

UNNATURAL CAUSES...is inequality making us sick?

A four-hour series airing on PBS and a national public impact campaign

ASK THE EXPERTS FORUM #3: MYTHS ABOUT HEALTH INEQUITIES

William Dow, Tony Iton, Dennis Raphael, and David Williams discuss diet, universal health care, the economic costs of poor health, the "healthy immigrant effect," and the difference between health disparities and health inequities.

QUESTION #1: Some people talk about health disparities. Others talk about health inequities. What's the difference?

DENNIS RAPHAEL: *Health disparity* is a term that tends to cloak itself in the language of science and epidemiology, and it's a very detached definition of the fact that some people live longer than others and some people are sicker than others. I find *health inequality* much more useful, because it's a relational term; i.e., when you have an inequality, some people have more than others. Finally, *health inequity* is a judgment, a statement of values that the inequalities we are observing are unfair and unjust. Some people would add that they're clearly avoidable.

For further reading, there's Paula Braveman's work¹ and Ichiro Kawachi has an article² on these definitions as well. So to summarize very briefly, *health disparity* is a term that epidemiologists and scientists tend to use to describe differences in health. *Health inequalities* refer to measurable differences in health status and health outcomes. And *health inequities* represent a stronger view that these differences are unjust and unfair and could be avoided if the will were there.

TONY ITON: In my work, we've tried to outline that health disparities are just a way to enter into exploration of these issues. It seems to be a good way to talk about these issues, because people, at least in the healthcare world, have heard of health disparities. But I agree with Dennis that the term is basically empty. I mean, disparity is a difference. So we use the term *health inequities* as soon as we have introduced people to the concept of health disparities to allow them to better understand there's a context to these differences and that these differences are driven disproportionately by factors that are outside the control of individuals. And that's what we think is important.

There is a tendency to individualize these things so we want to make people aware of the social and environmental context of those differences and how individuals cannot shape those environments by themselves.

DAVID WILLIAMS: In my work with the Robert Wood Johnson Commission for Better Health,³ we really don't emphasize any of these terms. We focus on improving the health of the population in general and saying that there are shortfalls in health for some and that some have more progress to make in terms

¹ e.g. Braveman P, Gruskin S. Defining equity in health. *Journal of Epidemiology and Community Health* 2003;57:254-258.

<http://jech.bmj.com/cgi/content/abstract/57/4/254>;

Braveman P. Monitoring Equity in Health and Healthcare: A Conceptual Framework. *Journal of Health, Population and Nutrition* 2003 Sep;21(3):181-192. http://www.icddrb.org/images/jhpn2103_monitoring-equity.pdf;

Braveman P. Health Disparities and Health Equity: Concepts and Measurement *Annual Review of Public Health* 2006;27:167-194 <http://arjournals.annualreviews.org/doi/abs/10.1146/annurev.publhealth.27.021405.102103?journalCode=publhealth>

² Kawachi I, Subramanian S V, Almeida-Filho N. A glossary for health inequalities. *Journal of Epidemiology and Community Health* 2002;56:647-652. <http://jech.bmj.com/cgi/content/abstract/56/9/647>

³ <http://www.commissiononhealth.org/>

of getting up to the optimal. But if you look at the commission's language, we don't focus heavily on disparities, inequities or inequalities, since part of the commission's challenge is trying to work within a bipartisan space.

These words have important meaning. I think *inequities* and *inequalities* are an accurate characterization of the problem, but some feel more comfortable with *health disparities*. In our work we're using the term *health shortfalls*.

QUESTION #2: How can health inequities be framed in economic terms so as to broaden interest in the issue? Is there a way to quantify this cost in terms of its impact on economic development or our ability to compete in a global market?

WILLIAM DOW: For many years, people have argued that there are negative economic effects from preventable illness and premature mortality. Certainly the families of individuals who experience poor health outcomes suffer strong negative economic consequences, particularly since they are likely to be disproportionately poor and have limited means to buffer themselves against such shocks. It has been harder to document these effects at the macroeconomic level, however. The 2001 WHO Commission on Macroeconomics and Health report⁴ summarized a great deal of information on this, and was quite influential, though their report focused on the negative consequences of poor health primarily among less developed countries.

In the United States, I helped write a report called "The Economic Value of Improving the Health of Disadvantaged Americans"⁵ as background for the recently launched Commission to Build a Healthier America. In that report, we translated health disparities into monetary terms using standard estimates of the value of a healthy life year. We estimate that closing education-related disparities in health and mortality would increase the level of "health capital" in this country by over one trillion dollars each year. Quantifying disparities in this manner may help the public and policymakers better understand the magnitude of disparities in comparison with other policy issues competing for attention.

DENNIS RAPHAEL: The OECD recently produced a report that shows the extent to which nations achieve positive labor outcomes such as high economic growth and lower unemployment.⁶ The report identified two pathways to solid economic growth, each with very different assumptions about how to organize a labor market.

The first group includes English-speaking nations such as Australia, Canada, Japan, Korea, New Zealand, Switzerland, the U.K., and the U.S. The other group includes North European countries such as Austria, Denmark, Ireland, the Netherlands, Norway, and Sweden. Table 2 provides a striking contrast between these two groups. Although both produce high employment outcomes, they differ profoundly in the amount of security provided to workers, the generosity of benefits, and the availability of training. Unionization rates are also noticeably different, as is the degree of union coordination in wage negotiation. Although employment and unemployment rates are very similar, they favor the North European nations. Other characteristics of these North European nations have important implications for

⁴ Macroeconomics and Health: Investing in Health for Economic Development. Report of the WHO Commission on Macroeconomics and Health, chaired by Jeffrey D. Sachs. 20 December 2001. <http://www.who.int/macrohealth/background/en>

⁵ Dow W, Schoeni RF. Economic Value of Improving the Health of Disadvantaged Americans, Technical Report for *Overcoming Obstacles to Health*. 21 January 2008. <http://www.commissiononhealth.org/Publications.aspx>

⁶ Organization for Economic Cooperation and Development. (2006a). *OECD economic outlook: Boosting jobs and income*. Paris: Organization for Economic Cooperation and Development. http://www.oecd.org/document/53/0,2340,en_2649_201185_36837109_1_1_1_1,00.html

understanding known health differences among these nations, for example, a significantly lower degree of income inequality and lower rates of relative poverty.

