

Chapter 2

Understanding Health Disparities

2.1 Introduction

Along with a broader definition of health, our view of disease causation and predisease pathways has also broadened as it has become clear that health risks are created and maintained by social systems and that the magnitude of those risks are largely a function of socioeconomic and psychosocial disparities (Halfon and Hochstein 2002). Therefore, our efforts to reduce health disparities can no longer be confined to only providing better access and more resources to meet the needs of the underserved. We must address the underlying social factors that determine health disparities. Too much emphasis is placed on individual lifestyle choices. We tend to forget that lifestyles are largely determined by social, economic, and environmental determinants.

Disparities in health outcomes and in the factors contributing to them are present early in life and are expressed and compounded by experiences during a person's lifetime. Risk factors are part of a person's biological make-up, embedded in the disparities of a family or community, and maintained by social, cultural, and economic forces in a given society.

There are multiple road maps to health, but one pathway that has emerged most strongly is the association between people's material circumstances or relative income, and health. What is important is how the level of material prosperity places an individual in relation to others. Projects designed to improve people's jobs and education do not change the sum total of disadvantage (Wilkinson 1999). There are a host of factors embedded in the phenomenon of poverty so there is no single explanation for socioeconomic differences in health. The cumulative effects of the multiple hardships of material disadvantage are disproportionate and synergistic, rather than additive. Therefore, piecemeal strategies for improving health among lower socioeconomic groups are not usually effective (Dutton and Levine 1989).

A 2010 Gallop survey of 200,000 Americans across incomes documents the severity of health disparities between low and high income Americans. Those making less than \$24,000 per year suffer from poorer emotional and physical

health, have poorer health habits, and have significantly less access to medical care (Mendes 2010). Low-income Americans are in a negative health feedback cycle—they have poorer health habits and high levels of physical illness, less access to preventive care and treatment, and live with heightened emotional negativity about breaking the cycle. Health disparities seem to be becoming more embedded at a time when more people are facing financial hardships. One-third of low-income Americans are uninsured and more than that say that there have been times when they didn't have enough money for healthcare (Mendes 2010).

Poor health is interwoven with the position of the poor in the social structure and larger culture of our society. The different ways to measure socioeconomic status be they income, education or occupation, yield a roughly similar picture of health inequities with common social consequences such as alienation. Inequalities in both health and economic status have persisted over decades and appear to be increasing. While most American men and women experience increasing longevity, less advantaged groups experience levels of longevity comparable to men and women in developing countries. Inequalities in health in the United States occur among both sexes and all ages, and for many people the detrimental effects of poverty on health begin in early life and worsen as they live to old age. The overlap between poverty and minority status creates a double jeopardy that deprives the poor of ever experiencing good health.

It is an established fact in rich societies the poor have shorter lives and suffer more from almost every social problem. Wilkinson and Pickett (2009) found one common factor that links the healthiest and happiest societies, the degree of equality among their members. Almost every current social problem—poor health, violence, lack of community life, teen pregnancy and mental illness—is more likely to occur in a less-equal society. That is why, according to Wilkinson and Pickett, America, the richest nation on earth, has per capita shorter life spans, more mental illness, more obesity, and more people in prison than any other developed nation. The social links between health and inequality draw attention to the fact that social, rather than material, factors are now the limiting component in the quality of life in developed societies (Wilkinson 1996).

In more egalitarian societies and parts of societies where there are smaller differences in income between rich and poor, the average health standards of the population are better and there is greater longevity. Egalitarian societies are also more socially cohesive (Wilkinson 1996). Many of the socioeconomic determinants of health have their effects through psychosocial pathways. There is strong evidence that the pathway is from income distribution through social relationships to health. In societies where income differences are larger, social environment is less supportive, there is a greater proportion of people who feel that they cannot trust others, and there is a higher rate of aggression toward other people and their property. James (1995) found evidence that income inequality and poverty increases stress on family life leading to more domestic violence and to more children growing up to become violent adults. The quality of people's social relationships has a powerful influence on their health.

Marmot (2004) views social inequities as the major causes of ill-health. He calls this "the status syndrome." The status syndrome is not simply one of income

or lifestyle differences; it is the psychological experience of inequality that has a profound influence on health. Marmot believes if we can understand social inequalities, we can mitigate their effects.

Why should our society care about income inequality? Kawachi and Kennedy (1997) pointed out that income inequality has spillover effects on the quality of life of a society, for example, the middle class flight from poor neighborhoods results in the progressive deterioration of public education. Those who are economically disadvantaged are also likely to be temporarily or permanently unemployed leading to their low productivity and contributing to the slower economic growth of the communities where they live. Income inequality threatens the functioning of democracy when the poor express low levels of trust in others, especially trust in their government. Therefore, it is not surprising that the poor are underrepresented among voters in our country. Wide income disparities tend to coexist with underinvestment in human capital measured by high school dropout rates, reduced public spending on education, and lower literacy rates. Finally, wide income disparities result in frustration, stress, and family disruption, which in turn, increase rates of violence, crime, and homicide in society as a whole (Wilkinson 1996).

