MCHB/DCAFH

Eliminating Health Disparities and Achieving Equity:

A Framework for Advancing the Health, Safety and Well-being of Adolescents

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CLAIRE BRINDIS: Good afternoon, this is Claire Brindis from the University of California San Francisco. This webinar is a very interesting session. I'm delighted that I'm able to do this under the auspices of the health resources and services administration, Maternal and Child Health Bureau, Office of Adolescent Health. The bureau and Office of Adolescent Health along with almost 30 national partners have been working on a national initiative to improve adolescent health. As one of our important priorities, we recognize the issues around health disparities and the reason for many health problems that many of you are working with in the field. Today I'm very fortunate I'm joined by two individuals whose professional lives have been dedicated to the interweaving of social justice, equity and advancing the health agenda for both children, adolescents and the general public. As the moderator of the session I am going to share with you some specific ways this session will be developed, and encourage each of you to think about questions you might want to submit to our panelists. The first information is that the slides will appear in the central window and should advance automatically.

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Please include your state or organization in your message so we know where you're participating from. The questions will be relayed onto the speakers periodically throughout the broadcast. If we don't have the opportunity to respond to your questions during the broadcast, we will email you afterwards. Again, we encourage you to submit questions at any time during the broadcast.

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Those of you who have selected accessibility features when you registered will see text captioning underneath the video window. At the end of the broadcast, the interface will close automatically and you will have the opportunity to fill out an online evaluation. Take a few minutes to do so. Your responses will help us to plan future broadcasts in the series and improve our technical support. Furthermore, I want to allow you to know that the webcast will be archived and be available at www.mchcom.com.

Now that I've dealt with some of the housekeeping issues, it is really a delightful opportunity for me to introduce to you our two speakers. Paula Braveman and Renee Jenkins. The sequencing of today will be I'll introduce to you briefly Paula's background, she'll give her presentation and then I will introduce Renee and Renee will give her presentation and then we'll have a question and answer period. Paula Braveman is professor of Family and Community Medicine and director of the center on social disparities and health at the University of California-San Francisco. She received her degree in medicine from UC San Francisco and an epidemiology from Berkeley and has practiced medicine in a range of settings. For more than 25 years Dr. Braveman has studied and published extensively on social disparities in health and healthcare and

actively engaged in bringing attention to this field in the U.S. and internationally. Her research has focused on measuring and understanding disparities particularly in maternal and infant health and healthcare. During the 1990s she worked with World Health Organization staff in Geneva to develop and implement a global initiative on equity in health and healthcare. Throughout her career she's collaborated with local, state, federal and international health agencies to see research translated into practice with a goal of achieving greater equity in health. She has been a member of the Institute of Medicine, the national academy of science since her election in the year 2002. It gives me particularly personal pride and honor in introducing Paula to you because we see this talk as really being a core element of looking at the whole topic through the structure that she will -- and the framework she's presenting. Paula, welcome.

PAULA BRAVEMAN: Thank you so much, Claire. It's really a great privilege to be participating in this event with Claire Brindis and Renee Jenkins. Talking with you about the social determinants of health disparities. You'll hear me saying next slide, that's the way the technology worked and I'm going to have a little disclaimer at the beginning of my talk. Those of you who know me will detect my voice sounds a little different. I'm fighting off the same cold as is felling many people right now. Don't make too much of it if there are some spells of coughing during this.

Next slide, please. I'm going to ask you to take a look at this cartoon. This is a very favorite slide of mine. In it you see the two fairly well to do gentlemen in what looks like an exclusive club and one of them is saying to the other, well, the poor are getting poorer, but with the rich getting richer it all averages out in the long run. The point of my showing you this slide is to underscore the point that when we talk about health disparities, we're not talking about averages. Averages undoubtedly are important and public health people

want to improve the average level of health in all populations, but when we focus on disparities, we're taking our attention off of solely the average and we're looking at differences between different groups of people and we're particularly interested in how some groups who are disadvantaged are faring in relation to other groups.

Next slide, please. Just to review some basic issues about the definitions, these terms will come up not only throughout my talk but throughout this webinar and subsequent ones. If you look in the dictionary and look up the term disparity it will just define it as a difference or it might say inequality. If you look up inequality it uses the synonym disparity or difference. When we say health disparities we aren't referring to any old kind of difference in health. The people who started and have sustained this wonderful movement focusing on health disparities in the United States and internationally, it's determined health inequalities but we'll be focusing on the U.S. Today. The people who initiated this movement had in mind a focus on a very particular kind of difference in health that strikes us as particularly unfair. I would also use the term inequitable as a synonym for unfair. Why is that type of disparity or difference particularly unfair? Because it takes a group of people who are already at an underlying disadvantage because of some social characteristics that they have based on their income, their education, their race or ethnic group. It might be gender or disability or sexual orientation. Whatever social characteristic puts people at a disadvantage in a society takes those people already disadvantaged and puts them at further disadvantage on health and we need our health to overcome disadvantage in other realms. Without your health you can't get as good an education, you can't get as good a job. Your health is one of those basic capabilities that we need. So not all differences in health are health disparities. It's a very particular kind of difference that we're referring to. Then to define the term health equity in a brief way, I would say that we're referring to fairness and justice in pursuing the best possible health for everyone. I

want to underscore that the best possible health for everyone. Our goal is not in pursuing the elimination and we won't be able to accomplish that. We want to pull everybody up to the same high standard. It's very important when you use or hear used these terms, health disparities and health equity to realize these are based on ethical and human rights concepts. They aren't just technical issues from the field of epidemiology. They're based on very firmly-held and universal social values that are reflected in ethical terms and in human rights principles and agreements, norms and laws.

