

PLACE MATTERS Design Lab Eleven: Poverty as a Social Determinant of Health*September 30 - October 2, 2009 ■ Martin Luther King, Jr. County**Prepared by: Vincent Lafronza, Ed.D., M.S., and Natalie Burke
CommonHealth ACTION Principals, and HPI Senior Consultants***OVERVIEW & PURPOSE**

We are delighted you will join us for our eleventh Design Lab (DL) learning experience. Building on previous labs, our national learning community will convene in Martin Luther King County in Seattle to support their *PLACE MATTERS* efforts. We greatly appreciate the King County Team's willingness to host us and organize the tour of their community. Additionally, we extend a warm *PLACE MATTERS* welcome to our special guest speakers.

For the benefit of all participants, and especially for new members of our national learning community, this concept paper provides a brief overview of the *PLACE MATTERS* initiative and context for the meeting in Seattle. Building on all previous DL concept papers (Concept Papers from DL1 to DL10 are available online:

<http://jointcenter.org/hpi/pages/design-labs>). The contents herein are intended to frame Design Lab 11 and to provide a brief overview of the *PLACE MATTERS* initiative for new Team members. Similar to previous meetings, DL11 provides an opportunity for peer networking and collaborative learning across *PLACE MATTERS* communities through discussion and strategizing within and among your Teams. In 2008,

program planners identified youth development and poverty as important themes for our 2009 programming. Towards this end, DL11 provides an opportunity to explore poverty as a social determinant of health.

Design Lab Eleven: Meeting Goals

1. Explore Martin Luther King County's Equity and Social Justice Initiative's progress.
2. Enhance capacity of Teams to communicate social determinants of health and the interrelationships among 'place'.
3. Enhance the development capacity of Teams to secure additional resources.
4. Enhance the capacity of Teams to convey effectively messages about *PLACE MATTERS* from both local and national perspectives
5. Explore the causes of poverty and its role as a social determinant of health.
6. Explore challenges and strategies to achieve health equity for the Hispanic population.
7. Explore opportunities provided by the American Recovery and Reinvestment Act and inform poverty prevention opportunities.
8. Engage in national learning community activities that support the continued development and implementation of county strategy plans.
9. Engage in Team building activities.
10. Convene and network with colleagues participating in *PLACE MATTERS* jurisdictions.
11. Provide a safe place to brainstorm new and innovative approaches.

POVERTY IN THE UNITED STATES

Poverty is a condition whereby individuals and families lack sufficient resources or income for basic survival. Extreme poverty is characterized by a lack of basic needs such as clean water, nutrition, food, clothing, shelter, and essential services to support living. While the world's poorest people do not reside in the US, poverty remains a significant challenge for many US residents, and especially, for people of color and for new immigrants.¹ In fact, compared with all industrialized nations, the US continues to have

¹To define poverty, the U.S. Census Bureau utilizes a set of money income thresholds that vary by family size and composition. A family, along with each individual in it, is considered poor if the family's total income is less than that family's threshold. The poverty thresholds do not vary geographically and are updated annually for inflation using the Consumer Price Index. The official poverty definition counts money income before taxes and does not include capital gains and noncash benefits (such as public housing, Medicaid, and food stamps). Race groups include persons of Hispanic origin. SOURCE: U.S. Department of Commerce, Census Bureau, American Community Survey, unpublished data, 2003.

the greatest levels of poverty within any wealthy country. Additionally, the US has the greatest disparities in health status.

Throughout the world, adverse health impacts from extreme poverty include severe malnutrition, infectious disease outbreaks, famine, and sometimes, war. Common impacts in the US include poor nutrition, mental illness, higher rates of chronic disease, lower educational attainment, and high crime and substance abuse rates. These outcomes result in a significantly lower life expectancy rate relative to countries with less inequity and greater safety net resources. As of 2009, the US Central Intelligence Agency data show the US losing ground with a rank of 50th in life expectancy, meaning that 49 nations have a higher life expectancy.² This poor ranking is particularly concerning because life expectancy of a nation reflects an overall quality of life measure.

The global causes of poverty remain complex. Since the beginning of any recorded human history, poverty has plagued human kind. Important causal factors include overpopulation, unequal distribution of resources, high living standards and costs of living, environmental degradation, inadequate education, inadequate employment, economic trends, political exploitation, structural racism, and cycles of low expectations associated with welfare states.³ But while opinions regarding poverty’s causes may vary, scientific evidence regarding the relationship between life expectancy and economics is clear – higher income is directly related to increases in life expectancy. Social epidemiologists refer to this as the socioeconomic health gradient.⁴

The direct effects of economic recessions on population health status are puzzling. Historically, economic recessions are positively correlated with mortality rates, meaning that mortality rates rise with economic expansions and drop with contractions (this is a procyclical relationship).⁵ While this complex finding may be counterintuitive, it is shown to be a consistent effect throughout industrialized nations. There are many complex reasons for these patterns, including an overall reduction in high risk activities during times of recession.

