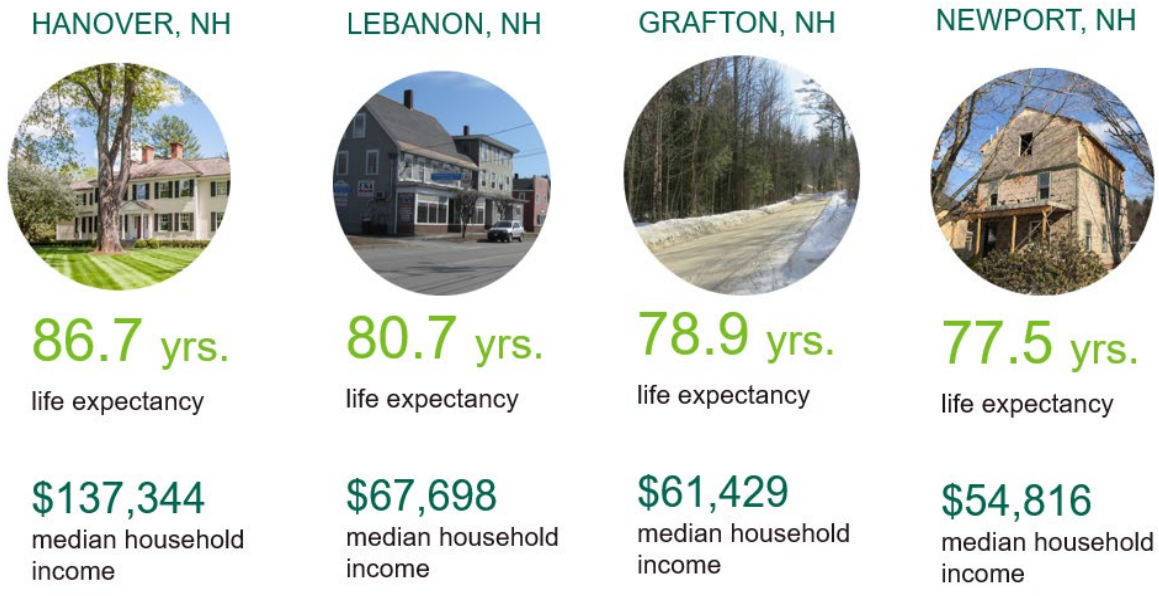
Additional Resources for Understanding Rural Health Equity

- The Nature of the Rural-Urban Mortality Gap: https://www.ers.usda.gov/publications/pub-details/?pubid=108701
- The Commonwealth Fund: In Focus: Reimagining Rural Health Care: https://www.commonwealthfund.org/publications/2017/mar/focus-reimagining-rural-health-care
- Rural-Urban Community Area Codes: https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/
- Rural Health Equity course materials available on the Dartmouth Health ECHO site: https://www.dartmouth-hitchcock.org/project-echo/enduring-echo-materials
- Advancing Health Equity in Rural America from the UC San Francisco: https://healthequity.ucsf.edu/publications#Advancing-Health-Equity-in-Rural-America--Report--Published-June-2022
- Achieving Rural Health Equity and Well-Being: Proceedings of a Workshop: https://pubmed.ncbi.nlm.nih.gov/30307731/
- Rural Health Community Toolkit from the Rural Health Information Hub: https://www.ruralhealthinfo.org/toolkits/rural-toolkit

- Rural Health Disparities from the Rural Health Information Hub:
  https://www.ruralhealthinfo.org/topics/rural-health-disparities

Disparities within Rural Communities

Not all rural areas are the same. Rural Montana looks different than rural Maine and there are important differences within areas that are designated as rural. In our New England geography, we see striking differences in health outcomes across relatively short distances, reflecting the complex relationships between socioeconomic, health behaviors, environmental, and access to health care services that intersect to impact health outcomes. Differences between New England communities impact the success—or failures—of interventions intended to decrease disparities and the ability to disseminate strategies across the region.



Sources: NH Wisdom (life expectancy 2016-20); D-H, NLH, MAHHC 2021-22 CHNAs (household income)

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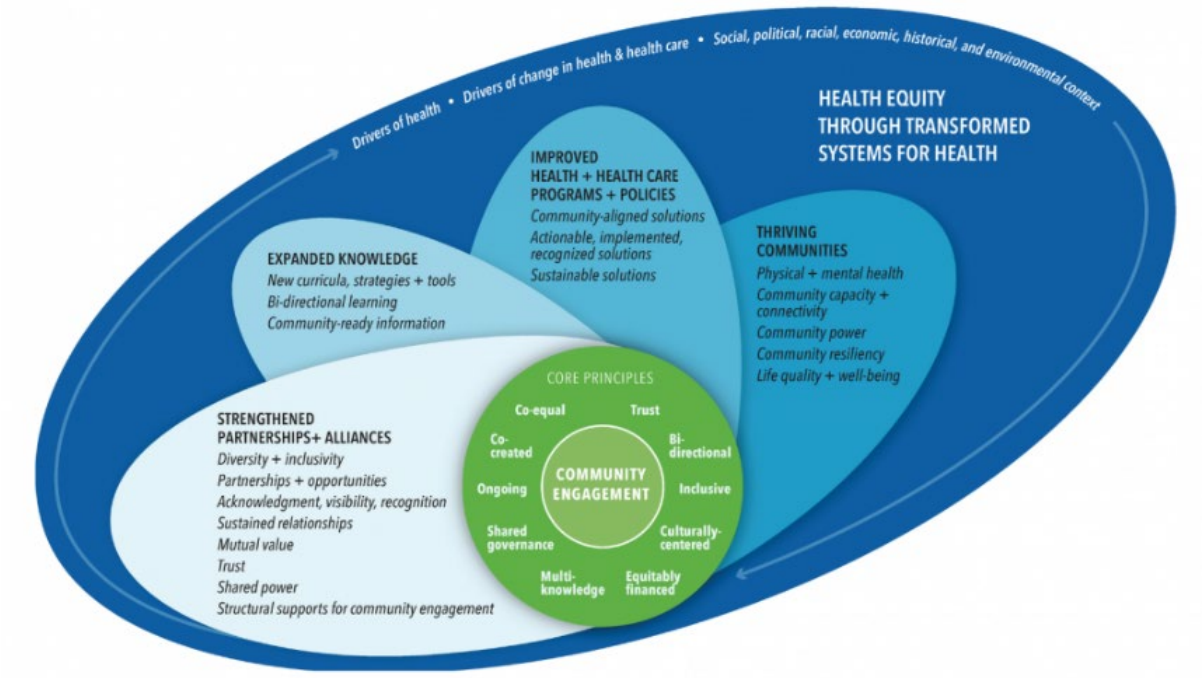
Models for Improving Health Equity