So now next slide, please. Now to talk about the social determinants of health disparities in relation to adolescents, I would like to start by posing a question to you. And my question is this. I'll bet that most of you on this call already know that in the U.S. we spend more per capita on healthcare than anyone else in the world. And yet when you look at this slide, you see life expectancy on the left. Infant mortality on the right and you see where the U.S. ranks either in relation to other generally industrialized countries and we rank low and we have consistently for a few decades since these comparisons have been made, have ranked at or near the bottom on life expectancy and on infant mortality. In addition, we have -- we not only rank poorly on international materials, next slide, please.

But we have huge disparities within our population, within our own borders and this slide here shows you life expectancy at age 25. I want to underscore that. We aren't looking at life expectancy at birth but the additional years of life remaining for someone at age 25 and looking at men on the left and women on the right. And people are grouped here, both men and women, are grouped according to their income expressed in increments of the federal poverty level. It's what the FPL stands for. The bar on the left represents the poor, with incomes that place them at or under 100% of the federal poverty level. The next bar to the right, the less dark green are for people we call near poor, incomes around 100 to

200% times the federal poverty level and the next bar people two to four of the poverty level and the next one is over 400% of the federal poverty level. The federal poverty level for the period relevant to this slide would be around $20,000 a year for a family of four and so four times the federal poverty level would be around $80,000 a year for a family of four. I want to underscore the fact that top income group that we have there, we're not looking at super wealthy people. We're looking at people who are solid middle class. Depending on what part of the country they live in they might be upper middle class and they're not super wealthy. You see a pattern when we look after health indicator after health indicator at different stages of the life course. As the income goes up the health improves. The measure is longer life. For men there is a difference of eight years between the life expectancy at age 25 for poor men versus the life expectancy for men in that higher income group. The difference for women is just a bit smaller. Of note here is that you see not just a big difference between the top and the bottom, but you also see a difference at each level. So even those in that not low income, say lower middle income group, the second bar from the right, they have a life expectancy of age 25 that's two years less than that of their counterparts who are in the higher income group.

Next slide, please. We see that same shaped we call it a gradient, a step-wise gradient of incremental improvement in health with increasing income and the same holds through, by the way, if we were looking by education we'd see that step-wise pattern. This is looking at child health and the likelihood that a child is in poor or fair health. And you can see that poor children are seven times as likely to be in poor or fair health but you even see a difference between the children in the top groups that as the income goes up, even in relatively smaller increments the health improves.

So next slide and then this looks at the -- at differences in health status and this is among adults at or over 25 years of age. This shows you the percentage of adults 25 and over who have poor or fair health. Looked at separately by racial or ethnic group. In our country, public health data has traditionally been reported by race. But it has not so often been reported by markers of socio-economic status. Markers like education or income. Sometimes the information is available in routine sources but people are so used to looking at things by race they often don't take advantage of that information. And because of this, because we are -- because traditionally we have looked at health data by race instead of socio-economic. When people see the big differences in health according to income or education, the first thing that they think of is that about race? The reason we did this analysis was to make the point that this is not about race. You see at least a striking income differences in health within each of the large racial ethnic groups. I'm not going to show you a slide but I want to make a brief comment about the fact that we also flipped the data the other way and we asked the question, if we look within income groups or if we look within education groups, do we see racial and ethnic differences? The racial and ethnic differences within income or education groups are much smaller than the income or education differences within the racial or ethnic groups but in most cases they still are there. That could be because we haven't measured socio-economic differences very well but that also could reflect other issues in the experiences that people have based on their race, they confer different advantages that translate into better or worse health so it's very important to look both at race or ethnic group and at socio-economic factors. I think sometimes people get caught up in a quandary that really doesn't -- that we should escape from. If the question is not should we be looking by race or ethnic group or looking by socio-economic factors, the answer is we need to look at both of the both are very important. I've asked you this question, why is it that we spend so much on medical care

and yet we rank so poorly internationally on the key health indicators and we have these huge disparities within our own borders?

Showing you this next slide looking at the mean annual death rate in children under 15 in England and Wales, the death rate due to scarlet fever in order to -- in order to raise the issue, can we find some clues? And here you see that a Scottish physician named Thomas McKuhn published a book in 1974 where he traced out the patterns of mortality due to a number of different causes, vital statistics from England and Wales over time going back as far as he could in history. What's striking about this is you see this precipitous drop in the death rate in children under 15 due to scarlet fever that occurs long before we have available the medical treatments for it. So what could explain this? And a lot of people have studied this and there have been a lot of debates. Some more unfriendly than others but I think it's fair to say that there is a general consensus that what this reflects is the huge impact on health of factors that are not medical. Factors that are in people's living and working conditions. That this precipitous drop in the death rate from scarlet fever is probably attributable to sanitation, clean water, gains in living conditions and working conditions with a lot less crowding and better ventilation. Some changes in hygiene practices could be part of it as well but it is not the medical therapies. They weren't around until much later. If we had the time I could show you a few more of these slides done by McKuhn. Each one with a similar message.

Next slide, please. So could it be that the reason that we rank so poorly on health internationally and we have these huge disparities, could it be we haven't been paying enough attention to some really crucial factors? Now, I think if you ask most people what do they think shapes health, the first thing that virtually everyone would say, they would say healthcare. I prefer to use the term medical care to distinguish it from health itself. And

then if you pressed a little further, most people would probably say Oh, yes, and personal behaviors, whether or not you smoke, whether you exercise or you drink excess alcohol, the fat content of your diet, fiber, those sort of personal health-related behaviors. And our approach to those to date has been to say well, we need to inform people about the importance of the personal behaviors and we need to exhort them to behave better and we need to think about creating disincentives to people for engaging in bad behaviors. But what we haven't done a lot of, at least in this country, is looking at what is it that might be outside the control of individuals that shapes the personal behaviors and that also shapes whether people get the medical care and the quality of the medical care that they get? We haven't been looking at living and working conditions, the kind of conditions that McKuhn thought in that slide that I just showed you. That McKuhn and other public health experts have got to explain these dramatic improvements in health long before the availability of effective medical therapies for them. Could it be that even beyond that, that we haven't been looking at what it is that sorts people into healthy and unhealthy living and working conditions? That sort of basic underlying economic and social opportunities and resources that people have? I would like to explore those a little bit further now. So let's go to the next slide. So what do we know about what affects health? If we had a webinar that was 12 hours long maybe we could start to scratch the surface of the general notions of what it is that affect health. In this short one I'll just be able to focus on a limited number of factors. But we know that, and we have -- this is not just a matter of common sense but there has been an accumulation of science over the last couple of decades, science trying to explain health inequalities in this country and internationally, that tells us that income -- we know income directly shapes medical care, whether you have, whether you receive it or not, it's quality in many cases. It shapes the quality of the housing we can buy, whether you can buy a house without red paint, a house whether you can buy or rent housing quarters without the led paint, the dust mites and molds that can trigger asthma attacks.

