community partnerships prevention environmental hazards burden of illness managed care culture fertility beliefs and values barriers to access diversity innovative research women's health disability health policy homelessness communication quality improvement violence aging outcomes substance abuse ethics technology stress placebo youth genetic testing information and decision making morbidity and mortality poverty patient satisfaction cost families work conditions caregivers risk factors population health

exchange

the Center for Health *and* Community

at The University of California, San Francisco

Surgeon General to Address Disparities in Health

On a mission to improve public health for all groups in this nation, US Surgeon General David Satcher will be the keynote speaker at the inaugural symposium of UCSF's Center for Health and Community on September 14, 2000. The theme of this inaugural symposium is "Surgeon General's Warning: Social Disparities Are Hazardous to Your Health." As the nation's top doctor, Satcher's passion for a renewed national commitment to public health, particularly the need to elucidate and eliminate racial disparities that result in higher levels of disease and disability, echoes the goals of UCSF's 250-plus social and behavioral scientists who have combined under the CHC umbrella. A widely respected public health official, researcher and former member of the UCLA faculty, he is only the second physician in history to also simultaneously hold the position of Assistant Secretary for Health. Prior to nominating Dr. Satcher to serve in his present post, President Clinton had appointed him as Director of the Centers for Disease Control and Prevention and Administrator of the Agency for Toxic Substances and Disease Registry, where he served from 1993 to 1998. For more information on the three-hour symposium, which begins at 2 p.m. in Cole Hall on the Parnassus campus, call 415/476-7408.

From the Director

As most of you know well, our health care system remains dangerously flawed—full of stunning successes that mask disturbing failures. The reasons are clear even if the solutions are not. No matter how much glory flows from unlocking biological mysteries and performing miracle surgeries, it is old-fashioned human behavior and social forces that drive an overwhelming percentage of health risk in this country. Smoking, diet, lack of exercise, alcohol, guns and sexually transmitted diseases are among the 10 most prominent reasons for early death in the US. This is to say nothing of their context—family, community, economics, culture, race and ethnicity—all of which exert an enormous influence as well.

Understanding how these forces fuse to affect individual health—and unearthing solutions—is a vast and underexplored challenge that shouts for collaborative biomedical, behavioral and social research. UCSF's Center for Health and Community (CHC) was created to meet that

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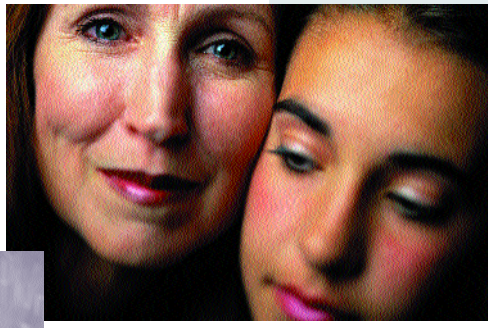
Volume 1, Number 1 June 2000

University of California San Francisco

UCSF

Center for Health & Community

Health disparities begin at birth...



The mission of the Center for Health and Community is to:

Facilitate multidisciplinary research that will provide more comprehensive understanding of problems of health, illness and health care

Develop and test new strategies for research and interventions to promote health, prevent disease and facilitate recovery

Provide more integrated teaching of basic and applied aspects of social and behavioral sciences, epidemiology and health policy to students in all four professional school.

Establish collaborative partnerships with community groups that enable the Center to fulfill its educational, research, and service priorities

As co-director of the Center for Reproductive Health Research and Policy, Claire Brindis is helping put the brakes on unwanted teen pregnancies in California. Together with UCSF obstetrician and gynecologist Phil Darney, Brindis is leading a team of experts in a cost-benefit analysis of California's Family Planning, Access, Care, and Treatment (PACT) program. Their preliminary work has already demonstrated that Family PACT—which now serves over one million young women each year and is expanding to reach young men as well—has saved $4.48 for every dollar invested. These findings were a major factor in the federal government's decision to set aside $900 million over the next five years for teen pregnancy prevention in California.

