SCIOTO COUNTY Health DEPARTMENT
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POLICY AND PROCEDURE	
SUBJECT/TITLE:	**Public Health Code of Ethics**
APPLICABILITY:	All employees
ORIGINALLY PREPARED BY:	Tracey Maloney
REVISION PREPARED BY:	Melissa Spears, REHS
EFFECTIVE DATE:	3/6/2020
HEALTH COMMISSIONER	Michael E. Martin, MD
REVIEW FREQUENCY:	5 years
BOARD APPROVAL REVISION DATE:	5/13/ 2022
REFERENCE NUMBER:	G - 2

The Public Health Code of Ethics

This code of ethics states key principles of the ethical practice of public health. An accompanying statement lists the key values and beliefs inherent to a public health perspective upon which the Ethical Principles are based. Public health is understood within these principles as what we, as a society, do collectively to assure the conditions for people to be healthy. We affirm the World Health Organization's understanding of health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity.

The Code is neither a new nor an exhaustive system of health ethics. Rather, it highlights the ethical principles that follow from the distinctive characteristics of public health. A key belief worth highlighting, and which underlies several of the Ethical Principles, is the interdependence of people. This interdependence is the essence of community. Public health not only seeks to assure the health of whole communities but also recognizes that the health of individuals is tied to their life in the community.

The Code is intended principally for public and other institutions in the United States that have an explicit public health mission. Institutions and individuals that are outside of traditional public health, but recognize the effects of their work on the health of the community, may also find the Code relevant and useful.

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Principles of the Ethical Practice of Public Health

1. Public health should address principally the fundamental causes of disease and requirements for health, aiming to prevent adverse health outcomes.

2. Public health should achieve community health in a way that respects the rights of individuals in the community.

3. Public health policies, programs, and priorities should be developed and evaluated through processes that ensure an opportunity for input from community members.

4. Public health should advocate and work for the empowerment of disenfranchised community members, aiming to ensure that the basic resources and conditions necessary for health are accessible to all.

5. Public health should seek the information needed to implement effective policies and programs that protect and promote health.

6. Public health institutions should provide communities with the information they have that is needed for decisions on policies or programs and should obtain the community's consent for their implementation.

7. Public health institutions should act in a timely manner on the information they have within the resources and the mandate given to them by the public.

8. Public health programs and policies should incorporate a variety of approaches that anticipate and respect diverse values, beliefs, and cultures in the community.

9. Public health programs and policies should be implemented in a manner that most enhances the physical and social environment.

10. Public health institutions should protect the confidentiality of information that can bring harm to an individual or community if made public. Exceptions must be justified on the basis of the high likelihood of significant harm to the individual or others.
11. Public health institutions should ensure the professional competence of their employees.

12. Public health institutions and their employees should engage in collaborations and affiliations in ways that build the public's trust and the institution's effectiveness.

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Values and Beliefs Underlying the Code

Health

1. *Humans have a right to the resources necessary for health.* The Public Health Code of Ethics affirms Article 25 of the Universal Declaration of Human Rights, which states in part "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family..."

Community

2. *Humans are inherently social and interdependent.* Humans look to each other for companionship in friendships, families, and community; and rely upon one another for safety and survival. Positive relationships among individuals and positive collaborations among institutions are signs of a healthy community. The rightful concern for the physical individuality of humans and one's right to make decisions for oneself must be balanced against the fact that each person's actions affect other people.

3. *The effectiveness of institutions depends heavily on the public's trust.* Factors that contribute to trust in an institution include the following actions on the part of the institution: communication; truth telling; transparency (i.e., not concealing information); accountability; reliability; and reciprocity. One critical form of reciprocity and communication is listening to as well as speaking with the community.

4. *Collaboration is a key element to public health.* The public health infrastructure of a society is composed of a wide variety of agencies and professional disciplines. To be effective, they must work together well. Moreover, new collaborations will be needed to rise to new public health challenges.