Unsafe housing conditions in the structure. Income shapes nutrition. We have a lot of evidence the more money that you have, the more able you are to buy a nutritious diet. Income also influences your opportunities for physical activity, whether you can belong to a gym, whether you're working two or three jobs and have the time to engage in physical activity. But beyond those individual level factors, we know that income also shapes the neighborhood conditions we live in. Can you own or rent a home in a neighborhood that is conducive to good nutrition and to physical activity? Is it safe to exercise there? Are there sidewalks, are there parks? Is it crime infested? Is there a grocery store that sells fresh produce within walking distance of you? Income also shapes levels of stress. I'm going to address that a little bit further in a couple of slides. Then income also shapes the social support that we have and how does that work? Because we tend to -- our social networks tend to be with people of similar income levels. And when your network includes other people who have resources, they can help you when you need a leg up. If you're desperate and struggling and your family members and your friends are also desperate and struggling they won't be able to help you in your time of need. But we also know we have to look not just at factors across someone's lifetime but also transgenerational factors. One of the most powerful of those is how parents' income shapes children's' education. How does that happen because parents income determines where they live and are they in a neighborhood that has good schools and/or can they afford to send their child to a private school if they're not in a neighborhood that has good schools? So that's a very direct relationship between economic resources in one generation and then social and economic resources that is education in the next generation. That education in the next generation is going to determine working conditions because it determines their job prospects. Can they get a good job? One factor that there has been a lot of interest in, I think I couple lateing evidence has the issue of the degree to which you have some control at work. Do you have any ability to participate in shaping your working conditions,

the flow of work, any decision making at all? It looks like that's a powerful independent factor in itself even after controlling for a whole host of other factors. And that factor of control at work is one of the -- is one of the issues that many experts in the field of health inequality or health disparities felt may be driving a lot of health disparities. Finally insofar as the parents' income shapes the next generations educational level it shapes the income prospects of that generation. You have potentially a vicious circle across generations as well as over someone's lifetime.

Next slide, please. Here just try to depict graphically how poverty and ill health can go in a vicious circle and so look around that oval, around the perimeter there and you see poverty going to poor health through some of the factors I was just discussing in the last side and poor health itself leading to more poverty. Why? Poor health leads to diminished job prospect, that's going to diminish income. So you have poor health to poverty and poverty to more poor health and then if you look at the center, they are just trying to illustrate some of the pathways involved and the complexity of it. It is terribly complex. Poor health leads to lower educational attainment. The child who is in ill health is less likely to have the same educational attainment that a child who is healthy can have and then that lower educational attainment leads to poor health itself either through pathways involving lower income, so that would be going to the right there, low educational attainment to a poor job and that poor job leading to poorer health because of low income and/or because of the working conditions, but low educational attainment we know can also lead to poor health because it limits one's health knowledge and what one can do with a piece of health knowledge.

Now, just want to focus in on that square that I've just highlighted there and go on to the next slide. And this one illustrates how low educational attainment and a poor job lead to

poor health. They can do so again through pathways that involve income or through pathways that don't necessarily have to go through poor -- to lower income. And one of the ways is in determining the individual's living circumstances but also in determining the neighborhood environment. Low educational attainment and lower income can lead to or exacerbate unhealthy behaviors. And that is a very important route to poor health. The role of working conditions I've mentioned, the issue of low control I have. There is a lot of evidence that has accumulated in the last 15 to 20 years about the role of stress in poor health. This is a common sense issue but before 15 to 20 years ago we didn't have the strong scientific evidence on it. And now what we know we've observed the relationship between stress, particularly chronic stress, and health for a number of health outcomes. Now, I would like to look at the next slide which will trace how it is that stress can actually get under the skin. How does stress get into the body? And here you just you see this figure of a person and cross section and stress the way it starts -- let's do the first -- for the person manipulating the slides if you'd press the page down first and so here you see that box saying a stressor. Any hardship you can name it. Maybe it's making the stressor that you're worried that you're about to become homeless because you can't make your rent or your mortgage payments. That has an effect on the brain. Specifically on an area of the brain called the hypothalamus. The next arrow down, please, hypothalamus sends a signal to the pituitary gland. That pituitary gland send another signal to the adrenal glands and they put out a stress hormone that affects many, many different organs and systems. In the short run a little surge of Cortisol is not necessarily damaging to health. It's part of what happens in our fight or flight response, which is a very good thing to have when you're facing a roaring lion and you want to run away and have a surge of energy to run away. But what we've learned in the last 15 to 20 years that chronic exposure to stress can lead to chronically elevated levels of Cortisol and those can damage multiple organs, including the heart and the kidneys and they can cause deregulation of some very, very

important systems in the brain, the system that is illustrated in this slide we're looking at now, the stress pathway from brain to body that system is referred to as the hypothalamus pituitary access. Chronically high levels of Cortisol can lead to deregulation. You could be at a later stage of your life not being exposed to terrible stressors and yet your body is acting in ways as if you were under continuing stress because of that HPA access was thrown out of whack during chronic stress, during childhood, a critical period like adolescence.