At the same time, a complex relationship exists between the safety net resources available to a given population and the extent to which economic booms and busts impact population health. For instance, data from Japan clearly show that shared economic growth (resources distributed

Category	Number (in thousands)	Percent
All children under 18	13,324	18.0
White only, non-Hispanic	4,255	10.1
Black	4,178	33.7
Hispanic	4,482	28.6
Asian	431	11.9

more equally across society) can indeed result in better health outcomes.⁶ Cuba provides another illustration of the beneficial impact of equity: “The equitable nature of health status in Cuba is reflected in, for example, the remarkably small health disparities that divide Afro-Cubans and whites in that country.” In countries like Cuba where an abundance of safety net resources are in place and greater equity exists across health outcomes, Cubans live as long or longer than populations of wealthy nations. Thus, absolute wealth or economic growth within industrialized countries does not drive health status. Rather, how a nation’s resources are distributed across an entire population has a more significant effect on health status.

² See <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2102rank.html>.

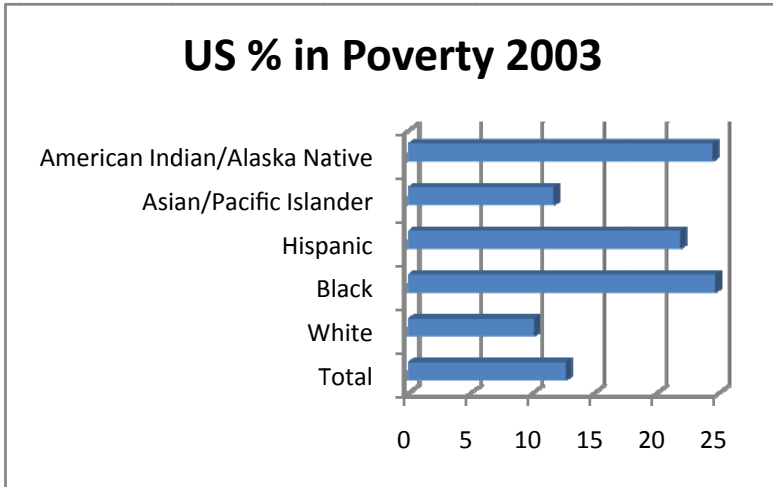
³ From *Fight Poverty* at www.mmbrico.com.

⁴ Adler NE, Boyce T, Chesney MA et al. Socioeconomic status and health. The challenge of the gradient. *American Psychologist*, 1994;49:15–24.

⁵ Bezruchka, S. The effect of economic recession on population health. *Canadian Medical Association Journal*, 2009;181(5).

⁶ *Ibid*, p. 281.

Additionally, Dehejia and Lleras-Muney reported better early life outcomes in the United States for mothers who conceive children during higher unemployment periods.⁷ This positive impact also was shown to reduce post-neonatal mortality rates.

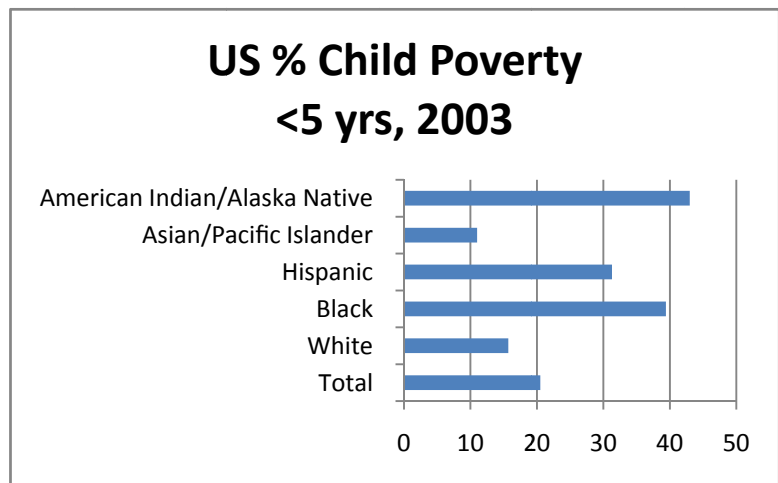


But recession studies often do not explore the long-term impacts of unemployment beyond the early years of life. Prolonged poverty, which differs from times of recession, consistently results in increased mortality, even given the shift from infectious to chronic disease risks.⁸

Recent figures from the US Census Bureau estimate an increase in the poverty rate from 12.5% in 2007 to 13.2% in 2008.⁹ This means that nearly 40 million people live in poverty in the US. Increasing

poverty is also associated with higher un- and under-insurance and chronic unemployment rates. The 2008 poverty rate for African Americans remains unchanged at 24.7%; for Hispanics and Asians, the poverty rate increased to 23.2% and 11.8%, respectively.