5. *People and their physical environment are interdependent.* People depend upon the resources of their natural and constructed environments for life itself. A damaged or unbalanced natural environment, and a constructed environment of poor design or in poor condition, will have an adverse effect on the health of people. Conversely, people can have a profound effect on their natural environment through consumption of resources and generation of waste.

6. *Each person in a community should have an opportunity to contribute to public discourse.* Contributions to discourse may occur through a direct or a representative system of government. In the process of developing and evaluating policy, it is important to discern whether all who would like to contribute to the discussion have an opportunity to do so, even though expressing a concern does not mean that it will necessarily be addressed in the final policy.

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7. *Identifying and promoting the fundamental requirements for health in a community are of primary concern to public health.* The way in which a society is structured is reflected in the health of a community. The primary concern of public health is with these underlying structural aspects. While some important public health programs are curative in nature, the field as a whole must never lose sight of underlying causes and prevention. Because fundamental social structures affect many aspects of health, addressing the fundamental causes rather than more proximal causes is more truly preventive.

Bases for Action

8. *Knowledge is important and powerful.* We are to seek to improve our understanding of health and the means of protecting it through research and the accumulation of knowledge. Once obtained, there is a moral obligation in some instances to share what is known. For example, active and informed participation in policy-making processes requires access to relevant information. In other instances, such as information provided in confidence, there is an obligation to protect information.

9. *Science is the basis for much of our public health knowledge.* The scientific method provides a relatively objective means of identifying the factors necessary for health in a population, and for evaluating policies and programs to protect and promote health. The full range of scientific tools, including both quantitative and qualitative methods, and collaboration among the sciences is needed.

10. *People are responsible to act on the basis of what they know.* Knowledge is not morally neutral and often demands action. Moreover, information is not to be gathered for idle interest. Public health should seek to translate available information into timely action. Often, the action required is research to fill in the gaps of what we don't know.

11. *Action is not based on information alone.* In many instances, action is required in the absence of all the information one would like. In other instances, policies are demanded by the fundamental value and dignity of each human being, even if implementing them is not calculated to be optimally efficient or cost-beneficial. In both of these situations, values inform the application of information or the action in the absence of information.

Notes on the Individual Ethical Principles

1. This Principle gives priority not only to prevention of disease or promotion of health, but also at the most fundamental levels. Yet the principle acknowledges that public health will also concern itself with some immediate causes and some curative roles. For example, the treatment of curable infections is important to the prevention of transmission of infection to others. The term "public health" is used here and elsewhere

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in the Code to represent the entire field of public health, including but not limited to government institutions and schools of public health.

2. This Principle identifies the common need in public health to weigh the concerns of both the individual and the community. There is no ethical principle that can provide a solution to this perennial tension in public health. We can highlight, however, that the interest of the community is part of the equation, and for public health it is the starting place in the equation; it is the primary interest of public health. Still, there remains the need to pay attention to the rights of individuals when exercising the police powers of public health.

3. A process for input can be direct or representative. In either case, it involves processes that work to establish a consensus. While democratic processes can be cumbersome, once a policy is established, public health institutions have the mandate to respond quickly to urgent situations. Input from the community should not end once a policy or program is implemented. There remains a need for the community to evaluate whether the institution is implementing the program as planned and whether it is having the intended effect. The ability for the public to provide this input and sense that it is being heard is critical in the development and maintenance of public trust in the institution.

4. This Principle speaks to two issues: ensuring that all in a community have a voice; and underscoring that public health has a particular interest in those members of a community that are underserved or marginalized. While a society cannot provide resources for health at a level enjoyed by the wealthy, it can ensure a decent minimum standard of resources.

The Code cannot prescribe action when it comes to ensuring the health of those who are marginalized because of illegal behaviors. It can only underscore the principle of ensuring the resources necessary for health to all. Each institution must decide for itself what risks it will take to achieve that.