2.2 Health Disparities: Definitions and Perspectives

According to the Centers for Disease Control and Prevention (CDC) health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations (CDC 2005, 2008). Health disparities are inequities that are directly related to the historical and current unequal distribution of social, political, economic, and environmental resources (U.S. Department of Health and Human Services 2010/2020).

The Institute of Medicine (2000) has defined disparities as differences in treatment provided to members of different groups that are not justified by the underlying health conditions or treatment preferences of patients (Smedley et al. 2003).

Disparities fall along a continuum from being minimally unjust to overt discrimination. At what point along the continuum differences become disparities is subjective, but the magnitude of the injustice and disparity is generally thought to be proportional to how much control individuals and groups have over the cause(s) of the differences (Herbert et al. 2008).

There is little consensus on what constitutes a disparity because disparities are not discrete or always easily observed and therefore their size or extent is unknown and not easily measureable. Therefore, one of the ways to reduce disparities is to strive for equity in health and healthcare services for all groups (U.S. Dept. of HHS 2011).

Health inequities have been growing in the U.S. and creating gaps in the distribution of illness, healthcare, and longevity. In public health these inequities are viewed as unnecessary, avoidable, and are considered unjust (Satcher 2010). They are maintained over time beyond the control of individuals (Hofrichter 2010).

Inequities are embedded in the history and culture of societies. They are matrixed in the structure of social, economic, and political institutions, and are expressed in various forms of social exclusion and exploitation. Changes in health policy alone have not and cannot solve the problem of health inequalities (Adler et al. 1993).

There are many groups of people in the U.S. who, for reasons of disability, color, income, sexual orientation and language, are disconnected from social institutions, and therefore are unable to access resources to obtain the basic necessities of life including health and child care, transportation, housing, and education. House and Williams (2000) explain, "...over the life course individuals first acquire varying levels and types of education, which in turn help them enter various types of occupations, which then yield income, which finally enables them to accumulate assets or wealth. Each subsequent factor in this chain of events is affected by prior variables." p. 83. Because inequalities are interconnected through their related causes and effects, they can be framed and understood through a social systems perspective (Robert and House 2000).

2.3 The Development of Health Disparities

2.3.1 *The Life Course Model*

The life course model of health provides a framework for understanding how children's health and environmental exposures are connected to the development of disorders, disability, and death among adults (Halfon and Hochstein 2002). This model proposes that health disparities exist across the life span but that childhood is a critical period in their development. Unique interactions occur at each stage of development which can generate or create risks for subsequent layers of disparities. Longitudinal data confirm that health disparities change as individuals move through the life course (Pavalko and Caputo 2013). Obesity in early childhood is an example of how being overweight at an early age increases the risk in adulthood of mortality and morbidity from coronary heart disease, colorectal cancer, and arthritis (Forrest and Riley 2004). The life course model also provides insights into adaptive mechanisms or social resiliency factors such as social support used to maximize health-enhancing capacities at various points in life (Pearlin et al. 2005). A major focus of the life course perspective has been to understand how early-life experiences shape adult health, particularly adult chronic disease and its risk factors and consequences (Braveman and Barclay 2009).

The development of health disparities in the U.S.-Mexico border region begins with birth and the high infant mortality rates per 1,000 live births for Mexico and the U.S. border (Fig. 2.1) (Woolf and Braveman 2011). These high rates are due to poor pre-natal services and utilization, low rates of immunization, and the adverse physical environment children are exposed to. Indeed, as many as 40 % of children who survive infancy grow up in the circumstances of poverty in a border state (Fig. 2.2). If the child survives and enters school the drop-out rate for Latino teens aged 16–19 years living in the Southwest is 15 % compared to non-Latinos (5 %)

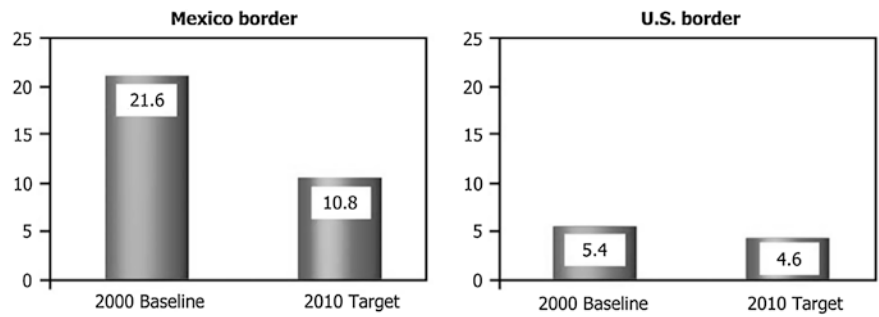


Fig. 2.1 Infant mortality. *Source* United States: National Center for Health Statistics, CDC. Mexico: INEGI/SSA, 2000

