

COMPANION SUMMARY

This document is intended to serve as a companion publication to *Portrait of Promise: The California Statewide Plan to Promote Health and Mental Health Equity*. The statements, facts, figures, and graphics contained within this summary are presented in greater detail in the complete document. To review this information in its entirety, please visit the Office of Health Equity web page at <https://www.cdph.ca.gov/programs/Pages/OHEMain.aspx>.



PORTRAIT OF PROMISE: The California Statewide Plan to Promote Health and Mental Health Equity

Report to the Legislature and the People of California by the Office of Health Equity, California Department of Public Health, August, 2015

Widespread, systemic inequities take a toll on the mental and physical health of our state's residents. Those who suffer disproportionately from the stress of discrimination or the constraints of poverty also suffer disproportionately from heart disease, asthma, arthritis, and cancer. As such, the health conditions of our most vulnerable populations will only improve as we

address the source of those conditions. We have a responsibility and an obligation to understand the barriers that impede all of California's residents from achieving their greatest health

potential – and to work together to remove those barriers.

The California Statewide Plan to Promote Health and Mental Health Equity ("Plan") is the first biennial report of the new Office of Health Equity (OHE),

>> CONT. PAGE TWO

“ It has taken hundreds of years of unjust social policies and practices to create the degree and magnitude of health inequities detailed in this report. ”

established in 2012 under the California Health and Safety Code Section 131019.5. The OHE, operating within the California Department of Public Health (CDPH), is tasked, first and foremost, with aligning state resources, decision making, and programs to achieve the highest level of health and mental health for all people, with special attention focused on those who have experienced socioeconomic disadvantages and historical injustice. The full document provides both a context for why this work is of utmost importance (the report) and a road map for how to achieve it (the strategic plan). It can be found on OHE's website, at <http://www.cdph.ca.gov/programs/Pages/OHEMain.aspx>

The full Plan is intended to illuminate the scope of the health equity challenge with compelling data and narrative. It makes the case that health is a basic human right, that health inequity is a moral and financial issue, and that health equity is in everyone's best interest. It also provides a brief summary of



the most pervasive social determinants of health, and it offers examples of programs, policies, and practices that have begun to make a difference in the state's most vulnerable communities. The Plan points to what California can do to capitalize on current windows of opportunity and minimize foreseeable threats.

The Plan's five-year strategic priorities:

1. Through assessment, yield knowledge of the problems and the possibilities.
2. Through communication, foster shared understanding.
3. Through infrastructure development, empower residents and their institutions to act effectively.

Goals for each of the strategic priorities were crafted for California overall as well as within the health field, among potential health partners, and within local communities for Stage 1 (2015-2018) and Stage 2 (2018- 2020) of the Plan. In this inaugural effort, the OHE also recognized the critical need to create goals aimed at building capacity for implementation of the strategic priorities. While the OHE facilitated the process for creating this document, the outcome reflects the thoughtful participation of hundreds of stakeholders.

California's population is the most diverse in the continental United States¹ and one of the most diverse in the entire world. The Latino population is the



state's largest ethnic plurality, at about 38 percent of the population, and is predicted to approach majority status by 2060 (see Figure 1). That makes California only the second state in the nation, behind New Mexico, in which Whites are not the majority and where Latinos are the plurality. The state's non-Hispanic White population in mid-2014 is estimated to be a fraction of a percent smaller than the Latino population, at 38.8 percent, down from 57.4 percent in 1990. Whites are trailed by the Asian/Pacific Islander population, at 13 percent (up from 9.2 percent in 1990); African Americans, at 5.8 percent (down from 7.1 in 1990); and Native Americans, at less than 1 percent.² California's human diversity goes beyond race and ethnicity. It also includes large shares of other subpopulations relative to other states, including Lesbian, Gay, Bisexual, Transgender, Queer, and Questioning (LGBTQQ) communities; persons with disabilities; undocumented immigrants; and many others. For instance, according to the 2010 census, California has one of the highest percentages in the nation of married couples of mixed race or ethnicity and is among the leading states in the num-

LATINOS ARE PROJECTED TO BECOME THE LARGEST RACIAL/ETHNIC GROUP AND WILL ACCOUNT FOR NEARLY HALF OF ALL CALIFORNIANS BY 2060