5. This Principle is a mandate to seek information to inform actions.

6. This Principle is linked to the third one about democratic processes. Such processes depend upon an informed community. The information obtained by public health institutions is to be considered public property and made available to the public. This statement is also the community-level corollary of the individual-level ethical principle of informed consent. Particularly when a program has not been duly developed with evaluation, the community should be informed of the potential risks and benefits, and implementation of the program should be premised on the consent of the community (though this principle does not specify how that consent should be obtained).

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7. Public health is active rather than passive, and information is not to be gathered for idle interest. Yet the ability to act is conditioned by available resources and opportunities, and by competing needs. Moreover, the ability to respond to urgent situations depends on having established a mandate to do so through the democratic processes of Ethical Principle number three.

8. Public health programs should have built into them a flexibility that anticipates diversity in those needs and perspectives having a significant impact on the effectiveness of the program. Types of diversity, such as culture and gender, were intentionally not mentioned. Any list would be arbitrary and inadequate.

9. This Principle stems from the assumptions of interdependence among people, and between people and their physical environment. It is like the ethical principle from medicine, "do no harm," but it is worded in a positive way.

10. This statement begs the question of which information needs to be protected and what the criteria are for making the information public. The aims of this statement are modest: to state explicitly the responsibility inherent to the "possession" of information. It is the complement to Ethical Principles 6 and 7, about acting on and sharing information.

11. The criteria for professional competence would have to be specified by individual professions, such as epidemiology and health education.

12. This statement underscores the collaborative nature of public health while also stating in a positive way the need to avoid any conflicts of interest that would undermine the trust of the public or the effectiveness of a program.

Represented on the Public Health Leadership Society (PHLS) Public Health Code of Ethics Committee are public health professionals from local and state public health, public health academia, the Centers for Disease Control and Prevention (CDC), and the American Public Health Association (APHA).

Source: Principles of the Ethical Practice of Public Health; Public Health Leadership Society
https://www.apha.org/-/media/files/pdf/membergroups/ethics/ethics_brochure.ashx

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POLICY AND PROCEDURE	
SUBJECT/TITLE:	Health Equity Policy
Distributed to:	All Employees
HEALTH COMMISSIONER	Michael E. Martin, M.D.
ORIGINAL DATE ADOPTED:	09/13/2019
PREPAIRED BY:	Traci Maloney, Accreditation Coordinator
REVIEW FREQUENCY:	5 years
BOARD APPROVAL DATE:	N/A
REFERENCE NUMBER:	G-2

POLICY: To promote health equity through our policies, processes, programs and interventions for the benefit of our community, to minimize health inequalities and disparities.

PURPOSE:

The purpose of this policy is to provide a high-level guidance for crosscutting factors of health equity. The Scioto County Health Department (SCHD) supports health equity in our programs, policies, processes, partnerships and interventions so we can ensure that social, cultural, and linguistic characteristics of the various populations we serve are incorporated into our services. SCHD utilizes this policy to include social, racial, ethnic, cultural, Sexual orientation, gender identity, linguistic characteristics, including Non-English speaking populations and the disabled in our services, policies, Programs, and interventions to promote health equity. The purpose of this Document is to provide SCHD employees with information, strategies, Resources, and interventions pertaining to health equity that we can utilize and promote health equity in our policies, processes, programs, interventions, and material.

BACKGROUND:

Social and economic opportunities and the physical conditions of communities (social determinants of health) impact health outcomes. Many of the ongoing

disproportionate poor health outcomes occurring among specific populations relates back to the inequitable distribution of theses social and environmental resources (Stillman, L. et al.2015).

Scioto County individuals with lower education levels, lower household income, or less access to health foods have a statistically lower chance of being in good health (Adler & Newman, 2002).