Next slide. So who has the most stress? If I'm making the point that stress can damage health for many, many different indicators. I think there has often been the prevailing view that it is the people at the top who have the most stress, the executive, the professionals, that's been a kind of prevailing thought. But the data don't support that. Here I'm showing you some data from a survey that our group has the privilege of collaborating with the California state Department of Public Health on, the Maternal and Child Health and adolescent health program in the California Department of Public Health. We call that survey the maternal and infant health assessment modeled on the prams survey. The likelihood a woman was exposed to certain very, very stressful life events during her pregnancy. We've grouped as in the earlier slides where we grouped people in increment of the federal poverty level from left to right, going from the poor to the highest income group, we've done that in this slide and the next one that I'm going to show you. Here we're showing how as income goes up, the likelihood that a woman, spouse or partner had a job loss during her pregnancy goes down. You see that step-wise pattern. I could show you from multiple stressful life event a similar pattern. The prevalence numbers would be different but that step-wise pattern you'd see that reiterated. This is for the spouse or partner's job loss. You would see that same pattern when we ask women about their own involuntary job loss. We were asking about an involuntary job loss not a woman

electively stopping work because she was pregnant and wanted to stop work. You see that pattern for homelessness, for food and security. See that pattern for economic insecurity and difficulty making ends meet. Now next slide, please. Just to look at a more psycho social kind of stressor you also see that pattern for the likelihood that a woman is separated or divorced during pregnancy. Again I'm not going to show you, you know, several slides on this but just to tell you that for other more psycho social stressors like separation or divorce we see the same pattern. Domestic violence and also for social support looking both at material support and emotional support. And so experiences of stress really are patterned socio-economically. They're also patterned along racial or ethnic lines and both African-American women and Latinos and American Indian women score higher on the prevalence of each one of these hardships than their white or Asian counterparts and they also black and Hispanic women also score higher on the number of stressors. I think in the literature there is some evidence that the number of stressors that you experience can be important itself over and above how stressful each particular stressor is.

So next slide, please. I've been talking about stressors at the individual level. Individual or family level. What we often fail to take into consideration are the stressors that women experience not just women, but that people experience and adolescents experience, people experience across the life course in virtue of the neighborhood they live in. If you think about it, there are so many ways in which your neighborhood can affect your health. The obvious ones are about physical danger. Mention safe places to exercise, pollution is there. Your access to healthy food. In many poor neighborhoods, there really isn't a store selling fresh food, healthy food around but there are other more subtle, more social ways. For example, these can be very, very important for adolescents. The availability of role models modeling healthy behaviors, the peer pressure that the kids are encountering.

These can have profound effects on the likelihood of substance abuse and particularly in critical periods like adolescence. Your neighborhood can affect your social networks and the support that you can get. Just the general stress that you feel. These two pictures that include here just the make the point. You probably have -- elicit a certain feeling in you. It's distasteful. Living in run down circumstances carry stress and despair. It is very important to underscore the fact that Blacks and it is also true of Hispanics, although that's not on this slide. Blacks and Hispanics of similar income levels live in very different kinds of neighborhoods other than whites. Although racial segregation is illegal but unfortunately it lives on and is strong and one of the main ways that many of us feel that health disparities are created and perpetuated. So it's very important to take into account and so a middle class African-American is much more likely than a middle class white to be living in a neighborhood that confers health disadvantages. That sort of thing is rarely taken into consideration enough in studies.

So I think I've mentioned -- next slide, please. That we need to think of how health disparities get created and how they get perpetuated. Not only across someone's lifetime, but across generations. And this slide is intended -- page down -- to illustrate some of that so you see starting in childhood and including adolescence in that, you've got that outer arch representing the social and economic opportunities and the inner one the living and working conditions that are created by those social and economic opportunities. And those influencing health. But those opportunities, those social and economic opportunities in childhood shapes one's social and economic opportunities in adulthood. Poor kids are much less likely to become wealthy or middle class adults. It's not that no one ever does but the chances are much lower for someone who starts off like this disadvantages for some of the reasons I was illustrating in previous slides and then the -- the social advantages and disadvantages in adulthood get shaped by the social advantages and

disadvantages in childhood and the health in adult hood that is shaped by the advantages and disadvantages in childhood. As adults start a family, next page down, please, as adults form families, have children, then those social and economic opportunities and those living and working conditions shape the health of the next generation in what could be a vicious cycle but if we can look for the points at which we can interrupt the vicious cycle could be a virtuous cycle leading to advantages rather than disadvantages.

Next slide, I don't want to spend a long time on this and we'll just see in the question and answer period how many people are interested in talking about this more.

But in this next slide that has all these different blue boxes on it, this is an adaptation of a diagram developed by a researcher in Sweden. Someone who has contributed a lot who studies health inequalities in Europe and here you see let's look at the boxes on the right. We see social position and by social position talking about relative social position as reflected by your income, your education and because of the legacy that we have of racial discrimination, even without active incidence of discrimination, people are getting sorted into different relative positions by race. For example, through racial segregation, and that that position leads to your social position, changes what your likelihoods are of being exposed to specific risk factors or advantageous exposures and then whether you're exposed or not gives you a different likelihood of developing disease or an injury. And then your -- whether you have an illness or are injured leads to different social consequences, depending again on the factors that shape disparities.