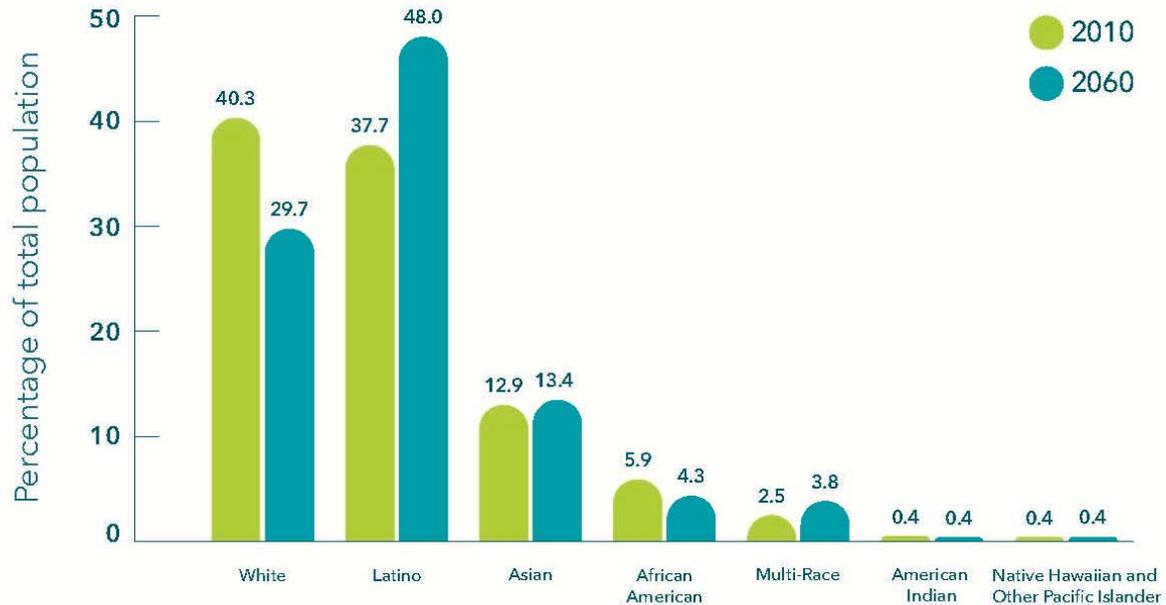


FIGURE 1: Percentage of California's population and projected population, by race/ethnicity, 2010 and projected 2060.

Source: California Department of Finance, Report P-1 (Race): State and County Population Projections by Race/Ethnicity, 2010-2060, Sacramento, California, January 2013.

ber of same-sex households.³ More than 42 percent of the state's population over the age of five speaks one of several hundred languages other than English at home, with more than two-thirds of those also speaking English well or very well, while about 10 percent do not speak English at all.⁴

California's diversity has been a source of great strength for the state's economy and cultural life, enriching California's schools, universities, communities, and industries with a kaleidoscope of skills and knowledge and with a determination to succeed.

Approximately one in three small business owners in California is an immigrant,⁵ and according to the Small Business Association, close to half of

all small businesses in Los Angeles are owned by immigrants, who make up about 34 percent of the city's population. Statewide, almost one-third of the state's 3.4 million small businesses are owned by people of color.⁶ At the national level, Latinos alone accounted for an estimated \$1.2 trillion in consumer purchasing power in 2012, a market larger than the entire economies of all but 13 countries.⁷

Despite these strengths, the great advantages of California's demographic diversity continue to be undermined by persistent, unjustifiable inequities in various social, economic, and environmental conditions that result in gaping disparities in the health of vulnerable

populations, especially low-income (below 200 percent of the federal poverty level) families and neighborhoods; communities of color; the very young and the very old; and those who have experienced discriminatory practices based on gender, race/ethnicity, or sexual orientation. These disparities in health status are a matter of life and death, shown by differences in death rates and life expectancy among the state's major racial and ethnic groups. Although the state's death rates have been steadily declining for almost all racial and ethnic groups, major gaps persist for African Americans relative to Asians and other populations as of 2010 (see Fig-

ure 2). Similarly, the state's average life expectancy of 80.⁸ years in 2010 masked a more than 11-year gap between Asian Americans, at 86.3 years, and African Americans, at 75.1 years.¹¹

One way of identifying the causes of health disparities is to examine the factors that produce and maintain healthy individuals, communities, and places. Many people assume that health is mostly a function of individuals' seeing the doctor regularly for good medical care and avoiding unhealthy behaviors, such as smoking and inactivity. However, most public health experts have adopted an upstream/downstream model of the causal factors that produce health, illness, and health disparities. In this model, factors such as medical care to maintain health or treat an illness or injury are



viewed as the immediate, or "downstream," determinants of health outcomes. These downstream factors are causally related to "midstream" health determinants, such as people's genetic and biological makeup, and individual health behaviors, such as smoking, unhealthy eating, or lack of physical exercise. Further "upstream" are a host of environmental, social, and economic factors that even more powerfully influence health outcomes for entire populations. The World Health Organization (WHO) has defined these upstream factors as "the conditions in which people are born, grow, live, work, and age. These circumstances," declared WHO, "are shaped by the distribution of money, power and resources" within every level of society,¹³ resulting in significant upstream health inequities and downstream health disparities that

ALTHOUGH DEATH RATES IN CALIFORNIA HAVE DECLINED, DISPARITIES PERSIST, WITH AFRICAN AMERICANS HAVING HIGHER DEATH RATES THAN OTHER RACIAL/ETHNIC GROUPS