The OECD concludes:

[T]wo striking facts emerge from Table 6.3 when looking at the two groups of countries with good labor market performance. First, on average, extremely different degrees of ‘interventionism’ in almost each selected policy area (with the exception of product market regulation) may lead to very similar employment and unemployment rates. This suggests that there is not a single road for achieving good employment performance. Second, the approach of the second group of countries (North European countries) has a clear budgetary cost. In these countries, governments spend on both active and passive employment measures about 2.5 times more, as a percent of GDP, than is the case in countries belonging to the first group (mainly English speaking countries). And, as regards active measures only, expenditures are more than three times higher. On the other hand, income inequalities as well as relative poverty rates appear to be lower than in the first group of countries. [p. 192].

	High Employment Outcomes			Low Employment Outcomes	
	OECD unweighted average	English-speaking countries mainly ^b	North European countries mainly ^c	Countries of continental and southern Europe, mainly ^d	Countries of eastern Europe ^e
Employment protection legislation	2.01	1.38	2.13	2.71	1.83
Generosity of employment benefit system ^f	27.81	18.23	39.86	36.17	9.59
Active labor market programs ^g	29.25	15.76	64.14	25.84	3.46
Tax wedge ^h	27.10	18.54	27.42	34.33	32.43
Union coverage	59.96	30.75	83.33	82.57	38.33
Union-coordination	2.88	1.88	3.92	3.79	1.33
Product market regulation	1.42	1.20	1.28	1.55	1.97
Employment rate	67.11	70.92	71.91	62.54	58.00
Unemployment rate	7.47	5.30	4.79	8.97	15.12
Total LMP	1.86	.09	2.68	2.60	.82

expenditures ⁱ					
of which ALMP expenditures ^j	.76	.39	1.31	.94	.25
Income inequalities (Gini) ^k	29.35	31.50	25.58	29.85	31.35
Relative poverty rate ^l	9.64	11.78	7.77	9.86	7.06

The findings from the OECD analysis are consistent with others indicating that no incompatibility exists between high labor market performance and a policy environment supportive of both the social determinants of health and population health itself. Indeed, for those concerned with producing employment policies that support health, the conclusions are clear: employment policies can, in fact, support economic growth, encourage labor participation, and reduce unemployment while also supporting health. Such policies are more typical of North European nations, especially the Nordic ones. While the employment policies of English-speaking liberal political economics may also produce high labor market performance, such outcomes clearly come at a high social and health cost.

QUESTION #3: Are Black Americans (especially women) more likely to be obese because of stress or lack of health/medical options?

DAVID WILLIAMS: Clearly, obesity has emerged as a major health problem, here in the U.S. and elsewhere. Nutritional problems – inadequate nutrition, an excess of refined foods, of high fat foods – are a major contributor to obesity, as well as a lack of adequate physical exercise. You can think of obesity as a problem when our overall energy intake is out of balance with our energy expenditure. So lack of medical options *per se* is not a driver of obesity, but stress plays an important role because it provides a context that affects individuals’ practice of health behaviors.

In response to stress, some individuals will eat more to make themselves feel better. So although obesity is frequently viewed as a problem involving major lifestyle factors, we have to step back and ask, what are the larger forces that affect access to good nutrition? How does where a person live determine their access to supermarkets and nutritious foods? How does where a person live, for example, determine their opportunities to find exercise and lead an active lifestyle? So stress is a factor, but it’s one of multiple complex factors outside the individual that shape access to good lifestyles that contribute to optimal health.

TONY ITON: What we’ve found suggests that low-income communities, particularly African American and Latino communities, are really canaries in a coalmine in America. They are a harbinger of things to come for all of us, in that they are more susceptible to the environmental determinants of obesity than are people who have greater access to resources, so consequently they will demonstrate the consequences of these environmental factors before other populations will. But inevitably, if we don’t start to address the environmental determinants of obesity, we will all be facing a much more obese future.

Several recent publications have shown evidence of a plateauing of life expectancies in certain southern counties and lower Midwestern counties of the United States. This suggests that the consequences of obesity and associated chronic diseases are starting to manifest themselves in shorter, sicker lives in certain parts of the United States. And it’s not an isolated phenomenon. We see that in many counties when you do within-county analysis, and we will start to see it more commonly throughout the United States if we don’t start addressing the environmental determinants.

DENNIS RAPHAEL: There's so much focus on obesity – tied into the ideology that it's somehow a voluntary choice – that it tends to divert attention from the sources of the obesity and the possibility that the source of the obesity is actually the same source as other health problems. Some people have argued that obesity is in fact an outcome of the same factors that are driving higher mortality and morbidity—that is, the stress, the deprivation, and experience of adverse living conditions.

I'd like to point out a wonderful article by John Komlos, who's written a variety of related papers, called "From the Tallest to (One of) the Fattest: The Enigmatic Fate of the American Population in the 20th Century."⁷ He points out that in the early part of the 20th century, the American population was among the tallest in the developed world, but now the Dutch, the Swedes, and the Norwegians are the tallest, while Americans have become the heaviest. And he has a nice presentation of how this reflects a weakening of the social safety net and the increased insecurity that Americans experience compared to other populations.

QUESTION #4: How much do violence and drug use contribute to poor health in our inner cities? Can you point to examples where changing the local environment changed people's behaviors?

TONY ITON: This is a common question we get in our health inequity work. We've done quite a bit of work trying to characterize the relative contributions of violence, drug use, and other commonly perceived measures of "inner city life" to the health disparities that we see. One view of violence and drug use is to see them as causes of poor health. Another view, to which I certainly subscribe, is to see them as symptoms.

I suppose it's easy to ascribe violence and drug use to the moral deficiencies of African Americans, Native Americans, Central Americans, or for that matter, Palestinians and even the northern Irish. But there are common, obvious root causes to alcohol and drug use that fester in so many communities in the United States: feelings of oppression, disenfranchisement, post-traumatic stress, and a sense of hopelessness.

There are numerous international studies that have shown that homicide and violence are more common in societies in which income is distributed more unequally, in which there is a wider gap between the rich and the poor. There are also numerous studies showing that crime and violence tend to be higher in areas in which 20% of the residents are poor. These same areas are often characterized by unemployment, high levels of residential instability, family disruption, overcrowded housing, drug distribution networks, and low measures of community participation, as well as high rates of high school dropouts, high rates of teenage pregnancy, and a disproportionate number of households headed by women.