But while pleased with the financial support and the decrease in teen pregnancies that the program has achieved, Brindis knows the problem is far from solved. By 2005, the number of teenagers in California will have increased 34% in 10 years, double the rate of other states. Young people of color, who have less money and higher rates of teen pregnancy, will fuel a good portion of that growth—creating a need for tailored messages.

"You have to keep an ear out for sentinel events," says Brindis, who remembers a young Latina woman who felt she had to have a baby because the father wanted to ensure that someone would be around to take care of his mother after what he assumed would be his early death. "This was a clear sign that there was something going on that had slipped under the radar," says Brindis. She notes that such stories can help open new avenues of research and point the way to solutions. How can we target young males in pregnancy prevention programs? If we know academic failure is a great predictor of teen health risks and teen pregnancy, how can we link this to public policy and pregnancy prevention?

Beyond teens

Health disparities around birth, of course, go beyond teens. Paula Braveman, a physician trained in epidemiology, and her colleague Susan Egerter have studied social disparities in maternal and infant health for over 15 years. Their 1989 New England Journal of Medicine paper on health disparities among newborns attracted national attention as one of the first pieces of evidence refuting a widely held hypothesis that the uninsured were "electively uninsured" because they were unusually healthy.

More recently, Braveman, Egerter, and Kristen Marchi have documented that level of income affects whether women initiate prenatal care during their first trimester of pregnancy—a critical period for the health of a newborn. As an outgrowth of that work, Braveman and

"Job loss is as an important risk factor for worsening health as high blood pressure, smoking, or obesity."

CHC researchers help:

- Prevent early childhood tooth decay in poor populations
- Understand the hidden health costs of unemployment or low wages
- Document the importance of minority physicians in caring for poor and minority populations
- Reduce smoking in minority populations
- Increase the rate of preventative cancer screening
- Improve communication between health professionals and their patients
- Reduce teen pregnancies
- Reduce the number of children in poverty
- Attain better access to prenatal care for poor women and women of color

continue throughout life...

Egerter are helping the state of California conduct an annual survey around birth weight and other indicators of the health of mothers and babies. Their goal is to produce policy-relevant information about health disparities that can then be used to improve care.

In an era of information overload, the Brindis and Braveman projects are filling the need for synthesized information. Says Brindis, "Individuals, health care providers, and policy-makers have to be able to make sense of it and make wise decisions about health moving forward." She believes a multidisciplinary approach is crucial. "Bringing together other disciplines challenges our conceptions and creates new and more effective frames for how we gather information and communicate our research."

Health disparities begin at birth, but they trail Americans throughout their lives.

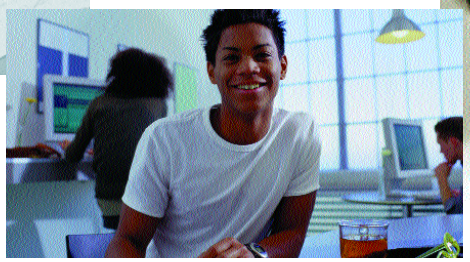
Jane Weintraub, Lee Hysan Professor, UCSF School of Dentistry, knows firsthand how these disparities affect young children. At San Francisco health centers, approximately 30% of children under age six—especially Latino and Asian children—already have Early Childhood Caries, a form of tooth decay that can be quite severe and expensive to treat. In response, Weintraub and Francisco Ramos-Gomez are leading an NIH-sponsored study that will enable researchers to identify children at risk for early tooth decay and test measures to prevent disease. Along with colleagues from the CHC, Weintraub is also proposing a center that will support research into why 2- to 4-year-old children from poor families are four times more likely to have untreated tooth decay than children from families with middle or high income. The center would design and implement ways to reduce or prevent the disparities.

At work

Not surprisingly, childhood disparities continue once we enter the workplace. Ed Yelin is principal investigator on the California Work and Health Survey, an effort to understand how work and workplace benefits affect everyone's health. To date, the survey has found little evidence that long hours or demanding working conditions have noticeable health effects. Rather, it is losing a job and working for low wages that have the most immediate impact.