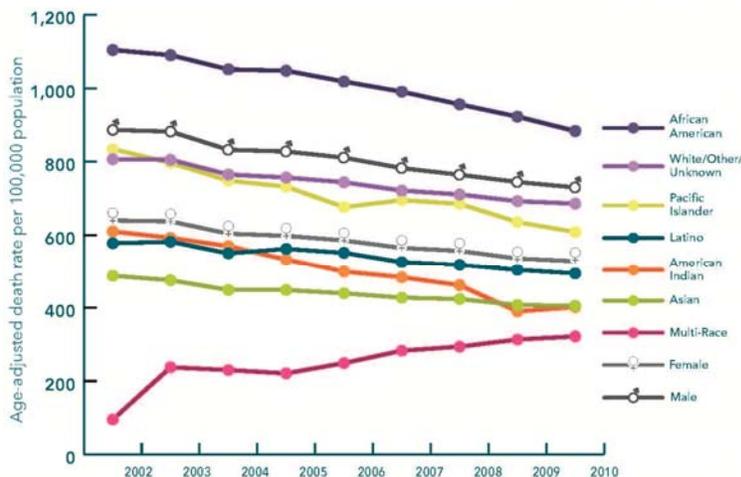


FIGURE 2: Death rates, by race/ethnicity and gender, California, 2002 to 2010. Sources: California Department of Public Health, Death Records; and California Department of Finance, Race and Ethnic Population with Age and Sex Detail, 2000-2010. Sacramento, California, July 2007. Note: Age-adjusted rates are calculated using year 2000 U.S. standard population.

disproportionately impact low-income populations, communities of color, and other groups that are subject to racism and discrimination. While public health researchers have differed on the relative importance of these various upstream and downstream health determinants, it is estimated that medical care, healthy behaviors, and genes and biology altogether account for only about half of a society's overall health outcomes,¹⁴ even though downstream determinants attract the majority of health funding and expenditures. The Social Determinants of Health What constitutes the other 50 percent of the determinants of health and well-being is a complex interplay of environmental conditions, such as air and water quality, the quality of the built environment (e.g., housing quality; land use; transportation access and availability; street, park, and play-



FIGURE 4: Achieving Health & Mental Health Equity At Every Level

Source: California Department of Public Health, Office of Health Equity, as inspired by World Health Organization, Robert Wood Johnson Foundation, and many others.

ground safety; workplace safety; etc.), and a whole host of socioeconomic factors. These latter factors include opportunities for employment, income, early childhood development and education, access to healthy foods, health insurance coverage and access to health care services, safety from crime and violence, culturally and linguistically appropriate services in all sectors, protection against institutionalized forms of racism and discrimination, and public and private policies and programs that prioritize individual and community health in all actions. Significantly, in contrast to the individual-level downstream determinants, these environmental and socioeconomic determinants have population-

level impacts. Understanding this is vital when designing and implementing health interventions, such as economic development programs in low-income communities, which can be targeted to specific subpopulations, communities, and neighborhoods, thus affecting thousands or tens of thousands of people rather than one individual at a time. When a society's principles and policies work to optimize these interrelated social determinants of health on the basis of justice and equity for everyone, health is created at the levels of the individual, the community, the environment, and society at large (see Figure 4).

The Office of Health Equity (OHE),

operating within the California Department of Public Health (CDPH), was created in 2012. The office continues California's multifaceted efforts to reduce or eliminate health and mental health disparities among California's vulnerable communities. The OHE was created both to build upon the existing network of public and private sector partnerships in all economic, social, and environmental sectors that influence health and mental health and to align all state resources, decision making, and programs to accomplish the following objectives:

- ▶ Achieve the highest level of health and mental health for all people, with

special attention focused on those who have experienced socioeconomic disadvantage and historical injustice;

- ▶ Work collaboratively with the Health in All Policies Task Force to promote work to prevent injury and illness through improved social and environmental factors that promote health and mental health;
- ▶ Advise and assist other state departments in their mission to increase access to, and the quality of, culturally and linguistically competent health and mental health care and services; and
- ▶ Improve the health status of all populations and places, with a priority on eliminating health and mental health disparities and achieving health equity.²⁸

To carry out its work, the OHE has been organized into three operational units:

- ▶ Community Development and Engagement Unit
- ▶ Policy Unit
- ▶ Health Research and Statistics Unit.

For many years, the relationship between socioeconomic status (SES), usually measured by income, education, or occupation, and health and mental health has been known. As individuals move up the SES ladder, their health improves, they live longer lives, and they have fewer health problems. Socioeconomic status is important because it provides access to needed resources that help people avoid risks, promote healthy behaviors, and protect health, such as “money, knowledge, power, prestige,

and beneficial social connections.”¹

Under the official federal poverty measure, California ranks 14th among the 50 states. However, California has the highest poverty rate in the nation when calculated according to an alternate (although unofficial) measure, known as the Supplemental Poverty Measure (SPM), which was developed by an Interagency Technical Working Group commissioned by the Office of Management and Budget’s Chief Statistician to better reflect contemporary social and economic realities and government policy. The SPM factors in the cost of housing; taxes; noncash benefits; and day-to-day costs such as childcare, work-related expenses, utilities, clothing, and medical costs. This alternate method adds nearly 3 million

California has the highest poverty rate in the nations according to the Supplemental Poverty Measure.