So it's hard to see how this concentration of social factors would be due to individuals choosing to engage in these behaviors just in these geographic places. It makes a little bit more sense to think about those factors clustering in areas where people have essentially lost a sense of hopefulness about the future and are suffering from issues like post-traumatic stress and essentially disengagement, disenfranchisement, from the larger society. I think you can have a philosophical argument about these things, but ultimately, when you're trying to change the levels of violence and drug use in the community, there's no evidence of successful strategies that have been sustained that are focused exclusively on individual behaviors.

However, there are numerous examples of successful strategies that have sought to change the social and physical environment in which these activities are occurring. In our county, we focus pretty heavily on youth development and have built resources for youth in high-violence-plagued neighborhoods to offer afterschool activities, opportunities for career development, opportunities and outlets for musical and

⁷ <http://linkinghub.elsevier.com/retrieve/pii/S1570677X03001011>

artistic exploration. And we've seen violence in these settings decrease dramatically. There are also examples of Housing and Urban Development Hope V initiatives that have rebuilt housing projects from the ground up and have seen profound reductions in drug use and violence.

I don't think it takes a lot of scientific research to see what the determinants of violence and drug use are in cities, not just in America, but around the world. But it requires a fair-minded and open-minded exploration of these issues to come up with strategies that have any promise of working.

I also want to add that we have over four hundred thousand death certificates that we've put into a database and analyzed for the patterns of death over time. We can calculate life expectancy over time, changes in life expectancy by race and ethnicity, and changes in life expectancy by geographic community. What we've seen is that the big gap in life expectancy between African Americans and whites – which has grown dramatically over the past 40 years – is due overwhelmingly to what we would describe as chronic disease – heart disease, cancer, stroke, chronic respiratory disease – and not to relatively exotic diseases like HIV/AIDS, or homicide for that matter. We found that there's a 15-year life expectancy difference between African Americans in West Oakland versus white Americans in the Oakland Hills, and when you subtract out homicide as a contribution to that difference, it only reduces that 15-year difference by one year.⁸

QUESTION #5: New Hispanic immigrants who don't speak English are among the most excluded and isolated groups in society, so wouldn't they suffer worse health outcomes as a result?

DAVID WILLIAMS: Most immigrants migrate to places where there are people they know or where there are relatives or friends. So immigrants are embedded in very rich communities, typically. Now, it's true that they are sometimes isolated from the mainstream as they negotiate their way in a new society. But they are nonetheless embedded in immigrant communities, which are a source of strength, and the networks and community cohesion that many immigrants enjoy during their early time in the United States probably contributes to their good health.

DENNIS RAPHAEL: I'd like to ask a question here. In Canada we have a healthy immigrant effect because in order to immigrate, you have to pass a medical exam or you're not allowed into the country. We also have a lot of people coming from very disorganized communities in Africa, for example, Somalia, and previously Central America. These people have to have the wherewithal to carry out immigration from these disorganized nations and communities and make it to Canada, so frequently you find that immigrants to Canada are very well put together. And what we find is that over a five-year period, they're much more likely to have their health moving from excellent or very good to good or fair.

DAVID WILLIAMS: Legal immigrants to the United States also have to pass a medical exam in order to migrate. There's plenty of evidence that immigrants are a healthier subset than the populations from which they come, just because of the challenges of picking oneself up and migrating to a new land. So that is certainly part of the story.

DENNIS RAPHAEL: To what extent are illegal immigrants being picked up on surveys that are showing the "healthy Hispanic" effect?

TONY ITON: First, let me say a little more about the healthy immigrant effect. We study this in Alameda County, where I work. We've actually created an environment where we can go door to door in

⁸ *Life and Death from Unnatural Causes - Executive Summary*. Report by the Alameda County Public Health Department, April 2008. http://www.acphd.org/user/services/AtoZ_PrgDtls.asp?PrgId=90

communities and ask people questions about their health and how that has changed since they've been in the United States.

It's amazing, but among immigrants, Latinos who represent the poorest subpopulations of our communities in Alameda County and elsewhere in California have overall the best health of anybody in these communities, including well-off whites. We have seen lower rates of hospitalization, lower rates of death, and lower rates of disease in immigrant Latino and Asian populations that are socially—by all the social measures—very poor and living in communities where one would expect high rates of chronic disease and other morbidity.

One of the things I find interesting about this question is the distinction between the social isolation of individuals and social isolation of communities. David touched on this when he pointed out it's false to assume that immigrant Latino populations are socially isolated at the individual level. They do immigrate typically to reunite themselves with family members or community members, and they form very tight social networks that have a health protective quality to them. They're extremely hopeful people; they're looking forward to the future. They're much less likely to engage in smoking and drug use and the kinds of risk behaviors that we associate with poor health outcomes.

So their better health may be a combination of the healthy immigrant effect (meaning it's only healthy people who can make the treacherous journey, legal and illegal, to a place like the United States); traditional or cultural practices and diets that are healthier and less associated with processed food; and/or social networks that protect communities. Ultimately, what changes over time is that they lose that drive, that sense of hopefulness, as America begins to encroach on their collective psyche and their social networks break down. People move, they get different jobs, they might move up the economic ladder, but in any case, they move out of their tight social communities and they come to look and act more like Americans.

QUESTION #6: Do other immigrant groups to the U.S. have a health advantage similar to Latinos? And does it erode for them as well? Is the health advantage true across Latino populations? Which groups are exceptions?

TONY ITON: We see something similar in all immigrant groups. The data is sometimes tricky to find because of the nature of how it's collected and how we describe people, but you see it most prominently in birth outcomes. For example, African immigrants to the United States have better birth outcomes than African Americans, even though you would expect probably the opposite. Certainly every other immigrant group, including white immigrant groups, has better birth outcomes than their American counterparts in the United States. So just looking at that phenomenon tells you something about how America may not be good for your health. And ultimately understanding why that might be the case is critical to ascertaining the factors that are health protective among immigrants.

DAVID WILLIAMS: We've just completed national research on mental health in the United States for Black Caribbean immigrants, Latino immigrants and Asian immigrants. Again, we see the same pattern for all groups: the immigrants do better initially, but with increasing length of time and stay in the United States, the health of Asian immigrants, Latino immigrants, and Black Caribbean immigrants declines. So it seems to be a pretty robust phenomenon across multiple population groups.