We also know that children living in the US experience a disproportionate burden of poverty relative to their adult counterparts, as children comprise approximately 25 percent of the total population but fall within 35 percent of the population living in poverty as defined by the federal government.¹⁰ And households led by single women of color fall within the highest poverty levels in the US.



The current economic recession provides unique opportunities for improving population health status. A *PLACE MATTERS* frame prompts us to ask important questions. Why is the current recession impacting some communities more than others? What policies can be developed to strengthen the safety net

available to all individuals and families most impacted by the recession? How might we best position communities to compete in the global market, through greater investments in education, and other approaches? How do we best communicate such issues of systemic inequity to policy makers and influential groups? Advocating for policies that strengthen our social safety net, invest in children and youth, structure economic policies that reduce inequalities in wealth, and support heads of single households should remain among our highest priorities.

⁷ Dehejia, R., & Lleras-Muney, A. Booms, Busts, and Babies' Health. *The Quarterly Journal of Economics*, 2004.

⁸ See <http://www.physorg.com/news171865398.html>.

⁹ Income, Poverty, and Health Insurance Coverage in the United States: 2008. US Census Bureau.

¹⁰ U.S. Bureau of the Census. *Income, Poverty, and Health Insurance Coverage in the United States, 2007*, Report P60, n. 235, Table B-2, pp. 60-5.

TOURING MARTIN LUTHER KING COUNTY

[Contributed By the King County PLACE MATTERS Team]

At first sight, the Seattle-King County area in the Pacific Northwest seems to be a land of wealth and good living. It is the epicenter of major industries such as Microsoft, Boeing and Starbucks. But take a closer look: the region's social inequities mirror national trends, and many communities are losing ground.

One government entity in the Pacific Northwest is tackling the problem directly. King County's Equity and Social Justice Initiative seeks to create a place of opportunity, fairness, equity and social justice where all people thrive.

King County stretches from the shores of Puget Sound to the western slopes of the Cascade Mountains. King County's 1.9 million people are about 70% white. Asian communities comprise 13.4% of the total population, Latinos 6.8%, African Americans 5.3% and mixed-race 3.2%. The Seattle-King County area has a national reputation for being politically progressive and culturally diverse.

The area's indigenous peoples included the following tribes: Duwamish, Snoqualmie, and Muckleshoot, including Stkamish, Yilalkoamish, Skopamish, Smulkamish, and Tkwakwamish on the Green and White rivers. During the late 1700s, diseases introduced by explorers disturbed the indigenous way of life. By the time settlers arrived in 1852, the American Indian population was much reduced. As commerce expanded to include hop-growing, logging, coal mining, and fishing and canning there was increased demand for transportation. In King County goods and people moved first in canoes, then on steamships, followed by railways, and streetcars in the late 1880's – 1900's.

Immigrants into King County during the 1880s and 1890s included Chinese, Russians, Greeks, Serbs, Sikhs, Filipinos, and Sephardic Jews. In the mid-1880s anti-Chinese hysteria raised its ugly head. In Squak (later Issaquah), white and American Indian hop-pickers attacked Chinese laborers brought in to pick at a lower price. The following year a white mob in Seattle forced Chinese residents out of town. King County's Chinese communities took years to recover.

Seattle grew by annexation, doubling in size in 1891, and doubling again in 1907. About this time, William Boeing discovered flying. He founded the predecessor of Boeing Airplane Co. in 1917. The firm pioneered international airmail, built aircraft for World War I, and founded United Airlines before federal regulators broke the company into its parts in 1934. The firm has sustained large segments of the economy of King County to the present day.