Models for health equity provide a theoretical foundation for understanding and addressing complex interactions that impact health outcomes and equity. These models help clarify, describe, and organize ideas about achieving health equity, guiding the development and implementation of programs and policies that reduce health disparities.

Improving health equity will require meaningful community engagement. Two models are presented here to illustrate how meaningful community engagement across sectors can inform efforts to improve health equity.

A Dynamic Relationship: Achieving Health Equity and Systems Transformation through Meaningful Community Engagement[8]



[8] Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. 2022. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health. NAM Perspectives. Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202202c.

The Assessing Community Engagement Conceptual Model centers community engagement and core engagement principles and identifies outcomes associated with meaningful community engagement that can form the basis for assessment or measurement efforts across various stages, models, processes, and partnerships of engagement.

Social Determinants and Social Needs: Moving Beyond Midstream[9]

A simple model using a stream as a metaphor for change, reinforces the need to work at various levels in the system and to align health equity work from downstream (e.g., clinic, hospital) to the community and then continue upstream to work on policies, payment models, regulations, and laws in order to change the

[9] "Meeting Individual Social Needs Falls Short Of Addressing Social Determinants Of Health", Health Affairs Blog, January 16, 2019. DOI: 10.1377/hblog20190115.234942

conditions that impact health. This simple, yet eloquent, model is an effective communication tool, helping people see where their work is focused in the larger health ecosystem and to purposefully think about what other interventions are needed 'along the stream' to transform the system.

Talking about Health Equity: Language and Mindsets

We know that words matter. How you talk about ideas shapes the way people think about the problems and solutions. Many of the terms used in work focused on improving health outcomes have multiple definitions or evoke a particular mindset. As an example, someone may think that *improving health* means improving health care services. We know that an individual's health is the result of complex interactions between socioeconomic factors, physical environment, genetics, health behaviors, and health care services. Improving health often requires improvement across multiple factors that impact health.

How you present ideas can impact the way people take action. What you emphasize, the connections you make, the words you use will impact how people make sense of the problem and the action they may choose to take.

Shifting Mindsets about Health Equity	
Framing to avoid	**Framing to use**
Blaming a person/people *Example: If pregnant women quit smoking, we could prevent 800 infant deaths.*	Attribute responsibility to system, policies, ideology *Example: Researchers estimate we could save 800 babies lives if we could connect families to tobacco treatment.*
Leading the communication with the problem (presenting numbers, definitions) *Example: Even before COVID19, there were rising rates of chronic diseases and deaths of despair.*	Begin communications with the aspiration *Example: Addressing unfair policies will lead to a just and fair society. Even before COVID19, there were*

	differences in rates of diseases between different neighborhoods.
Crisis messaging and failing to identify solutions *Example: Tobacco related diseases kill many people.*	Be clear that solutions exist and are within our reach *Example: We can effectively decrease tobacco-related diseases by making all workplaces smoke-free.*
Focusing on **who** experiences disparities *Example: Poor black people have worse health outcomes.*	Explain the **how** disparities arose. Provide explanations about causal relationships. *Example: Poverty and discrimination increase stress which increases catecholamine release leading to higher rates of cardiovascular disease. Unjust and unfair policies contribute to generational poverty and chronic stress. These policies explain how some neighborhoods have worse health outcomes compared to others.*
Adapted from Webinar on Framing Health Equity June 30, 2021 https://dialogue4health.org/web-forums/framing-health-equity-communication-strategies-that-work	

The following resources are presented with the goal of increasing our ability to communicate clearly and frame complex issues so others can understand the problems and help create solutions:

- Framing Health Equity. Communication Strategies that Work. When you are communicating, it is important for you to understand your audience's mindsets. https://www.frameworksinstitute.org/presentation/framing-health-equity-communication-strategies-that-work/

- Webinar on Framing Health Equity June 30, 2021 https://dialogue4health.org/web-forums/framing-health-equity-communication-strategies-that-work
- Advancing Health Equity: A Guide to Language, Narrative and Concepts: https://www.ama-assn.org/about/ama-center-health-equity/advancing-health-equity-guide-language-narrative-and-concepts-0