TONY ITON: If I could offer just one distinction perhaps—and the data for this is very hard to come by, but we're seeing some of this—and that is between immigrants and refugees. Refugees may come from war-torn areas where there's a lot of post-traumatic stress. They're forcibly dislocated from their ancestral lands and homes. They are not purposely seeking to immigrate; they are reluctantly being caught up in these refugee expatriations. We found that within those populations, we see higher levels of mental stress

and chronic disease, and we think this is related to the conditions and circumstances under which they come to the United States. They are very different from people who are seeking a better future. In most cases, they are frequently people who would not have immigrated otherwise and who may have suffered substantially along the journey, particularly if they've spent years, perhaps decades, in refugee camps, with the psychic trauma that adds to their outlook.

QUESTION #7: If U.S. health inequalities are so bad, why do people from other countries, socialist and communist, choose to come to America for better care?

DENNIS RAPHAEL: First, the United States is the only developed country in the world that doesn't have some form of government-managed healthcare. And the United States is absolutely unique in that the average American is not assured of timely care that's equal to the kind of care that could be achieved by people who are wealthier or who have greater economic resources. There's no doubt that if a person has wealth and money, they can certainly receive the absolute best healthcare in the world by coming to the United States and spending volumes of money. Of course, you all know that the United States spends an incredibly large amount on healthcare, because it's driven by the fact that so much money is being made on it.

I've lived in Canada for 35 years. First of all, I've never known anybody who has gone down to the United States to get healthcare. And second, polls have repeatedly shown that Canadians consider their healthcare system, which is basically government managed but privately delivered through physicians and hospitals, to be superior to the U.S. system. People certainly get to choose. I have access to any number of hospitals or personal physicians that I wish to take care of me.

The issue of public versus private healthcare is heavily politicized in the U.S. Certainly those who are in favor of continuing the healthcare system the way it is will highlight the odd Canadian, the odd Frenchman, or the odd Swede—again, these people would have to be wealthy in order to afford to come to the United States to receive healthcare—but overwhelmingly, what you'll find is that in the United Kingdom, Sweden, and Canada, there is an absolute pride and support of the fact that access to healthcare is not something that people need to worry about.

Our system, which was developed in the late 1950s through the mid-'60s, is publicly financed through general revenues and privately delivered, but non-profit. So your average family physician works for him or herself, but he or she can only charge according to a fee schedule. Similarly, all hospitals are public and non-profit, so we see their funding managed and they have to negotiate with the provincial governments, but again, they are managed independently. But there's a shared ownership among Canadians of the healthcare system.

TONY ITON: I'd just like to add something, if I may. I grew up in Canada and my parents still live there. In the United States, we ration healthcare by ability to pay. In Canada, healthcare is rationed according to need. Everywhere in the world, healthcare is rationed. It is an expensive resource and a critical social resource. In most countries, it is determined to be a right and not a privilege. But in the United States, healthcare is not a right; it is a privilege of wealth.

That is why people who have wealth can come here to purchase the newest level of technology and the highest and greatest technological marvel to diagnose or treat their difficult to treat or cure disease. Of course that's a good thing, but the cost of that is, unfortunately, in the American system, many people who have need but don't have the ability to pay are denied healthcare, and they suffer the physical and psychological consequences of essentially being excluded from this system.

DENNIS RAPHAEL: The other thing I want to mention is that when people talk about a single payer healthcare system or universal healthcare, it's more than the fact that you can go to a doctor when you're

sick. Every Canadian, every Frenchman, and every Swede doesn't have the worry that if they get sick they're going to lose everything. So a universal healthcare system is a strong social determinant of health not because it deals with physical or mental illness, but because you can live your life without having to think twice about having health insurance and what will happen if and when you get sick. That security is an oft-overlooked piece. You can't underestimate the importance of knowing that you could go to any quality hospital if you keel over tomorrow and not think twice about the medical bill. That certainly reduces anxiety.

TONY ITON: We've been arguing that as well; that the benefit is undervalued. The notion that you're part of something gives you a sense of belonging and hopefulness. We have clinics in middle schools and high schools in Oakland, not because we think that the kids need healthcare and therefore benefit from it. Some of them do, but for the most part, young people are healthy. We think that it shows them that we value them; that they're part of something and that we are investing a lot in their futures. So if they get sick or if they have a question, they have a place to go and they don't have to pay; they don't have to be privileged or have insurance to be able to access that. Again, it's not because we think we're going to change their health trajectory with pills or diagnoses, but because we believe that they feel valued as a result of having access to these things.

QUESTION #8: To what extent can the high costs of medical care in the U.S. be attributed to the fact that Americans tend to be sicker than people in other countries?

WILLIAM DOW: It is difficult to quantify the exact contribution of health status to international medical cost comparisons, but conventional wisdom is that this is a relatively small part of why the U.S. spends so much on medical care. One way of thinking about the face validity of this proposition is to consider that U.S. life expectancy is 78 while in the United Kingdom it is 79; in comparison, per capita health expenditures in the United Kingdom are less than half that of the United States. But you are right that the United States does have higher disease prevalence than many other countries, and we spend a lot of money to treat this higher disease burden. One recent study to quantify the effect of higher morbidity in the U.S. versus Europe estimated that if our prevalence rates of 10 key diseases were lowered to European rates, then expenditures among adults over age 50 might be about 15% lower.⁹

DENNIS RAPHAEL: Numerous analyses indicate that it is clearly the market-driven, for-profit nature of the U.S. health care system that is responsible for its high health care costs.¹⁰

QUESTION #9: The U.S. is a capitalist society, not a socialist one. So, two questions: is it possible to remedy health inequities with market-driven solutions, and aren't differences in health simply an unfortunate but inevitable part of the way we live?

DENNIS RAPHAEL: Sweden, Norway, Denmark, and every other European nation are also capitalist, yet each of them takes better care of their citizens than does the U.S. The issue is not capitalism *per se*, but whether capitalists are allowed to call all the public policy shots without taking into account the needs of citizens. In no nation on Earth have solely market-driven solutions been successful in reducing poverty, providing accessible health care and providing for the security needs of the majority of its citizens.

⁹ Thorpe KE, Howard DH, Galactionova K. Differences in Disease Prevalence As A Source of the U.S.-European Health Care Spending Gap. *Health Affairs* 2007;6:w678-w686. <http://content.healthaffairs.org/cgi/content/abstract/26/6/w678>.