During the Vietnam War era, the region experienced the upheavals and reforms of the rest of the country. Young men went to war and students protested the war. Black contractors and their white allies picketed all-white construction sites. American Indians and Alaska Natives conducted fish-ins to regain their treaty fishing rights. Black students at the University of Washington founded the Black Student Union and prevailed upon the administration to begin Black Studies. Chicano students organized. Women organized. The National Organization for Women formed its Seattle chapter in 1970. The environment became a concern. In Seattle the first Earth Day was observed in 1970. And in 1975 two young men founded a small computer firm that would come to equal Boeing in its impact on the county: Microsoft.

The history of the Pacific Northwest reflects the complexities of the nation's ongoing struggle to achieve racial and social equity. Early trading relationships between Northwest tribes and European settlers soon

gave way to armed conflict, usurpation of land and establishment of tribal reservations. Chinese, Japanese, Filipino and other Asian communities succeeded in establishing strong communities, yet experienced periodic waves of repression, legal containment or expulsion. The most infamous of these was the forced relocation and internment of approximately 110,000 Japanese Americans in 1942 under Executive Order 9066. African Americans migrated to Seattle-King County to escape Jim Crow conditions in other parts of the country; once they arrived, they were forced to navigate a seldom-acknowledged system of restricted employment and segregated housing. Prior to the civil rights movement, African Americans and other people of color in Seattle were systematically excluded from higher education and many professions and industries. The current racial makeup of Seattle neighborhoods is a legacy of restrictive, race-based covenants and redlining that were common in Seattle until the early 1950s. In 1964, the voters of Seattle voted down a local “Open Housing” initiative by a margin of two to one.

When it comes to racial and other systemic inequities, Seattle-King County in 2009 is no different than any other city in the United States. Race influences where we live, where we work, how well we do in school, how long we will live, and the likelihood of our involvement in the criminal justice system. To this day, people of color in Seattle-King County account for a disproportionate number of people living in poverty. In 2006, the poverty rate of American Indians/Alaska Natives and African Americans was 30%. People of color also continue to experience discrimination in employment, housing, education and public places. Significant inequities exist in environmental justice, criminal justice, health and education.

Geography still plays a part in defining inequities. The north ends of both Seattle and King County, which historically were racially restricted areas, continue to have better outcomes in health, education and other indicators.

A Snapshot of Inequity in King County

Workforce and Economic Development

- According to the 2008 Communities Report¹, only 46% of jobs in King County pay a living wage that would be sufficient for a family of four with two fulltime employed adults (\$35,687 per worker). 76% of jobs do not pay a living wage for a single parent with two children (\$58,293).
- In 2007, the median income of African American households was 51% of the median income earned by white households in King County. This declined from 64% in 2000.¹
- 29.1% of African Americans in King County lived below 100% of the federal poverty level in 2007, almost four times greater than that for whites (7.6%). In 2007, the poverty level was \$20,650 for a family of four.¹

Criminal Justice

- In 2005, the per capita custody rate for felonies among young African American men was 2,608 per 100,000 males age 18 to 24, which is about seven times as likely to be incarcerated for a felony as white males the same age.²
- Youth of color (ages 10 to 17) in King County are almost six times as likely as white youth to be held in a state or county juvenile detention facility. *Good News:* The number of youth in custody declined by 42% from 2000 to 2005. *Bad News:* The racial disparity slightly worsened over that time period.³

Family Support and Child Welfare

- Children of color in King County are more likely to live in single-parent households: white children 18%, African American children 47%, American Indian and Alaskan Native children 37%, and Latino children 25%.⁴
- In 2004, American Indian and Alaskan Native children in King County were nine times as likely as white children to be in the foster care placement over 60 days.⁵

Education

- Educational attainment varies by region in King County. According to the US Census, in 1999 the percentage of adults ages 25 and older without a high school diploma in east King County was 5.5%. These percentages varied from 7.3% in north King County, and 10.5% in Seattle, to 13.4% in south King County.⁴
- In 2007, 46.6% of whites ages 25 and older in King County have a bachelor's degree or higher educational attainment, more than twice as likely as African Americans in the same age group to have a bachelor's degree or higher educational attainment (19.8%).⁶

Housing and Homelessness

- People of color account for almost 30% of residents in King County but accounted for 64% of the sheltered and transitional housing homeless population according to the 2008 One Night Count.⁷
- African Americans account for 5.4% of the population in King County, yet they accounted for 40% of the emergency sheltered and transitional housing homeless population.⁷

Health

- Averaging over 2003-2007 in King County, American Indian and Alaskan Native infants were almost four times (13.7 per 1,000 live births) as likely and African American infants twice as likely (8.6) to die in the first year of life than white (3.8), Asian/Pacific Islander (3.8), and Latino (4.2) infants.⁸
- Averaging over 2003-2007, age-adjusted mortality rates for diabetes among African Americans (57.7 deaths per 100,000 people) and American Indian/Alaskan Natives (42.8) were higher than death rates among Asian/Pacific Islanders (23.1), Latinos (27.0) and whites (18.1).⁹