Now to the page down button, please. So that social stratification is what I mentioned, that would be by income, by education, by race or ethnic group but it could be by gender, by disability, sexual orientation and now number two the differential exposure that when we're

thinking in policy terms, we want to think about where is it that we can get into those vicious cycles and interrupt the vicious cycles. We want to look at how can we change the fact that some people are systematically more likely to be exposed to some health risks. And now the next page down, please. It's not just as simple as a different exposures and different likelihood of exposure, there are also different vulnerability. Wonderful work has been done in adolescent health on youth assets and that's what we're talking about here is how your underlying assets, which come from your social position, in fact, tightly linked to social position, how those can have an effect on the likelihood that if you're exposed you develop disease or the likelihood that you suffer bad consequences of disease if you do develop it. What do I mean by social consequences of disease? If I develop a severe illness that makes me not very mobile now, I am much more likely to be able to keep my job and continue to be productive than I would be if my skills were manual. If I was a domestic worker who could not work. If I was physically disabled. That's an example of the different social consequences of ill health. The different social consequences lead to further stratification and the whole policies can influence these different points along the pathway. And I think we want to think about where we can -- where we can influence, where we can interrupt the vicious cycles and turn them into virtuous cycles. I'm almost done at this point.

This is a cartoon a colleague found and gave to me, much to my delight. And in it you see the physician telling the patient. What I like about this one when it doesn't make me weep, what I like about it is that I think it illustrates the way we've been approaching things. We've been saying to the individuals well, get your stress down, you know, improve your health behaviors, get that stress level down. And we haven't been looking at what it is that might constrain or enable that person and the kinds of factors that maybe only society can have an impact on.

Next slide, please. This is the last one. Again, I apologize for my hoarse voice, the remnants of this cold. Getting back to the question that I started off with, why is it that we spend so much on medical care and yet we perform so poorly in relation to other countries and we have such huge really wholly unacceptable health disparities within our borders? And could it be that we're just not looking enough at what -- let's do a page down, please. You see the personal behaviors, page down, medical care, that this narrow view and like that last slide saying to the man, well, deal with your stress, reduce the stressors in your life and improve your health behaviors, that we're not looking at what it is -- page down, please, we aren't looking at what it is that shapes both the medical care and the personal behaviors and also directly shapes health in many other ways, not just through medical care and personal behaviors. For example, through housing where we have not been putting enough attention on policies that would promote healthier homes, neighborhoods, schools and workplaces. And now page down again and that we haven't been paying attention to what it is, then, that sorts different people into different more or less healthy living and working conditions. The underlying economic and social opportunities and resources that are often reflected in income and education and race, and that need to be dealt with at the policy level through policies to promote economic development, to reduce poverty. Policies in the youth development category I would include here. These policies to promote child and youth development and education during the period of infancy all the way through college. And a metaphor that I would use, think of the living and working conditions as -- that's giving people the fish. I'm sure you've heard that metaphor. Should you give someone a fish or teach them how to fish? And giving someone a fish now that's important to have the fish, to have something to eat. That outer category that often gets neglected, that's the teaching people how to fish. That's the capacity building. That's the youth development perspective for those of you in that field. So all of the material that I've

been presenting I think I've presented it mainly in general terms and haven't tailored it specifically to the adolescent field but it is all absolutely applicable to adolescents and think of that as just one of those life stages in that continuum in what we want to turn -- we don't want it to be a vicious cycle, we want it to be a virtuous cycle. Thank you very much.

CLAIRE BRINDIS: Thank you so much. Really have appreciated all the work that you've done in this field and also the fact that you have really helped us in thinking about the framework for looking at health disparities. Now it's my great pleasure to introduce to you Dr. Renee Jenkins from Howard university and adjunct professor of pediatrics at Washington university in Washington, D.C. She graduated from Wayne state School of Medicine and she was in Jacobi hospital in New York City. After completing her fellowship, Dr. Jenkins started an adolescent medicine program at Howard University. In 1994 see was appointed department chair of pediatrics and served in this capacity until March of 2007. Dr. Jenkins was inducted as president of the American Academy of pediatrics at the 2007 annual meeting and currently the principal investigator at Howard for the D.C./Baltimore research center in collaboration with the children's national Medical Center and Johns Hopkins university pediatric department primary care division.

Dr. Jenkins may be familiar to many of you. Her research is on adolescent pregnancy prevention. They range from violence prevention and health issues of minority children. She lectures in the U.S. and abroad. Dr. Jenkins, thank you so much for being the bridge between what Dr. Braveman has presented to really the focus on adolescents. Thank you.

RENEE JENKINS: Great, thank you. Good afternoon, everyone. I'm really glad to be part of this presentation series, especially having the opportunity to work with Claire and also with Paula, who is doing some work with us in our center. This is really a great

opportunity. I really enjoyed the sort of profound lens that Paula provided in terms of how we need to rethink perhaps how we're approaching some of these interventions are adolescents. I'll walk through our focus so what does it mean in terms of how it's impacted on adolescents and look at the end at some of the interventions and what impacts they've had to some degree in children and offer some opportunities for us to think about how we might approach reducing disparities. And I think as Paula pointed out, which means bringing everybody up to a higher level and working that through with adolescents. I'll do a broad brush looking at some of the categories of health, safety and well-being for adolescents and also considering that part of that is the developmental issues, health access, health services and health outcomes. I think as these webcast series progresses there will be more focus, background and action related specifically to adolescent services. So let's get started.

First slide. I think this really sort of talks about why it's important for us to look at health, safety and well-being of adolescents. By creating safe and nurturing environments for today's youth, when we focus on assets and minimize chances for engaging in health risk behaviors we can ensure that tomorrow's adults will be healthy and productive. So in a mode, in a sense, this is securing our future by making sure we make investments in adolescents at this stage.

Next slide. I think what is different about looking at this with children and adolescents is that we're not just talking about what the health status is now. We are really saying we can influence by giving greater opportunities to young people, allowing them to really fulfill their full potential developmentally so again it has even, I think, more of an urgency to approach it than perhaps even talking about what happens in adults.