The study has documented that people who lose their job are twice as likely to experience a decline in health than those who don't. (And those with health problems are more than twice as likely to lose their job.) Yelin adds, "This disproportionately affects people of color. African-Americans, Latinos, and those with low levels of education

include, but are not limited to health care...



were substantially and significantly more likely to experience job loss in our survey."

The study also found that the "working poor" were twice as likely to experience a worsening of health than those who were above that level. Here again, in California 30% of employed Latinos live in poverty, as do 21% of employed African-Americans.

Yelin and his colleagues are now spending a lot of time in Sacramento, helping legislators understand the consequences of these findings. "We need to make employers and policy-makers aware of the hidden health costs related to layoffs and low wages," says Yelin. "We also need to educate providers so that they understand that job loss is as an important risk factor for worsening health as high blood pressure, smoking, or obesity."

In minority communities

If patients are from minority communities, finding a doctor—or any health professional—may be difficult. According to a 1996 New England Journal of Medicine article, co-authored by CHC member physician Kevin Grumbach, California communities with high proportions of black and Hispanic residents were four times as likely as others to have a shortage of physicians. In his subsequent research, Grumbach has documented that those shortages extend to many of the health professions. Nurses, nurse practitioners, and dentists are all harder to find in minority communities. So are fully staffed hospitals. Grumbach's work has also noted that black and Hispanic physicians are disproportionately responsible for care in these communities, but since the dismantling of affirmative action in California, minority enrollment in medical schools has declined. This deepens the already increased threats to health.

Such findings explain Grumbach's involvement with a community task force in the San Francisco community of Bayview Hunters Point. The group addresses community concerns about high rates of disease among community residents and environmental hazards in the neighborhoods. "This is an attempt to get out of the ivory tower and engage a community of people in examining their key health concerns," says Grumbach. "It's helped empower the community...now we have to translate that into action."

As we age

UCSF physician Eliseo Perez-Stable, director of the Center for Aging in Diverse Communities (CADC), is also interested in improving the overall health of poor and minority communities, particularly that of older residents.

Perez-Stable believes that disparities in health care are often characterized by difficulties in cross-cultural communication between patients and health professionals. His belief stems from a number of studies. He mentions one in particular on heart care that found African-Americans were less likely to get bypass surgery and less likely to get catheterization. For these particular procedures, the differences did not appear to be due to disease severity or socioeconomic status. Perez-Stable acknowledges that one conclusion would be racism, but says, "Discrimination alone seems too simple. Somehow the risks and benefits of these procedures were not being adequately communicated or understood."

To help alleviate the disparities—and understand better how health professionals communicate cross-culturally—the CADC is determined to develop:

- Minority investigators, because minorities are underrepresented in much of the research in health care, partly out of mistrust of the process.
- Effective measures of self-reporting, since the current methods for gathering information from minorities tend to be less effective than they are for non-Hispanic whites.
- Community outreach efforts that match investigators with community-based organizations in order to increase the involvement of underrepresented communities in both research and their own medical care.

Perez-Stable already has a formidable record of community health activism.

> "...high proportions of black and Hispanic residents were four times as likely as others to have a shortage of physicians."

CHC researchers help:

- Identify the health consequences of being uninsured on chronic illness
- Understand the role community clinics play in managing illness for uninsured populations
- Identify the barriers to care for insured minorities
- Expand ways to measure the quality of care specific to minority populations

He has worked with the National Cancer Institute to develop a self-help guide for smoking cessation and, in San Francisco, helped develop a program that encourages Latina women over 50 to come back for second mammograms and pap smears. He also works with physicians and case managers to help them understand some of the communication gaps they may experience with minority populations.

It is nearly impossible to separate the way we finance and deliver health care in this country from health disparities that continue to plague us. Here again, the heated debates about managed care, the uninsured, and government-financed care tend to be emotional and politicized, not always informed by objective reality. CHC faculty members are in the reality-check business.