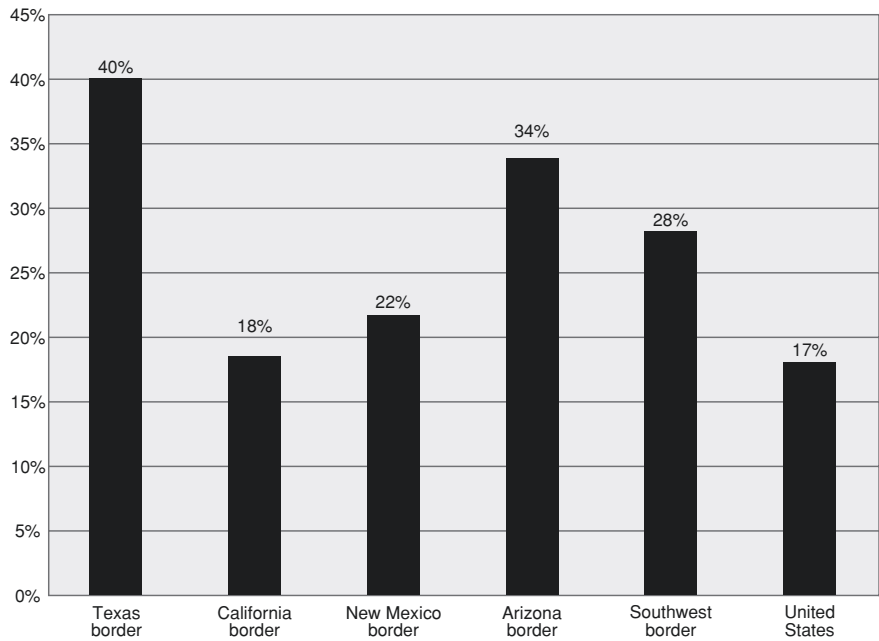


Fig. 2.2 Percent of children in poverty, 2000. *Source* Border Kids Count Pocket Guide, Annie E. Casey Foundation

(see Fig. 2.3). Teenage births on the border are higher (17 %) than for the U.S. as a whole (12 %). Childhood obesity is at epidemic proportions with 22 % of 4th graders being obese and 39 % being overweight (U.S.-Mexico Border Health Commission 2010; LaFe Policy and Advocacy Center 2006).

Health and the general quality of life along the U.S.-Mexico border, especially in the colonias, has been a victim to systemic social and economic injustices (Lusk et al. 2012). Isolated efforts have been made primarily at local levels to advance health promotion and disease prevention, develop leaders, and build community

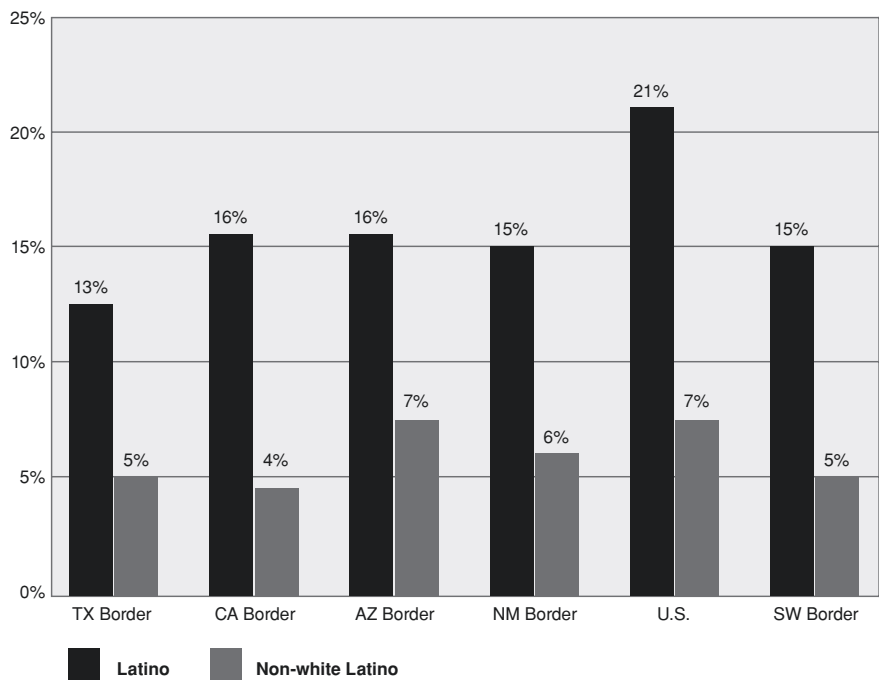


Fig. 2.3 Percent of HS Dropouts, teens (16–19). *Source* Border Kids Count Pocket Guide, Annie E. Casey Foundation