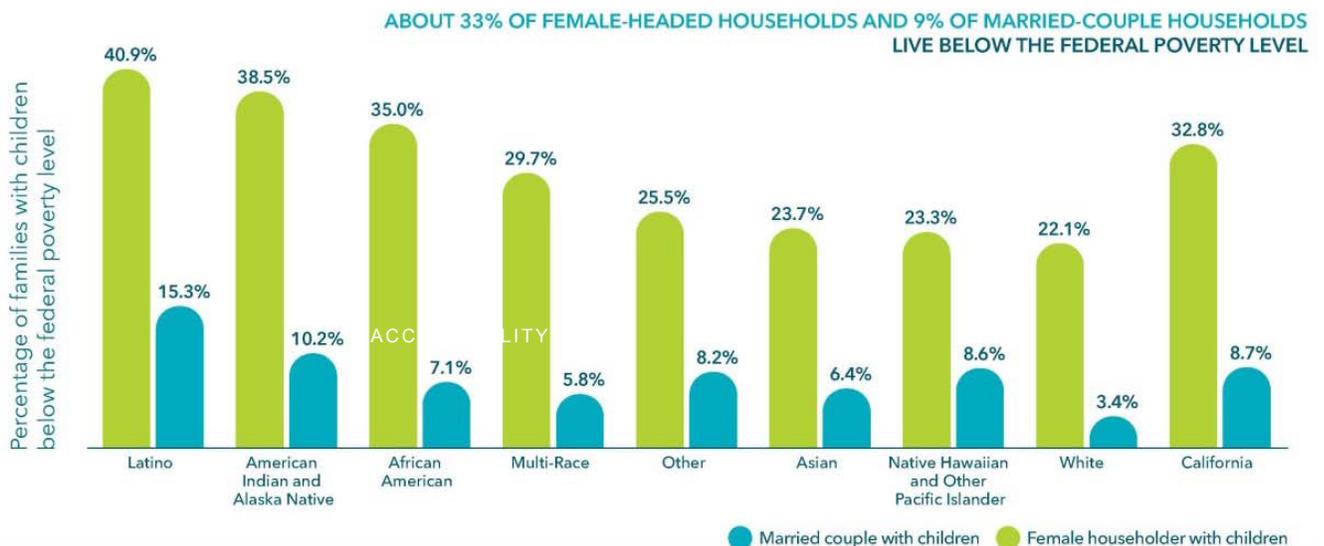


FIGURE 6: Percentage of families whose income in the past 12 months was below poverty level, by race/ethnicity, California, 2006-2010. Source: U.S. Census Bureau, American Community Survey, 5-Year Estimates (2006-2010).

Strong Public Support for Universal Preschool

Reflecting a growing public focus on preschool since President Obama proposed universal access to high-quality preschool for all low- and middle-income 4-year-olds, an April 2014 survey by the California Field Poll, a nonpartisan public opinion news service, registered strong voter support for extending California's transitional kindergarten to include all 4-year-olds at an estimated cost of \$1.4 billion. The poll found that 56 percent of those without young children, and 57 percent of people overall, support the idea. Latinos registered the greatest support (75 percent), followed by African Americans, at 72 percent. The 2014-15 Budget Act allocates funding to support the expansion of California State Preschool Program for 3- and 4-year old children from low income families.

more people to the official poverty rate, meaning that nearly one in four Californians would be considered poor.⁴

Extreme income inequality is especially acute among California families headed by a single mother, one in three of which has an income below the poverty level. The disparity is even higher for families led by Latino, American Indian/Alaska Native, and African American single mothers (see Figure 6). This suggests that the persistent (if improving) inequity in wages between men and women, with women being paid 75 percent of comparable wages paid to men,⁵ is not simply a women's issue but also a serious family issue that contributes to additional inequities in quality of life for children. Almost half of the state's 2 million children age 3 or under live in low-income families.⁶

Many of the basic foundations for life-long health, prosperity, and well-being are formed in early and middle childhood. That observation, increasingly recognized in policy, research, and

clinical practice,¹ means that, as a society, we can minimize many of the health inequities featured in this report by focusing attention and resources on ensuring that our children – all our children – are provided with the strongest possible foundations for future success.

In purely financial terms, early investment in childhood education is a winner. The rate of return on a \$1 investment is 7 to 10 percent annually “through better outcomes in education, health, sociability, [and] economic productivity and [through] reduced crime,” according to University of Chicago economist and Nobel laureate

James Heckman. Over a lifetime, the return on that \$1 adds up to \$60 to \$300.²

One of the most successful ways of supporting healthy early childhood development is through high-quality infant and toddler care, whether provided by parent(s) who feel prepared and supported, or by family or outside day care providers, Head Start, or preschool programs.³ Getting ready to learn is especially important for the nearly half of all California children who live in low-income families (less than 200 per-