¹⁰ Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada - N Eng J Med 2003;349:2461-2464. <http://content.nejm.org/cgi/content/short/349/8/768>

WILLIAM DOW: Let me begin with the latter question. While some degree of health differences will always exist, and they are certainly related to the way we live, the many features of our social structure can have major influences on how large or small those health disparities might be. These range from the support that mothers and young children receive during the critical early months of life, to the educational opportunities that society affords vulnerable children, to the structure of our neighborhoods and workplaces, to the type of safety net that society makes available to the less fortunate. All of these influence the exposures that people have to health threats as well as their ability to respond to those threats.¹¹

Regarding the first question, moving toward the “straw man” of a pure capitalist *laissez-faire* society would no doubt worsen health disparities. It is perhaps more helpful to highlight types of policies that could reduce disparities but still be consistent with the long-run efficiency goals of conservative economic principles, for example, promoting a “level playing field,” helping children to better get an equal start in life regardless of the circumstances into which they are born. Such policies include support for pregnant women and families with young children, early child development programs, equal access to quality schools, and so on.

Another set of disparity-reducing policies consistent with economic efficiency principles are those designed to remedy *externalities* (i.e., circumstances in which market prices are distorted and hence lead to inefficient market actions). Examples of such policies include cigarette taxes (which assess smokers for the negative effects of second-hand smoke, medical costs incurred by the rest of society, etc.), pollution taxes, zoning laws, and workplace health initiatives. In a similar vein are *public goods* (that individuals will under-provide in the absence of government coordination, due to “free-rider” problems), such as crime enforcement, recreation areas, and public health interventions.

Finally, good capitalists understand the value of making investments that will have high returns for society in the future. Policies that improve health can lead to future social returns such as via a healthier and hence more productive labor force. Too often we fail to take into account such factors when considering the pros and cons of social policies. While it is likely true that many of the most aggressive policies for reducing health disparities are justified primarily on the basis of moral values for how we should treat the disadvantaged in our society, it is important to recognize that there is a subset of powerful policy recommendations that could receive broad political support even on the basis of economic efficiency grounds alone.

QUESTION #10: Is it your sense that overt, and covert, negative expectations of Black men contributes to an increase in underlying resentment and, therefore, potential increase in disease susceptibility and decreased life expectancy?

DAVID WILLIAMS: There is some interesting research that suggests that larger societal stereotypes and negative expectations affect both the academic performance and the health of not just African Americans, but other persons who are negatively stigmatized by society. One example of this would be the work by Stanford researcher Claude Steele on what he calls “stereotype threat.” He showed that if you give African Americans a test and you tell some of them this is a test in which Blacks tend to do poorly, those who are told that Blacks tend to do poorly will do worse than those who were just told to take a test. And he’s shown that it’s not just African Americans who are susceptible to this, but also white women—if white women are given a test and told that women do more poorly than men—and white men, if they are told that whites do more poorly than Asians on a test. So it’s a pretty robust phenomenon. When you

¹¹ *Reaching for a healthier life: Facts on socioeconomic status and health in the U.S.* Report by The John D. and Catherine T. MacArthur Foundation on Socioeconomic Status and Health, 2007.
<http://www.macses.ucsf.edu/News/Reaching%20for%20a%20Healthier%20Life.pdf>

tap into a societal stereotype of a group, even when those members are aware of it, just highlighting that negative characterization seems to affect their performance.

There is research by Jerome Taylor at the University of Pittsburgh and others that shows that when African Americans buy into society's negative stereotypes about their group—that Blacks are lazy and inferior, for example—they do more poorly on measures of mental health and are at a higher risk of substance abuse. This work goes under the rubric of internalized racism. But another important consequence of those larger negative societal expectations is how they get translated into actual health outcomes, and there is a growing body of scientific research that shows how, among stigmatized racial/ethnic populations, experiences of discrimination are a source of stress that actually leads to premature onset of disease and other negative health effects. So there are multiple ways in which the larger racism within society adversely affects both the socioeconomic opportunities and the health of disadvantaged racial/ethnic populations.

TONY ITON: Fundamentally, the issue is, as David said, internalized racism – people butting their heads against an unyielding wall who, over time, give up. We see this in our public health practice every day. You only have to look into the eyes of young people to see that hope extinguishing, and for the most part, hope equals health. Once hope fades, health soon follows. We see it in particular in young people around the time of middle school, very young kids. We've measured this through youth development surveys, standardized instruments that measure kids' sense of their developmental assets: how much resiliency they have in their lives and how much risk they face.

Very young kids in very under-resourced communities tend to have pretty high measures of hopefulness. They are protected in their environments despite the fact that there may be poverty and crime and a number of other adverse social forces operating. But as they progress into 7th, 8th, and 9th grade, they become much more influenced by their peers and their immediate environment rather than by their families and other protective forces in their lives. In many of these communities, the kinds of supports that young adolescents need in order to feel hopeful about their futures are lacking, so we see that extinguishing of hope in middle-school kids. By high school it's very difficult to turn that around, so we see high school drop-out rates and violence and many of the other activities that are associated with kids who don't see a future for themselves.

It's not just internalized racism; it's also a stigmatization associated with class status and disability. We see this also among kids who have major disabilities. Knowing about this gives us an opportunity to intervene, to create opportunity structures, as we call them, in communities to both extend the hopefulness that is inherent in young people and protect them against the deleterious social forces that devalue them systematically as they age.

QUESTION #11: To be healthy requires discipline and making smart choices. These are the same elements that bring a person wealth. It's no secret that Americans are fat and in poor health because they eat a high-fat, high-sodium, highly processed diet. Aren't we just letting people off the hook by blaming society?

TONY ITON: This is a perfect example of American dichotomous thinking: it's one thing and not the other; it's black, not white; it's on, not off; it's zero, not one. In fact, that's just completely false. Even when you look at individuals who have become successful, the notion that they are successful due exclusively to their own gumption, essentially surviving against the odds, has been disproven over and over again. People who are successful invariably have advantages—not always, but more often than not—that others don't. So to argue that it's all about individual choices, individual responsibility, individual talent, is a disingenuous argument when you look at the data.

Yes, individual choice does matter, but the context in which people are making choices matters as much, if not more. People who don't have opportunities to exercise healthy choices, or have limited opportunities to exercise healthy choices, are much less likely to succeed and be healthy. I use the analogy that if I give you a tennis ball and I say, "Juggle it," most people can do it. If I give you two tennis balls, and say, "Juggle them," most people can probably do that too. But if I give you three, four, five balls, the number of people who can do this starts dropping off. Well, people in many under-resourced communities are juggling five, six balls all the time and they don't have support; they don't have somebody helping them out. So despite the amount of individual talent, fortitude, and gumption, they're going to drop balls. And to the extent that they are constantly being given more balls to juggle, the likelihood increases that they will become unsuccessful, that they will become stressed, and ultimately, they will give up. That's what we see in these communities. It's not an either-or, individual responsibility versus social responsibility. Social responsibility sets the context for individual choices.