capacity, however, it has been difficult to maintain lasting positive effects (Ford et al. 1998; Iton 2010). Factors such as racism, social neglect and isolation, and the limited resources of extreme poverty, help to sustain a sense of powerlessness about positive change in this international region. There is evidence that racially stigmatized and disenfranchised populations have worse health than countries that have policies that through enhanced participation, empower individuals and groups to take control of their lives and health (Williams and Mohammed 2013a, b). Virtually all countries endorse the right to health and to a standard of living adequate for health (Braveman et al. 2011).¹ The persistence and deepening of border poverty challenges these rights (Mondragon and Brandon 2004).

2.4 Causes of Border Health Disparities

Iton (2010) points out that wealth is the strongest determinant of health in the United States and many developed countries. It is the means by which individuals access a variety of social and health benefits. Although health is consistently worse

¹ There are different definitions of health disparities or inequalities. International definitions focus on socioeconomic differences, while in the U.S. health disparities often refer to racial or ethnic differences. For a discussion of definitions see Braveman et al. (2011).

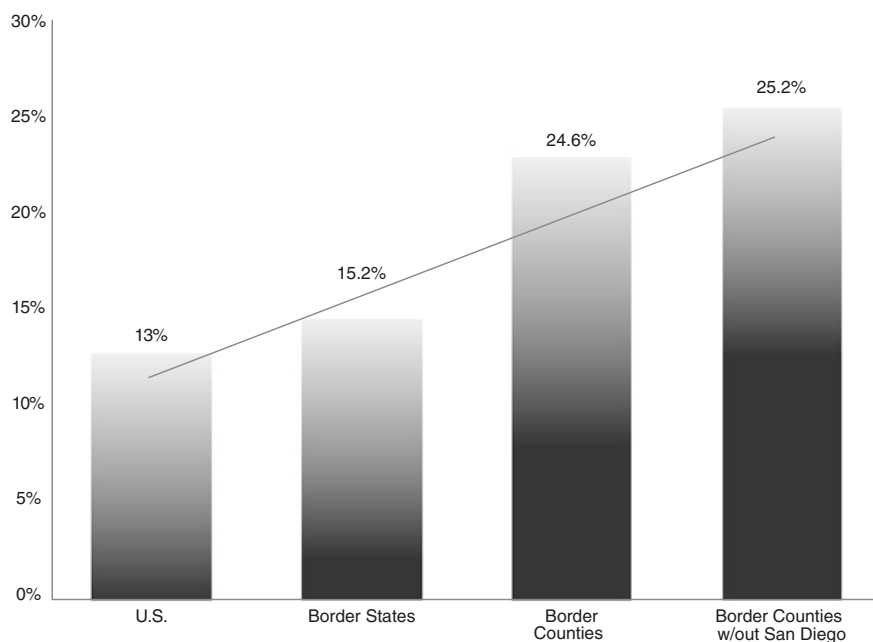


Fig. 2.4 Percent Living below poverty level in the U.S. and border region. *Data source* U.S. Census Bureau, ACS, 2008

for individuals with few resources, the degree of health disparities in the U.S. varies by race/ethnicity, income, time and geographic location (Adler and Rehkopf 2008).

The single most substantial source of health disparities in the U.S. and U.S.-Mexico border is poverty (Pettit and Nienhaus 2010) (see Fig. 2.4). Figure 2.5 shows a 52-year perspective of poverty in the U.S. from 1959 to 2011. The poverty rate in the U.S. in 2011 was 15 % or 46.2 million individuals, the highest rate since 1993. This is one indicator that the U.S. health status is slipping. Other developed countries have lower child poverty rates and maintain a stronger safety net to help disadvantaged families maintain their health (Woolf and Braveman 2011).

Table 2.1 shows the breakdown of poverty in the U.S. for the general population, for Latinos, and for children. Within the Latino community people living in poverty reached record numbers in 2011; more than 13 million individuals.