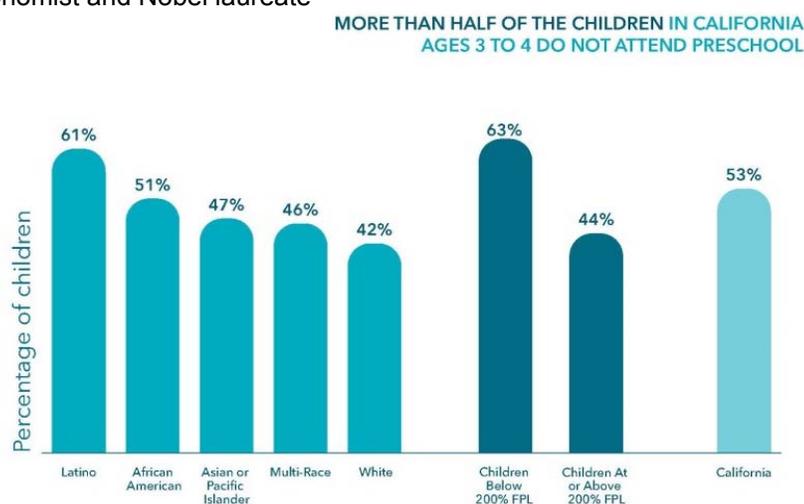
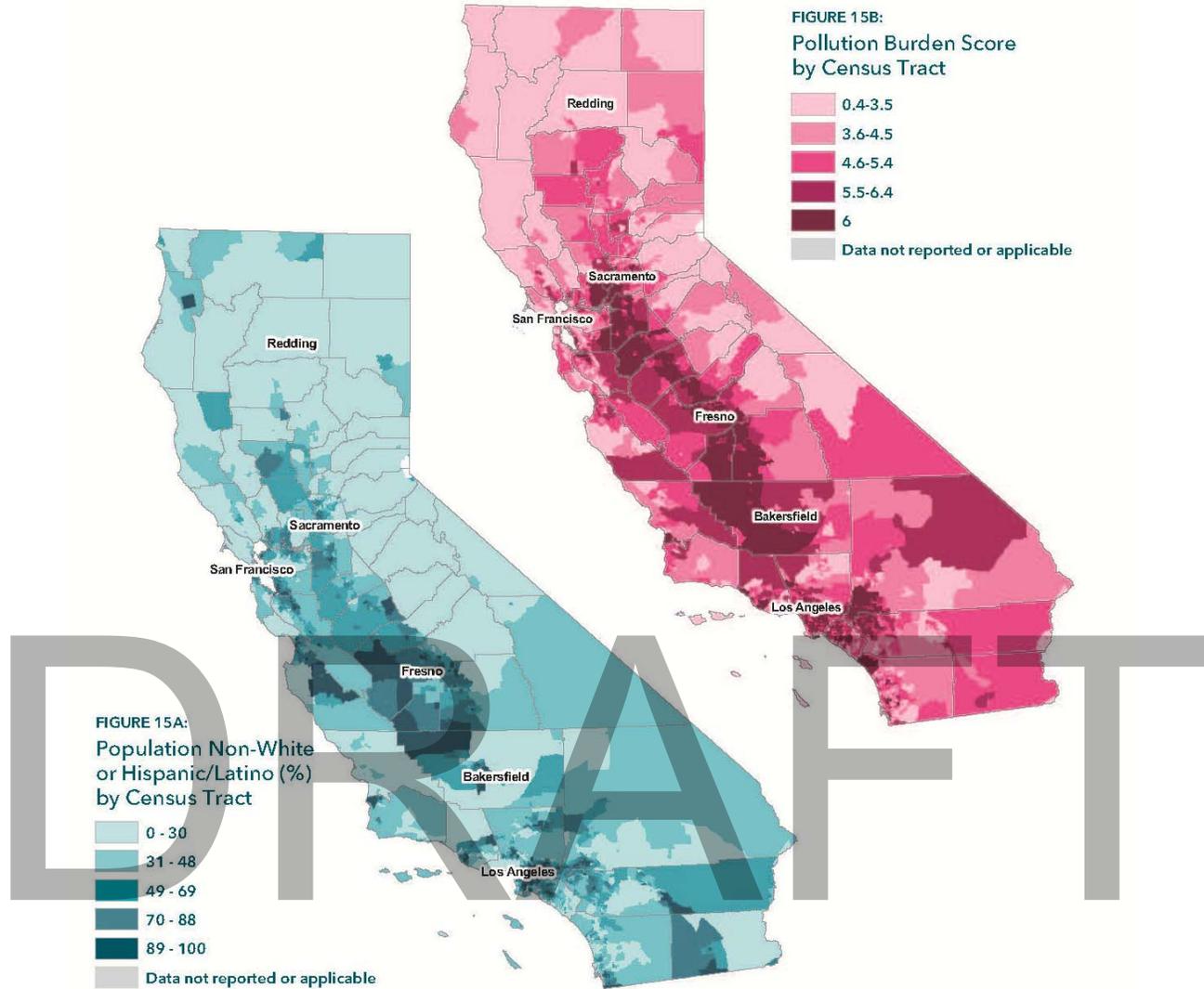


FIGURE 9: Percentage of children in California ages 3 to 4 who are not attending preschool, by race/ethnicity and federal poverty level (FPL), 2009-2011. Source: U.S. Census Bureau, American Community Survey, 3-Year Estimates (2009-2011). Analysis by the Annie E. Casey Foundation, KIDS COUNT Data Center.