Next slide. When we look at this model, for example, that came from the IOM committee on children's health, what it depicts basically is I think what Paula said, is that when you think about the framework, if you link one outcome to another, that we don't, you know, there is a potential trajectory here and that the trajectory is influenced by the issues of social environment, biology and physical environment but also influenced by the policies and services that exist in the time frame that that infant develops through adolescence into early adulthood and so understanding more about what shapes those outcomes and influences are really where we need to be. The more recent publication from IOM on Adolescent Health Services puts it in a framework that says context matters. Social context and factors such as income, geography and cultural norms and values can profoundly affect the health of adolescents and the health services they receive. I think again what we're trying to paint here is really getting to what some of these contextual influences are. This model was put together by a colleague at children's national Medical Center, Jill Joseph, in a grant, is that we're not looking only at the personal factors, which I think tend to be emphasized so frequently, but we know that we need to look at the issues that I think Paula has spoken so eloquently to around neighborhood social context and the social/political context. When we think about it not only nationally but what happens in different state and county levels these things can influence what the potential outcomes and status issues is for adolescents. We're now seeing more studies in the child and adolescent literature, it has shown us that there are health system bias issues that relate not only to cultural competence but really to differential treatment based on race and ethnicity. So these are at least some specific contextual factors and we're singing from the same song sheet that we need to begin to look at more closely.

Next slide. Paula actually presented at a conference, invitational conference we had on starting early a life course perspective on child health disparities. What she challenged the

group to do through childhood overall but I think now certainly looking at adolescence is to attempt to really understand what that period represents. It could represent the critical period where, if something does not occur, or is not stimulated, there could be permanent effects. Is it a sensitive period during adolescence where a certain intervention may have larger effects early in adolescents or late in adolescents or vice versa or more cumulative effect across the developmental trajectory and pathway through child adolescence. Where our interventions are most successful or effective, we still don't understand for which types of health outcomes or conditions we're likely to understand that framework. But I think we certainly ought to be asking these kinds of questions in some of the research we're looking at relative to adolescence. Another presenter at our conference really challenged us to begin to look at some of the inputs that we know about. For example, parenting behaviors. I think also parenting educational status. We already know has effects. We also ought to be looking at issues related to resilience as well as to issues related to risk. And sometimes when we're talking about psychological or biologic functioning we focus a bit more frequently on risk than we do on resilience. Especially as we look at studies that look at within group differences, we really need to look more at the resilience issues in terms of parenting behavioral and socialization that really support the asset concept for ethnic and minority adolescents.

Next slide. The other urgency is that our population is becoming more diverse and you see here some of the census bureau projections are that 35% of our young people are going to be in the future in the racial and ethnic minority category. I think the trajectory for the census bureau even goes further than that.

Next slide. We also see, especially relevant to Paula's talk, that the black and Hispanic young people and even our Asian population still have poverty rates that are higher than

whites. And it appears in this data that the poverty rates are going down, which is a good sign. I'm not so sure it takes into account our current economic situation we're in but at least in 2006 they were going down. And so I think there are two points here. One that they change over time, but point two is that there still are significant differences. I think another point that Paula brought up was that perhaps some of our measures in terms of poverty and resources are probably not as sensitive as we would like them to be in order to even understand this more. But I think we at least ought to be looking across and within groups at these issues as we begin to really understand the impact of potential interventions that support adolescents being successful in terms of their health status and health outcomes.

Next slide. What we know is there are disparities. There are disparities in accessing youth and these are from the in center strategies report on adolescent health disparities. We see here that disparities exist in care areas either in preventive care in terms of identifying a primary care doctor or having a medical home, but they also exist in terms of dental care and mental healthcare. What we don't see, which is interesting, is the disparity is really interesting in terms of delayed medical care in the past year where we see that white adolescents are also likely to have delayed medical care in the past year. So there is not that significant disparity as we look at that. Next slide. But when we look at disparities in health status with the exception of special healthcare needs, we look, for example, at perception of personal health status, we see significant differences for African-Americans under -- who are more likely to perceive their health status as poor. We also see when we look at issues of overweight or risk that Hispanic and black youngsters have higher rates there and when we look at limited access to exercising we also see, especially for Latino youngsters, higher rates there. So what we don't have, which I think Paula in some ways has challenged us to look at, what are some of the other lenses we should be looking at

these differences in. Certainly looking at them either by geography when we look at rural or urban youngsters, but also looking certainly at socio-economic status, that is an important measure. We really have not done as much as we really could. One of the areas that I think even provides additional challenges, when we look at a set of behaviors, for example, sexual behaviors, there is -- when you look at it interesting variability in terms of the outcome measures are, even when you look across ethnic and racial groups. And let me just say for example. We know that the pregnancy rates -- we have data that says the pregnancy rates for black and Hispanic youngsters are going down and they've been going down more proportionally for black young women than for Hispanics.

Next slide. We see that not only in the pregnancy rates but we see that in the birth rates and especially what you can see here that the trend for black non-Hispanic young women has again fallen over time for birth rates even with a greater velocity than it has for Hispanic young women. When we look at another sexual behavior, next slide, such as STI rates, we see that those rates are still incredibly higher in African-American and Hispanic young women. And even in Asian youngsters those rates are higher. And so what we know from our -- what we've been shown from our data that looks at high school surveys is that condom use is up for this population. And we know that sexual activity rates are reportedly higher in Hispanic and Latino youngsters but why the difference in terms of the success we've been able to see in terms of their using birth control methods more frequently, why is that not registering in terms of better rates for chlamydia, next slide and for gonorrhea rates. So this is the same sort of pod of behaviors and why are we seeing different outcomes related to similar behaviors? So I think that even within groups and even within behaviors to try to understand what some of the cultural and environmental issues are relative to why we have differences within behaviors I think are challenging to those of us who are trying to create interventions to reduce these kinds of outcomes.

Next slide. Another paradox is what we see in the area of injuries. If we look at ethnic differences in injury rates here, by injury episodes, we, in fact, see non-Hispanic whites with higher rates of injuries reported. The episodes for 10,000 population. But when we go to look at injury death rates, we see again the ethnic disparity in terms of reporting here so that we see for many of the injury deaths higher rates for Blacks, Hispanic and American Indian or Alaska Natives. So why the episodes that don't translate into injury deaths? Are we talking about the mode of injuries, access to healthcare when the injuries are sustained? Are we talking about people who may not be able to get the healthcare or they're treated differently when they get to healthcare? I think there are some studies that are now in the literature that suggest there may be multiple reasons for these type of differences but certainly when we do interventions we need to understand these modalities.