Nearly 15 % of Latino households experienced food insecurity, the rate for children under 18 being 34.5 % (see Table 2.2).²

² Income levels of the communities on the U.S. side are below the U.S. national average, whereas income levels of communities on the Mexican side are above the Mexican national average. The situation is reflected in the poverty rates, which tend to be higher than the national average on the U.S. side and lower than the national average on the Mexican side. In other words, the income gap and poverty rate differences in the border region are smaller than the differences between those same measures for the two countries as a whole. See Anderson and Gerber (2008). Also, Centers for Disease Control and Prevention (2005). Also, U.S. Dept. HHS (2011).

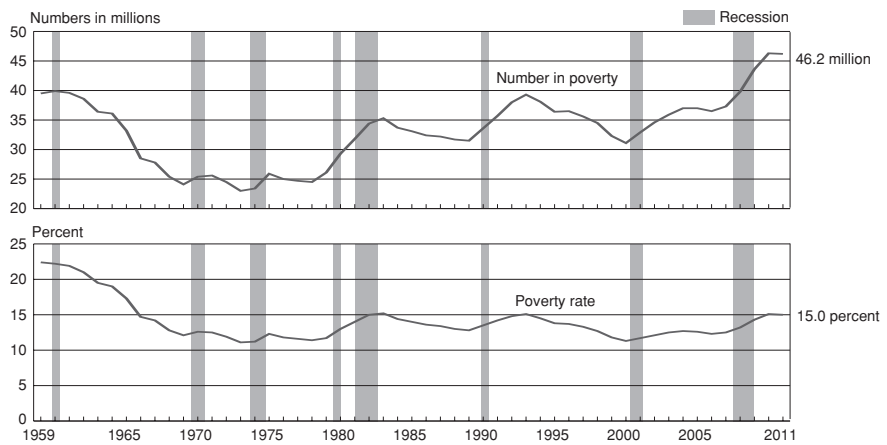


Fig. 2.5 Number in poverty & poverty rate: 1959–2011, United States. *Note* The data points are placed at the midpoints of the respective years. *Source* U.S. Census Bureau, Current Population Survey. 1990 to 2012 Annual Social and Economic Supplements

Table 2.1 U.S. Poverty, 2011 Data

	General population (%)	Latinos (%)
Individuals	15.0	25.3
Children under 18	21.9	34.1
Children under 5	25.1	36.0

Source U.S. Census Bureau
Household Food Security in the United States in 2011. U.S. Department of Agriculture, Economic Research Service, September 2012

Table 2.2 Food insecurity, 2011

	U.S. general population	U.S. Latinos
Households	14.9 %	26.2 %
	17.9 million	3.8 million
Individuals	16.4 %	28.3 %
	50.1 million	13.8 million
Children under 18	22.4 %	34.5 %
	16.7 million	5.5 million

Source USDA Economic Research Service
Statistical Supplement to Household Food Security in the United States in 2011. U.S. Department of Agriculture, Economic Research Service, September 2012

Three of the ten poorest counties in the U.S. are located in the border region. Twenty-one of the counties on the border have been designated as economically distressed areas.

2.5 Colonias

The colonias are one of the border regions' largest pockets of poverty. Mexican Americans living in colonias are one of the most disadvantaged, hard to reach minority groups in the U.S. (Mier et al. 2008). A colonia is a rural shanty town or colony characterized by poor housing, inadequate physical structure, and a weak social infrastructure. Colonias are a form of self-help housing settlement. In the 1990s colonias became a common name for the slums that developed on both sides of the U.S.-Mexico border. While colonias have existed along the border for decades, the signing of the North Atlantic Free Trade Agreement (NAFTA) in 1994 has significantly increased the number of people living in colonias due, in part, to the low-paying jobs in maquiladoras.

There is no formal census of colonia residents as lots are acquired informally, no subdivisions are recorded, and there are no community development offices. Estimates are that approximately half a million people lived in 2,000 colonias in Texas in 2007. Texas has the largest concentration of people living in colonias on the U.S. side of the border. New Mexico has the second largest, followed by Arizona and California. Over 50 % of colonias have fewer than 2,000 residents; only seven colonias exceed 10,000 population. Overall, these communities lack infrastructure (paved roads, water and sewer systems, and electricity), have high levels of poverty, high unemployment, limited health care and educational opportunities, and a disproportionate number of Hispanics. Colonias are often defined by what they lack. There is a persistence of physical infrastructure deficiencies. The civic infrastructure lacks consistent, strong leaders. Colonias continue to attract poor people. There are insufficient funds at all levels to address basic needs (Esparza and Donelson 2008).

Despite being categorized, colonias vary within the border region from small clusters of homes near agricultural employment opportunities to established communities whose residents commute to nearby urban centers (Table 2.3). Also, colonias have varied histories; some have been in existence since the 19th century while others have emerged in the last 50 years.