LATINO OR NON-WHITE POPULATIONS ARE MORE LIKELY TO LIVE IN AREAS WITH A HIGH BURDEN OF POLLUTION



Source: California Environmental Protection Agency (Cal/EPA) and the Office of Environmental Health Hazard Assessment (OEHHA), California Communities Environmental Health Screening Tool, Version 2.0 (CalEnviroScreen 2.0), 2014.

cent of the federal poverty level),⁴ a disproportionately large share of whom are non-White. Despite the evidence demonstrating the importance of early childhood care and enrichment, only 6 percent of income-eligible children under age 3 are served by any publicly supported program.⁵ Some reasons proposed for this are transportation barriers, especially for rural areas; cultural, language, or literacy barriers; lack of awareness; and staffing or facilities

issues. As shown in Figure 9, about three in five low-income children ages 3 to 4 are not attending preschool, including three out of five Latinos and more than half of African Americans.

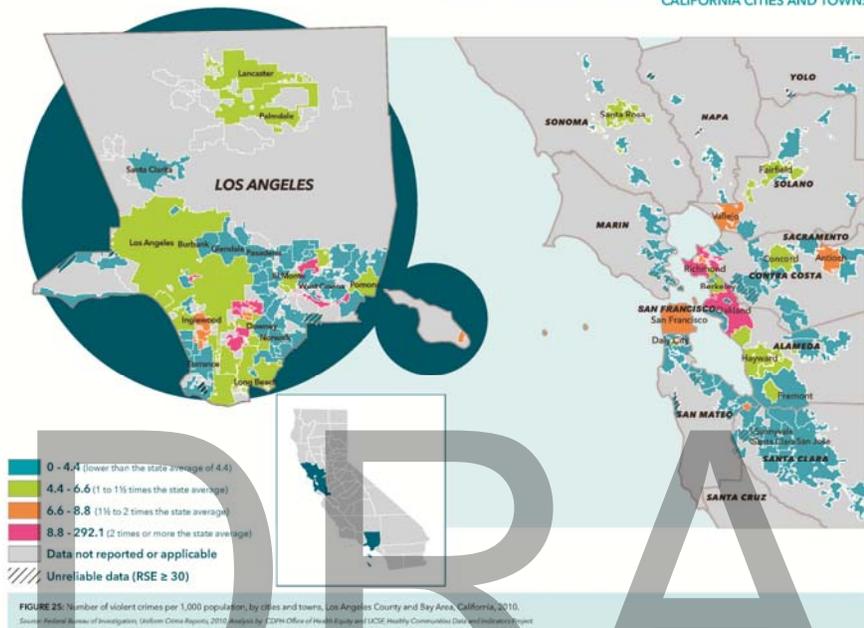
The environment – the air we breathe; the water we consume; the soil that nourishes the food we eat; and all the natural and human-made conditions of the places we live, work, learn, and play – has a profound impact on the health of every one of us. Yet low-

income families, communities of color, and certain other vulnerable populations, especially children, are disproportionately subjected to environmental perils that have been causally linked to epidemic rates of various respiratory problems, including bronchitis, emphysema, asthma, and other diseases, disabilities, and chronic health conditions.¹ Figure 14 illustrates that the pollution burden tends to be high in California’s Central Valley, where Latinos and non-Whites

make up a large proportion of the population. Despite having achieved impressive improvements in overall air pollution quality in recent decades, California is still home to the top five cities in the nation for both ozone pollution and year-round and short-term particle pollution, the two sources of the most negative health effects of polluted air.² The state's smoggiest cities are also the cities

relationships among residents, including the degree of mutual trust and feelings of connectedness among neighbors. For instance, residents of close-knit neighborhoods work together to create and maintain clean and safe playgrounds, parks, and schools. They exchange information on child-care, employment, and health access, and they cooperate to discourage crime and other negative behaviors, such as domestic violence, child abuse, substance abuse, and gang involvement, which can directly or indirectly influence health. Conversely,

THE RISK OF CRIME CAN BE HIGHLY DISPARATE FOR NEIGHBORING CALIFORNIA CITIES AND TOWNS



with the highest densities of people of color and low-income residents who lack health insurance.³

Across the country, when you ask people what they want their neighborhood to look like, the answers are fairly consistent. People want neighbors who care enough about the neighborhood to work together to create and maintain a healthy and safe environment, with convenient access to cultural and economic opportunities, and where their children can play, learn, and thrive in an atmosphere of trust and security.¹ In other words, they

want neighborhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment. Such characteristics are essential to community mental and physical health and health equity.²

An analysis of the literature on neighborhood-level social determinants of health shows that, among other factors, the collective health of neighborhoods is highly subject to the social



less close-knit neighborhoods and greater degrees of social disorder have been related to anxiety and depression.³