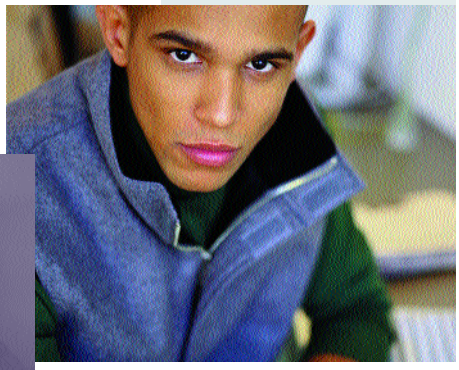
Anthropologist Gay Becker, for example, has written extensively about the way health care crises affect people's lives and how individuals cope with those crises. In her recent work, Becker conducted a series of interviews with members of ethnic minorities who had chronic illnesses, such as asthma, diabetes or congestive heart failure. The interviews lend a human face to what it means to have one of these diseases without insurance. "There is no question that the uninsured found their illnesses more harrowing and more bewildering," says Becker. In her work, African-Americans and Latinos were uninsured in much larger percentages than other groups interviewed—a finding that echoes earlier studies.

The lack of insurance often has a devastating and mushrooming effect on individual health. Becker's interviews confirmed that the uninsured are more likely to delay seeking medical care, unlikely to seek it except in a medical emergency, and often go long periods of time unmedicated or undermedicated for their chronic condition. Usually, by the time they do seek care in emergency rooms or free clinics, the problem is advanced or acute. To make the disparity worse, the uninsured have considerably less knowledge about their illness than those who were insured, have more trouble controlling the illness because they do not follow basic self-care procedures, and take more risks.

Becker's paper also argues that community and low-income clinics play a critical role in the health of the uninsured, and so must take it upon themselves to educate their patients about managing chronic disease.

The impact of managed care

But while insurance and more active community clinics might help provide continuity of care, Kathryn Phillips has discovered that it may not solve some of the other barriers to good health. In her recent work, Phillips and her colleagues have found that such things as



long wait times for an appointment or unresponsive providers can decrease the quality of medical care, particularly for Hispanics and Asian-Americans.

In a study published in the July/August 2000 Health Affairs, Phillips and her colleagues describe barriers to care reported by racial and ethnic groups—and explore the extent to which these barriers vary between those enrolled in managed care versus non-managed care plans. The study found that while most insured people express satisfaction with their care, a substantial percentage report barriers. Minorities were more likely than non-Hispanic whites to report these problems, regardless of the type of insurance, with Hispanics and Asian-Americans reporting these problems in the biggest numbers. "Race and ethnicity," says Phillips, "are among the key individual predictors of access barriers."

Phillips believes the study can be used in a number of significant ways, beyond pointing the way to more research. Most notably, she believes that we might begin using access barriers as legitimate measures of the quality of care. She also believes the access barriers might be used to measure how proposed and current policy changes differentially affect racial and ethnic groups.

As befits the international reputation of UCSF, the CHC's work extends across the nation and around the world.

CHC director Nancy Adler, for example, heads The MacArthur Foundation Research Network on Socioeconomic Status and Health. This international group of scientists has already established that the influence of socioeconomic status goes beyond the poor or uneducated, and affects everyone, regardless of their position in the socioeconomic hierarchy.

Now these scientists are tracing the paths by which socioeconomic factors influence health. Stress exposure is one clear path. Adler and her colleagues have shown that the lower people are on the socioeconomic hierarchy, the more that constant adaptations to stress inflict wear-and-tear on the body. The more stress-related wear-and-tear, the much higher the risk for disease and early death.

But Adler's group has also found that psychological factors may mediate this process. That is, how individuals perceive their social standing is equally or more strongly related to their physical and mental health than objective factors, such as education, income, or occupation. A recent volume of Annals of the New York Academy of Sciences, co-edited by Adler, examines in considerable detail the relationship between socioeconomic status and health in industrial nations.