Despite their growth in the 1950s colonias have remained unnoticed until 1990 when a federal definition of colonias was created.³ In the U.S. border counties, 25–30 % of the population is uninsured. The average yearly income is \$14,500. Educational attainment is lower when compared to the rest of the U.S. and unemployment is 250–300 % higher than that of the rest of the U.S. Estimates are that 85 % of colonia residents are U.S. citizens.

Hispanic residents along the border experience poverty at more than twice the U.S. rate. Most colonias residents work in nearby cities, primarily in low-wage

³ In 1990 the Cranston-Gonzalez National Affordable Housing Act (NAHA) created a federal definition for colonias. Under NAHA a colonia is an "identifiable community" in Arizona, California, New Mexico, or Texas within 150 miles of the U.S.-Mexico border, lacking decent water and sewage systems and decent housing and in existence as a colonia before November 28, 1989.

Table 2.3 U.S. border Colonias

	Rural border colonias	Border colonias	United States
Population	1,650,448	5,586,664	301,461,533
Hispanic population (%)	52.0	61.8	15.1
Poverty rate (%)	20.7	23.8	13.5
Population living in small town/rural (%)	100	29.8	21.2
Homeownership (%)	72.7	67.7	66.9

Source Border Colonias Housing Assistance Council (HAC) Tabulations of the American Community Survey 2005–2009 Five Year Estimates

service jobs and in manufacturing and food processing activities. The colonias are also home for many migrant farmworkers, but they are only a small part of the population.

Although there have been significant economic changes due to international trade agreements, major problems associated with general poverty continue to exist. Without sustained federal, state and local government and private funding for health programs, infrastructure and education, the border population will continue to lag behind the rest of the U.S. (U.S.-Mexico Border Commission 2010; Rodriguez-Saldana 2005).

2.6 The Poor and Homeless: Embedded Disparities

Poverty lingers in the U.S. as it does in other parts of the world. The usual reasons for the persistence of poverty are the lack of education and skills, lack of the opportunity to change one’s social class, lack of social, human and economic capital, discrimination, and imperialism.

Other reasons why poverty lingers is that it has deep generational roots, pessimistic attitudes, and the loss of hope that things will change.

There are connections between poverty and homelessness. Not all poor are homeless, but all homeless are poor. The homeless are drawn from a pool of the extremely poor (Auletta 1999; Rossi 1989). Poverty and homelessness have been identified as two of several indicators of the social health of the U.S. The Fordham Institute for Innovation in Social Policy has studied indicators of the social health of America and published trends in these indicators each year since 1987, to increase public awareness of social conditions (Miringhoff and Miringhoff 1999). Like economic indexes, the Index of Social Health uses key social indicators that assess the quality of life such as child abuse, suicide, drug abuse, health care, and core socioeconomic indicators that measure well-being, including average income, poverty, and inequities.

Poverty and homelessness are not one problem, but many; they are not a condition, but the result of a process; the societal resources needed to assist them

are chronically inadequate because we only deal with the most visible part of disparities. One of the limitations in increasing our understanding of the process of becoming poor and homeless is our tendency to stereotype so that the poor and homeless are viewed as homogeneous.

We usually hear that people “fall” into poverty and once fallen, they cannot “climb” out of it. The “fall” is usually attributed to faults of the social structure or to individual shortcomings or failures. Cotter (2002) suggests that poverty is a multilevel problem. Poverty is a process of disconnectedness that involves individuals and families facing an accumulation of broken or breaking social connections to social institutions. Disconnectedness takes many forms, including joblessness, the inability to meet financial obligations and making severe and sudden changes in one’s lifestyle. The rapidity of the progression into poverty is variable depending on individual and familial circumstances and the available alternatives (Trickett and Beehler 2013). Nevertheless, disconnecting from an acceptable lifestyle to a stigmatized one is an experience of profound loss.

Similarly, homelessness is a process of disconnectedness. The homeless are not only poor but they have no place to live—they carry their identity with them. One of the key predictors of being poor and homeless is a family history of poverty and homelessness; these problems are generational and cyclical. Most youth who are homeless have experienced broken, rejecting, hateful, and oftentimes violent relationships in their families.