The improvement of long-term health outcomes, particularly for populations experiencing the greatest inequities in health over time, requires a shift in focus to the upstream factors that are the underlying cause of ill health. Such health inequities include disparate rates of disease, disability and premature death. A shift to upstream factors provides all individuals, regardless of socioeconomic conditions, the opportunity to attain their full health potential.

Recognizing this shift, NACCHO released, in 2009, guidelines to assist local health departments in moving from an "improvisational" approach to addressing upstream factors to one that is systemic and institutionalized by infusing a health equity lens throughout the department. PHAB included a health equity standard in the Standards and Measures for local health department accreditation. The standards note that excellence in local public health practice includes health equity incorporated in policies, processes and programs. Other national benchmarking, assessment and health improvement systems also include social determinants of health and health equity factors.

KEY TERMS:

- **Equity**: the absence of avoidable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically.
- **Health equity**: when individuals or communities reach their full health potential by over coming barriers or inequities.
- **Health inequities**: differences in health that are avoidable, unfair or unjust. Health inequities are affected by ethnic, racial, social, economical, and/or environmental conditions.
- **Health disparities**: the inequalities that occur, in the provision of healthcare and access to healthcare, across differential racial, ethnic, and socioeconomic groups.
- **PHAB:** Public Health Accreditation Board
- **NACCHO**: National Association of County and City Health Officials
- **Social Determinants of Health**: conditions in which people are born, live, learn, work and play that affects a wide range of health outcomes. The social environment refers to social, economic, and cultural norms, patterns, beliefs, processes, policies and institutions that influence the life of an individual or community.
- **Health equity lens**: A systematic approach to viewing the current state for how it either addresses or perpetuates health inequities.

HEALTH EQUITY POLICY GUIDELINES

The following are the high-level guidelines for considering health equity when developing policies/procedures and programs at the SCHD.

A. Apply a health equity lens to new programs, policies, services and interventions to ensure they include public health actions to break the cycle of health equity.
B. Apply a health equity lens to current and new programs. policies, services and interventions to ensure they do not create or perpetuate health inequities.
C. Provide an opportunity for stakeholders and the community to participate in decisions regarding policies, programs, services and/or their material as appropriate.
D. Incorporate the social, cultural and linguistic characteristics of the target population into the policies, programs, services and or material.
E. Consider health equity and social determinants of health in assessments, improvement planning, surveillance and other monitoring efforts.
F. Identify opportunities to increase education on the social determinants of health for program participants.
G. Support an ongoing, all-staff professional development program that aspires to the attainment of core competencies in health equity and cultural competency.

SOURCES

Adler NE, Newman K. Socioeconomic disparities in health: pathways and policies, Health Affairs 2002; 21(2):60-76.

Stillman, L. and Ridini, S., Embracing Equity in Community Health Improvement, Health Resources in Action, May 2015.

DECISION MAKING AUTHORITY

The final responsibility for decisions relative to this policy is with the Health Commissioner, unless otherwise specified by the Board of Health. Recommendations from the Ethics Review Committee are not binding and may be modified by the Health Commissioner or the Board of Health.

F. CITATIONS & REFERENCES

Link to Centers of Disease Control, Public Health Ethics webpage:
https://www.cdc.gov/od/science/integrity/phethics/

American Public Health Association, Public Health Ethics Statement:
https://www.apha.org/~/media/files/pdf/membergroups/ethics_brochure.ashx

I. CONTRIBUTORS

The following staff contributed to the authorship of this document:

1. Nichole Bache, BSN, RN, Director of Nursing

J. APPENDICIES & ATTACHMENTS

Ethics Review Committee Process Workflow Diagram
New Philadelphia City Health Department, Principles of Ethical Practice in Public Health

K. REFERENCE FORMS

Ethics Committee Referral Form.

J. REVISION & REVIEW HISTORY

Revision Date	Review Date	Author	Notes

K. APPROVAL

This document has been approved in accordance with the "800-001-P Standards for Writing and Approving PPSOGFs" procedure as of the effective date listed above.