Next slide. But what is the impact, for example, in some of the interventions in increasing access? This is a children's study not specifically related only to adolescents. This is data from New York that looked at the ability to access usual source of care and preventive care one year after S-chip was implemented within that state. What we see here is the kind of outcomes we would really like to look at as we approach disparities, that is, in the -- during SCHIP, once SCHIP was implemented, that the rates for usual source of care percentage went up for whites, as well as the Blacks and Hispanics and essentially eliminated the disparity in accessing usual sorts of care for these groups. So access can be when there are services available. Potentially one of the interventions that begin to reduce and eliminate disparities in some areas.

When we look -- next slide -- at a very vulnerable population such as children of immigrants, we see here on the left side of the slide when we look from 1995 to 2005 we see for U.S. Citizen children born and native born families the uninsured rates going up and the access to Medicaid and SCHIP rates going up. On the other hand, when we look at immigrant children we see the uninsured, we see the exact opposite. We see the uninsured rates going up and we see access to Medicaid and SCHIP going down. But when you insure immigrant children, we see that if you compare insured immigrant and uninsured immigrant, that you are much more likely to have well child visits in the past year and much less likely to have E.R. visits. So again, access to care can make a difference in terms of disparity outcomes for ethnic and racial groups as well as vulnerable groups such as immigrant populations.

Next slide. This is another study that shows sometimes in very hard to reach populations you need to think of different strategies. And this strategy with the case management approach where there were lay intervention people or people who had similar language to this primarily Spanish-speaking population, that essentially there was a difference between the usual sorts of reaching out to this group and using a case management approach and here we see that the children were much more likely to obtain health insurance, much more likely to continue to be insured, and much less likely to be sporadically insured when this intervention was used. So I think this previous set of slides really shows that we have some evidence that at least access when we're able to change that, may have an effect specifically on usual sorts of care which influences the ability to have preventive care.

So next slide. So in closing, I think much like Paula painted out in her last set of slides, there are a number of levels in which policy and environment can be impacted upon for

which we can design interventions to reduce disparities and to promote equity. I think we have a challenge at the national level that we are hopefully addressing coming up with looking at models we can use for universal health coverage. It is especially important when we look at racial and ethnic minority populations who are very mobile especially in the western groups where we have people who are agrarian population. That will be important. But also that we begin to look at funding research and demonstrations that look at how to reduce disparities and promote equity that can be adapted and modified across states. At the state level, legislative intervention is important, as well as programs within states that allow creative opportunities for interventions with funding and also state health entities making those successful programs, disseminate them across states. We see the community interventions that are culturally specific and language friendly that promote youth development. At the individual level in families within the medical home in terms of what is offered that's appropriate for adolescents and that we emphasize not just risk issues when we work with adolescents within a medical home but we also look at asset development. I guess the questions for us as part of this webinar are really how can we make a difference? Either at the health professional organizational level, at those of us who are part of health delivery systems, either private or public, and those of us who are direct providers of healthcare to adolescents, how can we make a difference? Thank you.

CLAIRE BRINDIS: Thank you so much, and thank you, Paula, both of you for doing such an outstanding job in really laying out a framework for looking at this whole very, very complex issue. We've had a number of questions and for some of you who we may not have a chance to respond during this webinar, our guest speakers will share their thoughts via email. But the first question that is very timely given the environment is the fact that many parents of low income has really tried to improve their housing and community environment for their children moving into purchasing homes and now we

understand and we haven't followed and tracked clearly what is going on with the economy and many of these parents are not able to keep their homes but yet now the society in general is blaming these parents about taking the risk. My question to both of you following on this individual's question who is Dr. Maria -- I'm sorry to mispronounce your last name." The real question is what are the kinds of approaches given individuals, especially poor individuals who live in these very undesirable neighborhoods, try to improve their lot and then it doesn't work and they're blamed further. Do you both want to make some comments?

>> Paula or--

>> I think I spoke for too long.

>> I think that's a really important question only because we're trying to help parents recognize that they do need to talk to their children and adolescents about what they're trying to do. So that they understand the positive aspects of their efforts. The American Academy of pediatrics has on its website now a set of primers to really help parents understand that you can't sort of have these things happen to your child and not really talk about it. That it's important for them to understand what is happening to them and that you are not going to abandon them and that their situation isn't going to be unmanageable. I think certainly the comment about society looking at them in a negative way, hopefully is not the thread that we're seeing now. As we see many more programs attempting to help low income and middle income people who have taken this risk to stay in their homes through some new programs. I think it's important for parents to be encouraged to seek out these programs to see how many of these programs are applicable to what their needs are. So I think one communicating with your adolescent and reaffirming your

commitment to their safety and care is important. But also trying to help direct parents to programs that allow them to stay in their homes for the stability and safety of their families, whether they're children and adolescents.

>> Paula, do you have any comments?

>> Just I think Renee gave a great answer. Maybe the only thing I would add is that I think in our society we have this predilection for placing all the onus on the individual and advocates and decision makers need to be able to say look, there are some circumstances in which it's the society that's responsible and specifically this housing crisis is an example of where really unscrupulous people and companies tried to trap people and it was a failure of regulation. And so that I think we need to speak -- it's usually not effective if we just talk about the societal responsibility without acknowledging individual responsibility. Given our culture we have to acknowledge both but I think we have to be ready to say there are some things that it is the society's responsibility.

>> Another question and this is from Paul Christianson who asked two questions. One having to do with Native Americans or American Indians and where do they fall within the data both Paula that you presented and Renee if you want to make any comments? The second question has to do with the provision of medical care which for the American Indians is from the federal government. Is that considered insurance? Perhaps the first question is around data around American Indians.