2.7 Health-Related Quality of Life in Colonias

Social and health disparities are prominent among Mexican-Americans who live along the border (Anderson and Gerber 2008; Barr 2008). Studies have shown that health-related quality of life is associated with poverty, low levels of education, being Hispanic or black, older age, female gender, disability, inability to work, unemployment, lifestyle behaviors, and chronic disease (Mier et al. 2008). Few studies have examined the health profile of Mexican-American adults living in colonias. One study obtained a high response rate (87 %) among adults 18 years and over living in three separate colonias in Texas. These researchers used trained interviewers who conducted face-to-face interviews in Spanish (Mier et al. 2008). Results showed that participants reported worse physical health compared to the U.S. population norm and Hispanic norm. Despite adverse living conditions in the colonias participants reported a level of mental health similar to the U.S. and Hispanic norms. Living in the colonias for ten years or more and a low level of education predicted poor physical and mental health. Poor mental health was associated with the perception that accessing healthcare services was problematic for colonias residents. Results from this study suggest that colonias residents, especially residents of ten years or more may have adapted to the limitations of their environment and their ability to access healthcare. In other words, colonias residents’ expectations regarding healthcare are realistic given their circumstances of living in extreme poverty.

2.8 Pathways to Poverty

There is a large body of literature to support the theory that family poverty adversely affects children's health through increased neonatal and post-neonatal mortality rates, lower intellectual capabilities, lower academic achievement, greater risk of injuries resulting from accidents or physical abuse/neglect, higher risk for asthma, and lower developmental scores on a range of tests at multiple ages (Weitzman 2007; Aber et al. 1997). Children who experience poverty during their preschool and early school years have lower rates of school completion than children and adolescents who experience poverty in later years (Brooks-Gunn and Duncan 1997; Leventhal and Brooks-Gunn 2000). Yet, we know little about the pathways by which poverty exerts its negative influence. Some models have been suggested (social systems; ecological) but there is no consensus on how poverty should be operationalized so that proposed models can be refined and tested (Aber et al. 1997).

Researchers emphasize that studies of socioeconomic inequalities should begin early in the life course. Poverty occurring early in childhood may cause developmental damage that affects individuals and families for a lifetime. Poverty is a dynamic variable; therefore data need to be gathered longitudinally to capture the effects of poverty at various life stages. Research methodology needs to be comprehensive yet, in depth enough to measure time-dependent variables.

2.9 Conceptualization of a Social Systems Approach to Understanding Health Disparities

Our knowledge of pathways or mechanisms of disparities has been limited because the focus has been on static variables rather than on process variables; the former can be quantified and measured while process variables are subjective, broad and interrelated. Indeed, pathways research requires a longitudinal research methodology of repeated assessments of variables over time. Process variables are usually interrelated with other process variables as well as with static ones. The interconnectedness of process variables is why disparities do not have identified beginning and ending points; they are a web of dynamic connections in a continually changing system.

Figure 2.6 presents a suggested social systems approach to understanding health disparities. A social systems approach is especially relevant to poverty because it is in constant flux and its causes and consequences exist at all levels of a social system. Figure 2.6 illustrates the interrelationships between the United States and Mexico at many levels in both cultures. The figure also illustrates the different types of data needed to focus on poverty and its corollaries of marginalization and homelessness. While the figure is presented as if the intervention process is linear it is in fact cyclical, relational and tied to the life cycle of individuals, neighborhoods and communities.