Unfortunately, California has many low-income neighborhoods, both rural and urban, where the opportunities or traditions for engagement in community service are lacking. While opportunities for social engagement benefit people across the socioeconomic spectrum, lower-income adults in California are less likely to have participated in a board, council, or organization

RATES OF SUICIDAL THOUGHTS ARE HIGHER AMONG BISEXUAL, GAY, AND LESBIAN ADULTS

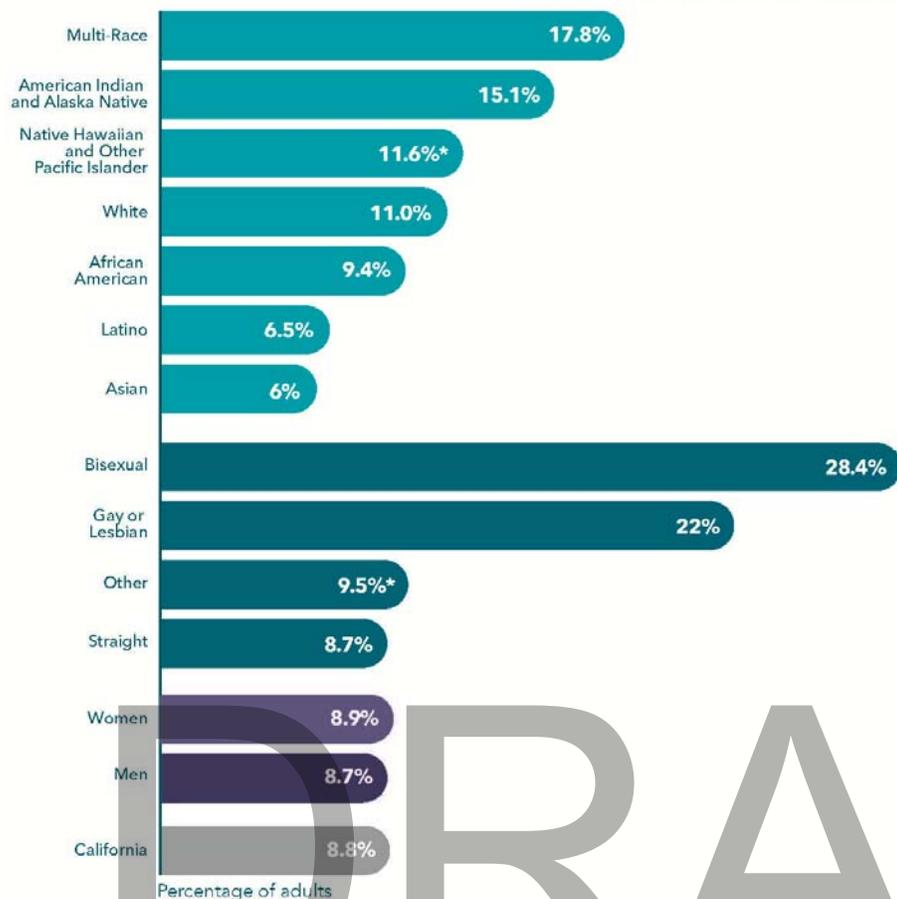


FIGURE 29: Percentage of adults who reported having seriously thought about committing suicide, by race/ethnicity and sexual orientation, California, 2011-2012.

Source: University of California Los Angeles, California Health Interview Survey, 2011-2012.
 Note: *Other* includes not sexual/celebrate/none.
 *Statistically unreliable data

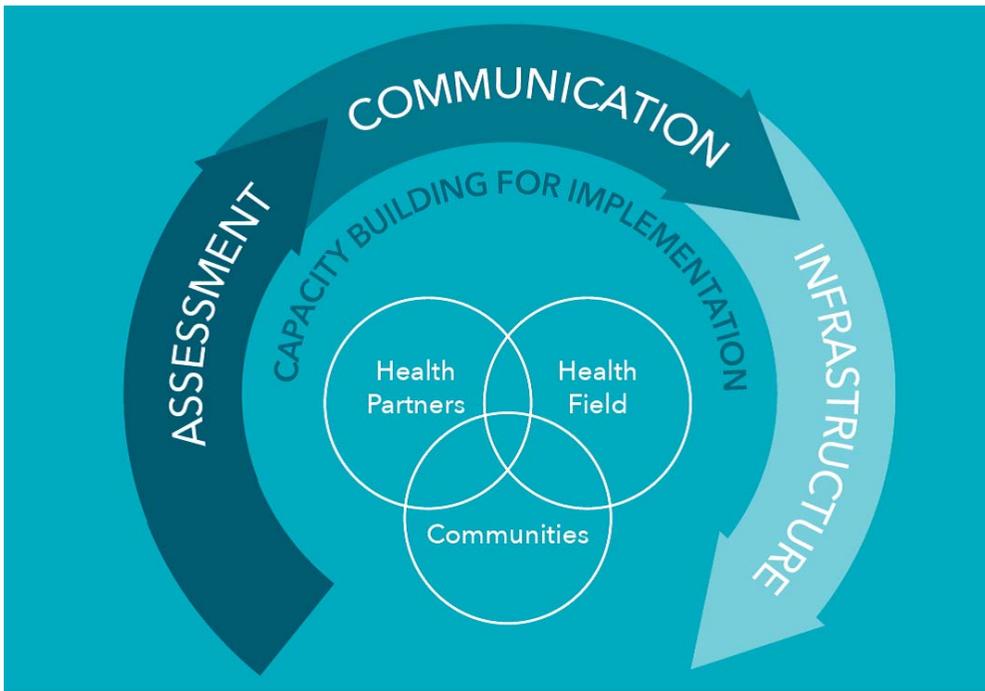
to reduce neighborhood gang activity, are important components in many community-based neighborhood improvement initiatives.⁷ The World Health Organization (WHO) defines mental health as “a state of well-being in which the individual realizes his or her own abilities, can cope with normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.” WHO adds, “Mental health is an integral part of health; indeed, there is no health without mental health,”¹ since physical health impacts mental health and vice versa. Mental