>> The second question is a little more complicated. I am not as familiar with the Indian Health Service. I know that that is theoretically supposed to guarantee healthcare to

Native Americans. I think it's primarily focused on Native Americans living on reservations but this is not an area of my expertise.

>> Also not an area of my expertise.

>> So I wish we could offer you more there but unfortunately neither one of us are the right folks. But in terms of the data, I think in some of the slides that you see I presented, there were some Native American data but especially around birth issues and reproductive health that's pretty much the most commonly cited data for Native Americans as is substance use data. But the ability to get really good data on Native Americans is really limited by the population sizes very often. But it is an area that we certainly need to be looking at more because it does not take much in terms of numbers to really negatively or positively perhaps impact on intervention.

>> Paula, anything else you want to add?

>> Perhaps only I completely agree with Renee. It's always a source of frustration for my group is the small numbers of American Indians so we often just don't have enough numbers to look at them. When we do have enough data, my own area is more maternal and infant
health, when we do have enough numbers the picture that comes out is a people experiencing profound disadvantages in multiple realms.

>> Thank you so much. Both of you have done and are interested in the area of adolescent pregnancy and pregnancy prevention and

reproductive health in general. These are areas affected by disparities. Do you have any thoughts on how best to articulate how social situations determine teen pregnancy? This is a question from Carla white.

>> Let me just start again give Paula a chance to rest her voice. I think there is an institute that has really looked at this on a research -- with research models that are broad in the way Paula talks about in that when they look at the educational opportunities that young women have, when they look at their ability to access reproductive health services, these are some of the factors that are associated with them electing or choosing to become active in delaying their childbearing or to use contraceptives successfully. Education and future aspirations have been part of sort of the social picture of girls who tend to be a lot more successful at, you know, managing to avoid teen pregnancy. That's a broad answer, I don't have the list of other factors.

>> That seems to me to be a very good answer and I would just add that Claire and other colleagues of ours and I, we recently completed a study supported by the California Department of Public Health because the Department of Public Health was concerned about the high rate of teen childbearing among Latinos and about the fact that the rate of decline in Latino/teen childbearing was slower than among other groups and we started with a literature review. The literature certainly pointed to the importance of the future aspirations and educational opportunities, job prospects among non-Hispanic whites and among non-Hispanic Blacks but at the time that we were doing that literature review there wasn't anything about Latinos. So that was an important element we looked at in the study that we did and I think the study findings came out loud and clear on that that yes, also for Hispanic teens, in the terms that you used Renee that were so articulate. Future aspirations and educational opportunities looked like a huge factor. Access to services

certainly. We found that among barriers, that the -- a lot of teens seemed to be getting into the family planning services but they left the visits without enough understanding of the proper use of contraceptives. Even among the teens using the services a lot of misinformation about the proper use. Also saw the role of men, the influence of the males and I know that's been looked at certainly in other -- across different racial ethnic groups. All of those came out as important and relationships with family seems to be very, very important.

>> Thank you very much. So I want to -- we have time for just one more question but I do want to put a plug in on being able to use the framework from today to help us also look at the issues from a community perspective and so on April 2, Thursday, we'll have a continuation of this series by looking at capacity building, interventions for communities and then on Wednesday, April 29th. We'll have a session devoted to the role of empowering youth for helping us to eliminate these health disparities and achieve equity. Our last question is for the moment from Monica, who asks, what are you envisioning to happen at the national level towards accomplishing health equity?

>> An easy question, right, Renee? The first thing that will move us in that direction, it won't solve things, but I think we have a lot of optimism on improvement, which is universal health coverage. I think everybody says look, just because you have a car doesn't mean you have easy access to services. I think we're all acutely aware of that. But that's a step. And to be able to do it in a way that becomes more systematic is another part of it. Because I think when you look at the issues that Paula brought out that we spend a lot of money but we don't have good outcomes has to do with the fact that we have a broken system. That the system is not sealed together. We have 50 states with 50 different systems for the most part. Until we're really able to, I think, do things that are

system supporting across states and within states, we're still going to have disparity issues. But I think we're on our way and all we can do is, you know, attack it incrementally and the first step is to get people covered so that they don't have a barrier to getting to services.

>> What I would just add to that is that I think this administration really gets it about the social determinants of health and very, very committed to early childhood development, investment in early childhood development and in education. K-college and that those are such crucial -- that's teaching someone to fish, giving them the capacity to be healthy. That we now know a lot about brain development and physical government even in the first five years. There is so much that happens that can limit the ability to be healthy later in life. It doesn't necessarily manifest in child health but shows up in later generations. And so I'm hoping that in spite of the economic crisis and the toll it will inevitably take that there will be a very serious investment in early childhood development programs. Early head start and if we can combine that with healthcare. I was being ironic when I said it was an easy question.

>> At least we know where to start. I also would underscore, I think, Paula's absolutely correct in terms of those other issues. But the other social determinant is family stability. And I think the economy and getting that sort of settled down with the issues that someone asked earlier. You have to have stability in terms of where you live and a roof over your head and food stability and, you know, the economic supports that are being given to families so families can stay together. Those are the kinds of social determinants that are going to be important in terms of child health outcomes and adolescent health outcomes.

>> Partly through the stress pathways is how that is where economic instability can take its toll on health.

>> We hope that this crisis can be resolved in an equitable way and I want to on behalf of the Maternal and Child Health Bureau, Office of Adolescent Health and all of the listeners today I want to thank both of you for doing an outstanding job in kicking off this series and really providing us with so much food for thought and really a context for thinking about new strategies, new approaches, new policy interventions as well as individual interventions that we should be planning for in the future. I would like to encourage everyone to complete the brief evaluation so we can continue to improve our next series and also that this presentation will be archived at www mchcom.com and again great thanks to our wonderful speakers today. Goodbye.