DAVID WILLIAMS: Let me just add that while there is a role for individual responsibility, there is a role for social responsibility, too. Social context is what can create barriers for individuals to make choices, and social responsibility and social policy can create opportunities that facilitate individuals making healthy choices. So the social component must be paired with the individual component.

DENNIS RAPHAEL: Paula Lantz, Ana Diez-Roux, and other American researchers point out that when you try to predict who's going to live or die, or who's going to be sick or die, behavioral factors certainly contribute, but the amount the so-called "risk behaviors" contribute pales in magnitude to the living conditions which people are exposed to, not only in their contemporaneous situation as adults, but the life experiences they've had as children. The best predictors of cardiovascular disease and Type 2 diabetes are adverse living conditions that people experience as children—in fact, frequently, as has been pointed out, prior to their being born. So even from a statistical predictability, the best predictors are adverse living conditions, and the United States is unique in subjecting a larger proportion of its people to adverse living conditions than most other developed countries.

QUESTION #12: If lack of control increases risk of illness, how can government programs be the answer? Welfare programs don't offer recipients more control. If the government is responsible for our wellbeing, doesn't that disempower us?

DENNIS RAPHAEL: That's a very interesting question, and I guess there are two aspects to it. The first is, "What does a nation, usually in the form of its government, offer to its citizens in terms of opportunities to be healthy?" In most developed countries, what you find is a shared understanding that—and this is even the case in the United States—everybody is entitled to elementary education, everybody's entitled to secondary education. But in the United States, people are not entitled to job security; they are not entitled to adequate housing.

There are two kinds of government programs. The ones that are typical throughout most of the developed world say, "We're all in this together, so what can we do to facilitate human development?" Certainly Abraham Maslow recognized in the 1960s that in order for people to be creative and productive, they have to have their basic needs met. So, in most developed countries, there's extensive effort to make sure that every child has a decent education, has food, has decent housing, and if they're capable and able, can go on to university whether they have the financial resources to pay for it or not.

Compared to many European nations, the United States, and to some extent in Canada and the United Kingdom, those commitments are not as strong. What you see instead is that governments step in, not to provide universal general financial income and educational support for the population, but only to respond to people that are the most in need, whether you want to call them homeless or call them hungry. The nature of these programs are such that, since they are targeted to the least well off and are combined

with the belief that people have somehow gotten themselves into these situations, these programs are frequently stigmatizing. So the questioner is actually right; they usually don't do very much to promote autonomy and self-control.

I think the point was well made in the final episode of the documentary. We know that 20 or 30 years ago when people lost their job, it was very easy to say it was their own fault—they pissed off their boss or they did this or they did that. Now, with the reorganization of the world economy, nobody's going to blame that guy in Michigan for losing his job at the Electrolux plant. But the difference is that virtually every developed country in Europe, less so in Canada and the United States, there's a responsibility to retrain these people, to keep them on their feet, to support their family as an entitlement. In the United States and Canada, we might give these people food stamps, we might give them unemployment benefits for a limited period, but clearly there's not the commitment to do what's necessary to support people through retraining and finding employment for them. So government programs may very well be disempowering and stigmatizing.

The problem is that in the United States, the amount of commitment to citizens, whether it's in terms of families, whether it's in terms of people with disabilities, whether it's in terms of job training, is among the lowest of any developed country, and that certainly contributes to the poor health profile of the United States.

TONY ITON: I would make an efficiency argument here, because I think Americans tend to respond to that. We regulate the stock market. Why? Because we want stock investors to have an equal opportunity to use their wits and their smarts and their instincts to be able to profit gainfully from the market. So we regulate that marketplace. Now, you could argue that's a socialized stock market, because the government is essentially setting the rules and it's not absolutely a free market endeavor. It's a regulated market, because it's more efficient to have the government do that. It's more efficient to have the government provide at least elementary education for people. Why? Because individuals can't do that on their own. They can stay home and read books and use what they have available to them, but it's not efficient. It makes more sense for a society to come together and say, "Look, we can do this more easily by ensuring that everybody has access to education." Similarly, for police and for fire, we could say, "Okay, everybody get your gun and protect yourself," but that doesn't make any sense; it doesn't comport with human nature.

It makes more sense for government to do certain things. Now, to equate government with welfare and a nanny state is an extreme understanding of the role of government. Perhaps it's informed by visions of sort of Soviet-style communism. But government is basically an agreement among people to do those things that individuals can't efficiently do on their own. To me, education and health care seem like two of those things that it's difficult for individuals to do by themselves. To build a house and understand that the house is built safely and securely and there aren't all kinds of issues that are prone to deteriorate in that housing is more efficiently done by government than it is by individuals. I think you could also argue that it's just more efficient to educate people—particularly preschool education, which has such a big bang for its buck—than it is to leave people to their own devices.

You know, we could disagree at the end of the day philosophically about which services are more efficient to provide to populations, but I don't think we can disagree that government has a role in ensuring the quality of various kinds of services that we all need. As Dennis said, there are basic needs that nobody can go without in order to be successful.

QUESTION #13: Your program asserts that other countries have better health because they are more equal and have better social supports. But many of those countries have homogeneous populations. Doesn't the incredible diversity of the U.S. mean that social, economic and health equity are harder to achieve?

DAVID WILLIAMS: This is a very common myth. I hear it a lot from Americans, that the diversity of the U.S. is a problem. We really ought to recognize that the diversity we have is a strength, and not a source of weakness.

To directly address the question, if we were to look just at the white population of the United States, as a country we would still be doing poorly, and we would still be at the bottom of the industrialized countries. Other countries in fact have a lot more diversity than the average American thinks exists out there. But also, diversity is not the problem, since even the largest group in the U.S., the white population, is doing poorly compared to these other countries. So we really have to look at how we are using resources, and how we are investing in the quality of life of all people in terms of making changes so that we can improve the health of all.