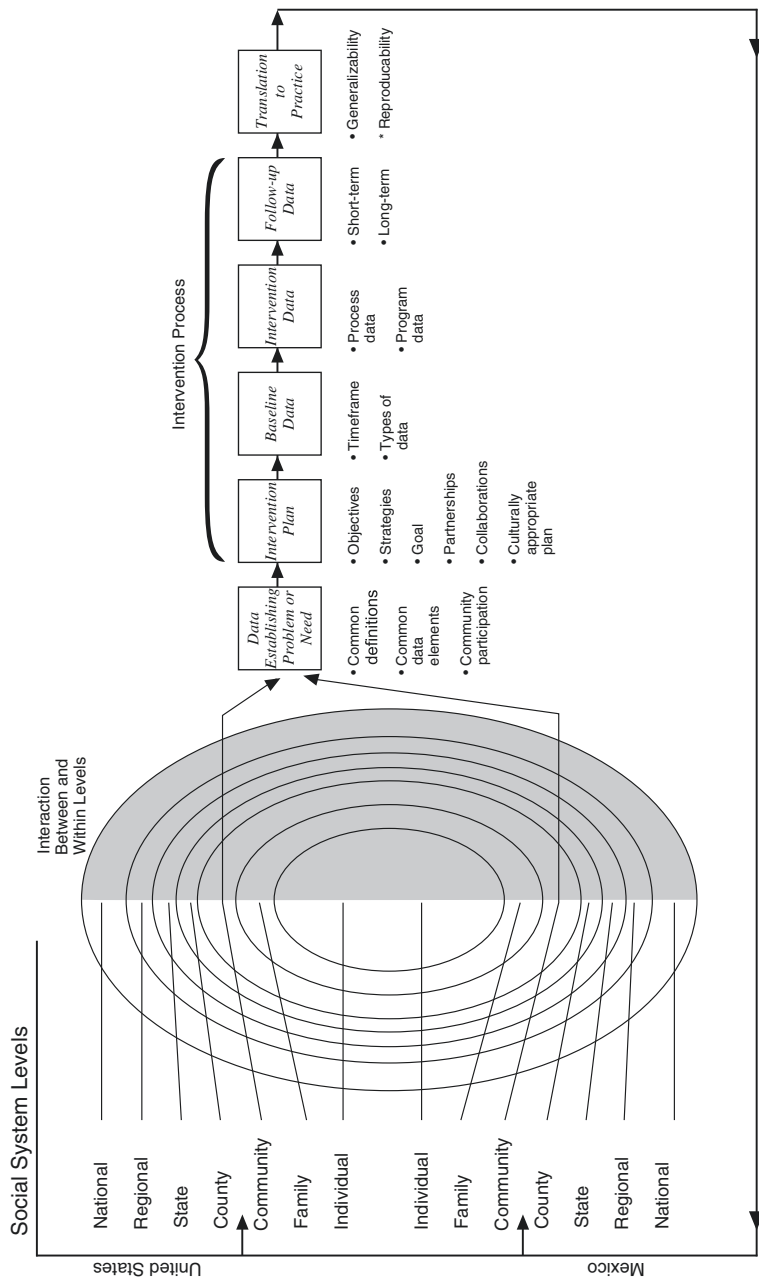


Fig. 2.6 A social systems approach to understanding health disparities

Whitbeck and Hoyt (1999), in a study of 602 runaways and homeless adolescents, identified variables that put youth at risk for poverty, homelessness, and marginalization.

A life events matrix was constructed for each adolescent enabling the researchers to construct a table of consecutive life transitions beginning at birth and ending with the adolescent's current living situation. The results showed a recurring theme or early independence for children resulting from multiple changes in caretakers and in residence. The more transitions the children experienced in family structure and residence, the earlier they initiated change on their own. Adolescents left homes characterized by loose family ties and multiple transitions. Frequently, problems spanned generations. Adolescents repeated family histories of alcohol and drug problems, mental health problems, and troubles with the law. The family portrait was one of multiple troubled family members, high levels of family conflict, and fragile, temporary family situations. Parent/caretaker alcohol and drug problems resulted in discomfort for the adolescents, diminished parenting skills of caretakers, and increased exposure to violence and abuse. Within families children became increasingly self-sufficient. Leaving home became easy; it meant escaping conflict.

Homelessness is a process of marginalization created by forced early maturation. The greater the family conflict and abuse the more the child separates from the family. The process of leaving separates him/her even more. Once on their own their options change; they transfer their allegiance to nonadults. Same aged social networks have critical developmental consequences; to get by, adaptation involves new survival skills. Results suggested that adolescents carried what they knew into early independence. Maladaptive behaviors learned at home were those used in their new networks. The researchers conclude that family factors may have resulted in early independence, but "too-early adulthood" extracts a heavy developmental price above and beyond the negative family experiences. Runaways are literally learning to become marginalized adults. While shelters exist in some cities, the more challenging problem is how best to intervene to teach healthy resocialization skills to adolescents who escaped from the most significant developmental period of their lives.

In this illustration the family is the focal system, but the subsystems of the family are dysfunctional because of parental unavailability and the lack of functional boundaries, common goals, and inadequate role performance by adults who are limited by the effects of alcohol and drugs. The major theme for dealing with conflict is to escape or lash out in anger and violence. The focal system lacks integrity and cohesiveness and belief in common principles such as respect for persons. Individuals in this dysfunctional social system have learned to survive, not adapt, to life by observing dysfunctional role models over several generations. Input into this system is limited because the key players do not view their behavior as dysfunctional and therefore do not see a need for help from outsiders. The output of the system is the young children who do not have the knowledge and skills or assistance to cope with the disruptions to their lives so they leave the system.

Intervention in this social system would involve changing the environment for the runaways, exposing them to healthy adults and peers, through teaching and mentoring helping them to see and practice healthy alternatives to their behavior.

This process will take resources, time, patience, reinforcement, and monitoring to keep the runaway interested, motivated, and supported so the appeal of a life of self-sufficiency does not draw them back to the street.

2.10 Summary

There is substantial literature on the relationship between health disparities, especially poverty, on the development of children, in particular the negative effects that follow children throughout their life cycle. The problem with existing research findings is that poverty and other disparities researchers do not gather longitudinal data so we know little about when and how health disparities interfere negatively with child development. Therefore, we do not understand how poverty is expressed as individuals and groups move through their life cycles. We have suggested that a social systems approach to health disparities will yield insights into how and when interventions can help to alter the momentum of poverty and its negative effects.

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