Data Sources:

1. Communities Count 2008: Social and Health Indicators Across King County. 2008. Communities Count Initiative. Produced by Public Health-Seattle & King County; Assessment, Policy Development, and Evaluation Unit. www.communitiescount.org
2. King County Department of Adult and Juvenile Detention.
3. King County Department of Adult and Juvenile Detention and Washington State Juvenile Rehabilitation Administration. Prepared by King County Office of Strategic Planning and Performance Management.
4. 2000 Decennial Census. US Census Bureau. Prepared by Public Health-Seattle & King County; Assessment, Policy Development, and Evaluation Unit, 7/2009.
5. Washington State Racial Disproportionality Advisory Committee and the Department of Social and Health Services (2008). Racial Disproportionality in Washington State. Olympia, WA. Page 93. Available at: <http://www.dshs.wa.gov/ca/pubs/DisproportionalityReport.asp>
6. American Community Survey, 2007. US Census Bureau. Prepared by Public Health-Seattle & King County; Assessment, Policy Development, and Evaluation Unit, 7/2009.
7. 2008 Annual One Night Count of People Who Are Homeless in King County, WA. Report prepared by Seattle/King County Coalition on Homelessness. Available at: your.kingcounty.gov/dchs/csd/Housing/Reports/OneNightCount2008.pdf

8. Linked Birth/Death Certificate Data: Washington State Department of Health, Center for Health Statistics. Prepared by Public Health-Seattle & King County; Assessment, Policy Development, and Evaluation Unit, 7/2009.

9. Death Certificate Data: Washington State Department of Health, Center for Health Statistics. 1990-2008 Population Estimates: Population Estimates for Public Health Assessment, Washington State Department of Health, Vista Partnership, and Krupski Consulting. January 2009. Prepared by Public Health-Seattle & King County; Assessment, Policy Development, and Evaluation Unit, 7/2009.

PLACE MATTERS FRAMEWORK – BRIEF RECAP

PLACE MATTERS is a national initiative of the Joint Center for Political and Economic Studies, Health Policy Institute (HPI) designed to improve the health of participating communities by addressing social conditions that lead to poor health.

The Joint Center Health Policy Institute (HPI) approach to reducing/eliminating health disparities involves identifying the complex underlying causes of health disparities and defining strategies to address these root causes. A growing body of research clearly supports the notion that interventions targeting social determinants of health can indeed modify patterns of health, illness, and health disparities. Systematic and evidence-based translation of this knowledge into policy and practice remains limited. Targeting upstream causes of health and measuring the indicators associated with social determinants of health are at the heart of our *PLACE MATTERS* work. ***Over a period of three to five years, PLACE MATTERS participants should be able to demonstrate and document progress, as well as the reasons for progress, toward redressing the social conditions associated with health inequities—and thereby toward reducing health disparities.***

PLACE MATTERS Unique emphases:

1. engage communities of color with poor population health status;
2. support multidisciplinary teams vis-à-vis a national learning community (supportive laboratory);
3. reduce/eliminate health inequities by addressing social determinants of health (i.e., actions should specifically address social issues at their roots, e.g., housing policies, etc.);
4. develop benchmarks and other means to monitor progress that demonstrates the effectiveness of addressing social determinants of health; and
5. document lessons learned and outcomes of addressing social determinants of health.

This Design Lab will indeed be another valuable opportunity for our *PLACE MATTERS* learning community and will serve as a critical building block in each Team's work to address the social factors that produce poor health outcomes thereby creating health equity. We hope you will find this *working meeting* productive and invite you to leverage your participation in *PLACE MATTERS* to enhance your efforts and to strengthen your capacity to improve the health and well-being of your community. We invite DL11 participants to arrive prepared to:

- further develop Team communications strategies that frame social determinants of health (**to be well prepared, we encourage all participants to review all preparatory meeting materials in advance**);
- engage in teamwork, taking advantage of formal and informal opportunities to solidify Team activities and to advance strategic action plans;
- enhance existing logic models to include communications activities;
- consider opportunities associated with the recession to strengthen the safety nets available to your communities; and
- seek opportunities to network with *PLACE MATTERS* sites to benefit your local *PLACE MATTERS* work.

We look forward to seeing you in Seattle!

PLACE MATTERS Communities