DENNIS RAPHAEL: Alberto Alesina and Edward Glaeser, the Harvard economists, talk about this point in their book *Fighting Poverty in the U.S. and Europe: A World of Difference*.¹² They have a graph illustrating that welfare states are more developed in more homogeneous countries. They do a historical analysis of trends in the United States, talking about the Progressive Era, then the New Deal, then the Civil Rights Movement. And they make the argument, which is reasonable, that in every country you have the left, the center, and the right, and each of these different ideologies will use whatever tools they can to get their agenda followed. They also make the argument that in heterogeneous societies, such as Canada or the United States, the right, the more conservative—whether you want to call it the business sector, the for-profit sector or conservatives—have historically used racism as a means of getting their agenda moved forward. They argue the Progressive Era came to an end when racism was used to split people.

The point is that it may very well be more difficult to have a shared commonality of views in more heterogeneous societies, but that's not a biological thing. It's just that historically, diversity has been used as a weapon to split people and to make it more difficult to come to communal agreement.

Finally, Canadian political economist Keith Banting, at Queens University, has put together a volume that examines the extent to which multiculturalism is incompatible with a well-developed welfare state.¹³ He concludes that it's not, but that may make things more difficult politically. Again, the most obvious point is that in the United States, the race card has been played to split people.

DAVID WILLIAMS: I also want to point out that although minority ethnic populations have higher rates of poverty in the U.S., the majority of poor people in the United States are white. If you actually look at the welfare programs, the majority of people receiving help from welfare programs are white. So I think the race card has been used to obscure reality.

DENNIS RAPHAEL: Of course, as you pointed out, by not having this shared responsibility, ultimately more white people suffer than Black people. But it's frequently seen as something that is biologically driven that you somehow can't get "yellow" people and Black people and white people to care for each other.

QUESTION #14: Your program suggests that inequities in health result from inequities in society. So, short of a revolution, what can be done?

¹² <http://www.oup.com/us/catalog/general/subject/Economics/Social/?view=usa&ci=9780199286102>

¹³ Banting K, Kymlicka W. *Multiculturalism and the Welfare State: Recognition and Redistribution in Contemporary Democracies*. Oxford University Press, 2006. <http://www.oup.com/uk/catalogue/?ci=9780199289189>

TONY ITON: I get asked this question a lot actually. Believe it or not, I've run into a fair number of people who think we do need a revolution. I don't happen to share that view. I think that, in essence, we have a series of choices to make around critical policies. The goal is to decouple the consequences of being poor from health—meaning that right now, poor health and poverty are tightly linked in this country. They're not exclusively linked, there are obviously other factors that weigh in, but they're incredibly tightly connected. And policy interventions can serve to decouple that unholy pairing.

By that, I mean explicit policy designed to reduce the social consequences of being poor in America. Being poor shouldn't have to mean that you get a poor education; it shouldn't have to mean that you lack access to quality preschool; it shouldn't mean that live in housing – if you are lucky enough to be able to afford housing – that is poor quality and prone to exacerbate things like allergies and asthma and the like. It shouldn't mean that you have to live in crime-plagued neighborhoods; it shouldn't mean that you have inadequate access to public transportation to get you to jobs; it shouldn't mean that you're relegated to jobs that don't pay a living wage that lifts people out of poverty. So the current social consequences of being poor in the United States are severe, and they tend to be associated with poor health outcomes.

Other countries have blunted the social consequences of poverty, either directly through trying to support people's income, or indirectly through trying to ameliorate the social consequences of poverty, or both. We do that in this country; we do recognize that people shouldn't be left entirely to their own devices, but the degree to which we make investments that ultimately pay off in a broader spectrum of opportunities for all varies dramatically from state to state, from locality to locality. On the spectrum of nations, we're relatively stingy when it comes to meting out the kinds of social support that are necessary for people to become successful and healthy. So I think there are a series of policy choices that we can make.

We are now seeing the consequences of having underinvested in education. We're being out-competed by many countries in the world that have created a much greater and robust crop of educated individuals that can compete in the high tech and science economy that we've gravitated towards. We have certainly seen the health consequences. We're paying a price for these under-investments and that's not rocket science. We can do better than this. We're smarter than this.

DENNIS RAPHAEL: There was a real brouhaha when Michael Marmot, who was head of the WHO Commission on Social Determinants, pointed out one of the purposes of his work was to decouple the relationship between poverty and health. The reality is that those countries that do well in health are the ones that not only reduce the consequence of being poor through universal daycare, universal education, universal free tuition, and universal dental care, but they also work hard to reduce poverty. I would suggest that, given the political dynamics of the United States, Canada, and other such countries, unless you restore the balance of power between what we might call “the wealthy” versus “the non-wealthy,” or the economy's managers versus the workers, you're not going to get those ameliorative efforts in any event.

When you look at countries where health is doing very well, where people are living longer, where poverty rates are low, these are countries that have a larger proportion of people living under collective employment agreements. For example, in Sweden and Norway, where people are very healthy, there's a whole basket of benefits that make life more secure; 80 to 90-plus percent of people work under collective agreements. In the United States, the *New York Times* commented that the unionization rate is now seven percent, which is almost unbelievably low. So we're dealing with two kinds of issues, one is the extent to which we decommodify the basic necessities of life. But also, I don't think you can provide public transportation, free university education, and good housing without getting at the source of social inequality, which is ultimately the wages and the power that people have in workplaces.

DAVID WILLIAMS: The problems we have in the U.S., the problems of health inequalities and our relatively low standing on health compared to other countries, reflect choices we have made as a society.

As we think about doing the things that Tony and Dennis have talked about, it's important to realize that the scientific evidence clearly indicates that these investments in health make good financial sense. It will pay off; it's a return to society for making those kinds of investments that improve opportunity, improve access to employment, and improve the health of the next generation. It's actually an investment; we get a good return on our investment. If you don't want to do it on moral ground, it actually makes good financial sense, as well.

QUESTION #15: Does equality make us well? Are there examples worldwide where racial and economic equality is enjoyed and health status a benefit?

DENNIS RAPHAEL: A lot of work has looked at the factors supporting health in developed wealthy countries. It seems there are three clusters of countries. The first includes the United States, Canada, the United Kingdom, Australia, and New Zealand. These countries are sometimes called “liberal political economies”; sometimes they're called “Anglo-Saxon economies”. These countries have evolved in such a manner that the communal programs of supports are minimal. As a result, or correlated with it, health tends to be not as good as it is in other countries. The second cluster of countries are called the “continental” or “conservative countries”; for example, France, Germany, Belgium or Holland. These conservative countries actually provide fairly good security for people. Life expectancy tends to be longer and crime rates are lower than in these so-called liberal countries. But the countries that have really put it all together in terms of providing people with security, and as a result people live longer and have lower obesity rates, are the Scandinavian countries.