Working for world health

Other CHC researchers are studying health disparities as they affect people all over the world, focusing particularly on the poor in low- and middle-income countries who have difficulty gaining access to high-quality medical care. CHC member Richard Feachem is one of 17 leading economists and policymakers from around the world appointed to the Commission on Macroeconomics and Health (CMH). The CMH was convened by the World Health Organization (WHO) to clarify linkages between health and macroeconomic development.

Feachem co-chairs one of the CMH Working Groups, dedicated to the study of "international public goods" for health. ""Public goods' is an economic concept that refers to goods that won't be supplied naturally by markets but that, if adequately supplied, will yield positive benefits for the international community," says Feachem's colleague and Policy Advisor to the CMH, Carol Medlin. The group examines three areas in particular: research, communicable disease, and information. The research piece will focus on incentives for R&D on drugs and vaccines for the poor, specifically, and the need for long-term capacity building of interna-

"How individuals perceive their social standing is equally or more strongly related to their physical and mental health than objective factors, such as education, income, or occupation."

CHC researchers help:

- **Deepen our understanding of how socioeconomic status affects health in all people**
- **Bring more health services and information to poor people around the globe, as well as insight to policy-makers and clinicians who are trying to improve care.**

tional research networks, generally. The communicable disease component will focus on preventing cross-border spread of infectious disease, the global spread of drug resistance, and achieving disease eradication—all of which require an international response. The information piece will focus on the collection and dissemination of information for the purpose of international disease surveillance and the standardization of health care data to allow cross-country comparisons.

Feachem also directs the Institute for Global Health (IGH), established in 1999 by the University of California, San Francisco (UCSF) and the University of California, Berkeley (UCB) in close collaboration with Stanford University and with leading corporations and organizations in the Bay Area. The mission of IGH is to improve health and increase access to effective and affordable health services in all countries by conducting research, developing and evaluating policy, providing high-level training, and forging consensus among leading scientists and policy-makers.

CHC's Paula Braveman also works to decrease health disparities globally. From 1995 to 1999, Braveman co-directed a WHO initiative on Equity in Health and Health Care. The initiative provided objective evidence about widening inequities in wealth and ways to monitor them, information that helped policy-makers understand the health impacts of their decisions upon the most vulnerable segments of their population.

Braveman, who also specializes in maternal health, believes joining her own expertise in epidemiology with that of social scientists is crucial. "The issues I examine need the perspective and insight of social scientists," she says. "The Center for Health and Community is important because it fosters and promotes that kind of collaboration."

Exchange is published by the Center for Health and Community at the University of California, San Francisco
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exchange

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challenge by bringing together over 250 clinicians and researchers who bridge the gap between medicine and social science. To advance our mission, we have identified four focus areas for research: health care delivery, community health, methodologies and measurement, and key populations and health problems. We shed light on these topics by fostering collaborative research efforts both within and outside UCSF, as well as creative partnerships with communities, clinicians, and policy-makers who are crafting and implementing solutions.

This inaugural newsletter focuses on health disparities because they cut across so much of what we do and because our keynote speaker at our September 14 symposium—Surgeon General David Satcher—has led the fight to make avoidable health disparities a national health priority.

> "No matter how much glory flows from unlocking biological mysteries and performing miracle surgeries, it is old-fashioned human behavior and social forces that drive an overwhelming percentage of health risk in this country."

The litany of preventable ills is well-known. People of lower socioeconomic status (disproportionately people of color) experience more chronic and acute stress and have markedly higher rates of ill health and premature death. They are also more socially isolated, prone to depression and hostility, and likely to live and work in environments that are hazardous to health. Yet no one has put together a framework for understanding the multiple ways that social, cultural and economic factors help to create these persistent disparities in health and well-being. Consequently, countermeasures have been slow to emerge.

At the CHC, we have begun that task. By documenting disparities and uncovering the reasons they exist, our faculty are shaping and informing the debate and, we believe, moving us toward more effective solutions. Prevention, as well as detection, treatment and education, are at the heart of our mission.

Nancy Adler

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