What Americans don't realize, though, is that 40-50 years ago, the United States was more equal than even these Scandinavian countries. Over time, there's been a shift away from equity, a shift away from equitable distribution of income in the United States, such that the United States has gone from being one of the healthiest and most equal countries to the opposite pole. If that can happen over 50 years, then there's certainly no reason why it can't begin to reverse itself.

So the brief answer is, yes, most countries, whether they're the conservative countries of continental Europe or the northern social democratic countries, are more egalitarian and they show the benefits of it: people are more secure; people live longer; and, for the most part, they have less illness than Americans do. But America has a history of having done that as well; it's just that right now we're not in a period where these kinds of approaches are in fashion.

QUESTION #16: It's obvious why the poor have worse health than the rich. But why would the middle class? They don't suffer from material want.

DENNIS RAPHAEL: There's a tremendous amount of insecurity in the United States. So if you're making \$60,000 a year versus \$80,000 a year, the difference isn't just about material possessions; it's also a reflection of how secure you are. The reality is that middle class people do not have everything they need to be healthy. They still—and this is uniquely so in the United States—can have medical emergencies, they can have medical bankruptcies, and if they lose their jobs, as factories close, they are left on their own. So the gradient is more a reflection of the tremendous amount of insecurity that runs through the entire gradient, but is especially focused on the people at the bottom. Frequently, some of the people who talk about the social gradient have very little understanding of the actual insecurities that even middle class people experience.

TONY ITON: I would also argue, or counter, that the social gradient is a *gradient*. The stress of the middle class proves the gradient rather than refutes it. You would expect that for each level of “social progress” there would be a commensurate level of health improvement. So people in the middle would

have more stress, more insecurity—particularly in the United States, as Dennis said—with respect to the potential to lose health insurance, the enormous cost and threat of bankruptcy, or just having to consider paying the tuition for your kid’s college. That is an enormous amount of stress and it’s getting worse. But it does support the thesis that people in the middle are going to be worse off than the very wealthy.

QUESTION #17: If you could pick one thing to change in order to improve health outcomes, what would it be?

DENNIS RAPHAEL: Well, in Canada, when I’m asked that question, I say a universal childcare system, because it would provide the most concrete benefits, especially for the most disadvantaged children, and it would also enable women, especially disadvantaged women, to gain employment and become more a part of society. The second thing I would argue for is to make it easier for people to organize their workplaces and form unions.

DAVID WILLIAMS: I would also pick investment in early childhood education, because it would ensure academic success. In the United States, 70 percent of prison inmates are high school drop-outs. Anything that we can do to ensure academic success will ensure socioeconomic attainment over the life course, which will ensure better health outcomes. The second thing I would mention is making investments in the infrastructure of disadvantaged communities to create opportunities—and I’m talking about opportunities for good jobs and a decent wage. Those efforts would have a ripple effect and have a dramatic health impact as well.

WILLIAM DOW: I will pick three: education, education, education. This is, of course, an expensive, long-run strategy. But many of the root causes of health disparities have developed over generations, and it will likely take generations to undo them. My best guess based on the research literature is that improving education for the current generation of kids is the most promising path for reducing disparities by the next generation. The next question is: what public policies would be most cost-effective at improving the quantity and quality of education of disadvantaged children? Do we invest in college loans, lower class sizes, higher teacher salaries, mentoring programs, anti-gang interventions, preschool access, or perhaps even need to start with interventions that comprehensively support new parents beginning in pregnancy?

TONY ITON: For me, it’s the early childhood experience: preschool education and high quality K-12 education that gives every kid the opportunities, should they so chose, to go onto college, a vocational school, or to a living wage job. That is not a difficult thing to create; it is not outside the bounds of affordability. Other countries have done it. In fact, we used to do it in this country. So all we have to do is remember where we’ve been to be able to get where we want to go.

QUESTION #18: Name three things that every person can do to work towards health equity.

DENNIS RAPHAEL: I wrote a paper that had ten tips for public health. I think the first thing, and this goes back to my training as a psychologist, is to recognize there’s a problem, recognize the U.S. has a real problem. Two, recognize the United States is an outlier in public policy and it doesn’t matter which public policy you pick. Third, as David has said, recognize there are benefits to shifting course. Life will be better if we address inequities. You will not only live longer, happier lives, but the problems that are driving health outcomes are also driving the very high U.S. crime rates and the tremendous insecurity Americans experience. These issues are the focus of tremendous policy activity elsewhere. In Canada we have no problem looking elsewhere to get policy ideas, but the United States has a real problem with that.

DAVID WILLIAMS: We are in an election season. The first thing is to vote for change. I think we cannot maintain the status quo. I agree with Dennis completely, we need increased awareness, so vote for change. Two, talk about it. Let people understand how all of these social factors out there are driving, helping, and hurting all of us. Three, help them connect the dots. Teachers need to understand that what's happening in schools has implications for health as well as academic and socioeconomic attainment. Community development policies are important in their own right, but they have health consequences too. So work across sectors and strengthen each other in our efforts to make a difference and improve life and health.

TONY ITON: I think that you have to be a personal example of what it is you hope to see change. For individuals, I think that means organizing yourself and your community wherever you are. You know, if it's your workplace, your family, your immediate neighbors, I think you need to get to know them, reach out to them, and build the social connections – the networks that are important to all aspects of human endeavor. We're social beings and we need to reconnect with our places and our neighbors. Prioritize amongst your friends and neighbors the issues in your community that you see as being problematic; typically, that gravitates to opportunities for youth. Once you've organized yourself and your community, you can build power, and once you have that power, you can use that power to tackle the big issues. Kids need mentorship, they need opportunities, they need caring adults in their lives that are outside of their families; many of them don't have families that can provide that kind of support.

We've been working with local businesses, for instance, encouraging them to adopt a school. And if they can adopt a school, they can do two things: one, provide financial and human resource for the school system; two, send the message to kids – and this is the most important part – that they matter, that they're valuable, that society cares about them, that we want to embrace them and support them. That's what individuals can do too. There's no individual in the United States who can't go and knock on your neighbor's door, get to know them, form, you know, an *ad hoc* committee to look at some of the issues for youth in your community.

So that would be my answer: to start where you are, as David says, use your power, take advantage of the fact that we are social beings. Our society and environment have gravitated towards breaking up social connections and fostering social isolation. We need to work against that, because human beings need to feel socially connected. When we're connected we have power. Use that power to effect the kind of change that we're talking about.