or to have worked informally to address a community problem, when compared with higher-income California adults. Low levels of neighborhood trust and cohesion may also be related to higher rates of criminal activity in disadvantaged neighborhoods. A 2010 study from the U.S. Department of Justice found a high correlation between low household income levels and rates of property crime, such as burglary.⁵ A similar relationship holds true for violent crime, as seen in Figure 25, where low-income, disadvantaged neighborhoods in the Bay Area and in South

Central Los Angeles have the highest crime rates. The combination of high crime rates and other social factors associated with low-income neighborhoods creates barriers to healthful behaviors, such as walking and playground use; puts children at risk for poor educational, emotional, and health outcomes; and makes children more likely to become victims or perpetrators of violent crime.^{5,6} Community-level crime interventions, such as well-lit, secure playgrounds; neighborhood watch organizations; and development of well-resourced teen centers

disorders, characterized by alterations in thinking, mood, and/or behaviors that are associated with distress and/or impaired functioning, contribute to a host of physical and emotional problems, including disability, pain, or death. In fact, mental health disorders are the leading cause of disability in the United States, accounting for 25 percent of all years of life lost to disability and premature mortality.² In California, suicide, which is a direct outcome of mental distress, is the third leading cause of death among individuals ages 15 to 34.³



Eliminate Health and Mental Health Inequities

The prevalence of mental illness and problems of availability, affordability, and access to mental health treatment and preventive services are areas of striking disparities on the basis of race, ethnicity, gender, income, age, and sexual preference. Various racial, ethnic, and other minority groups and low-income individuals of all races experience higher rates of mental illness than do Whites and more affluent individuals. Further compounding the problem, these individuals are less likely to access mental health care services, and when they do, these services are more likely to be of poor quality.⁴ In California, almost one in six adults has a mental health need, and about one in 20 (and one in 13 children) suffers from a serious mental illness (SMI), according to a recent study by California HealthCare Foundation.⁵ The study found that nearly half of adults and two-thirds of adoles-

cents with mental health needs did not get recommended treatment. Other findings included significant racial and ethnic disparities for incidence of SMI, with Native Americans, multiracial individuals, African Americans, and Latinos all experiencing rates above the state average. A notable exception to the link between race/ ethnicity and mental illness is the suicide rate, which is highest among White men.⁵ This is an area that could benefit from additional understanding, as White men do not report having seriously thought about committing suicide any more than their multiracial and American Indian and Alaska Native counterparts do (the data on Native Hawaiians and other Pacific Islanders is statistically unreliable). When the data is examined by sexual orientation, rates of suicidal thoughts are highest among Bisexual individuals, followed by those who identify as Gay or Lesbian (see Figure

29).

Health and mental health inequities have surfaced through a culmination of unjust policies and practices over multiple generations. As such, there is no one-to-one relationship in eliminating the inequities; it is a many-to-many relationship. The individuals who have been involved in developing this Plan have identified many intersecting, complementary interventions to turn the tide on the many inequities that are well documented in the accompanying report. These interventions have as their basis assessment, communication, and infrastructure development for California overall, as well as within the health field, among potential health partners, and within local communities.

Assessment will yield knowledge of the problems and the possibilities. Communication will foster shared understanding. Infrastructure development will empower residents and their institutions to act effectively. This approach speaks to our intention to identify and disseminate actionable information on inequities and disparities to develop and align sustainable multi-sectoral infrastructure and support. There is growing interest in health and mental health equity, yet many do not know what this terminology means, how it impacts them and others, or why they



should be involved in this work. We see an opportunity to build and strengthen the existing network of individuals, organizations, and institutions committed to promoting health and mental health equity—work that is also strongly linked to addressing the social determinants of health. Working to address the social determinants of health includes working to broadly improve the economic, service, and built environments in which people live, work, learn, and play. To expand this network, we must understand who is already engaged in this work and reach out to those who have a potential interest in engaging in it. In order to be both motivated and successful in reducing the inequities caused by the social determinants of health, partners need access to one another, models that work, and data that is relevant and user friendly. They also need as much support as they can get in build-

ing their capacity to effectively implement and sustain their interconnected, mutually advancing infrastructures

It has taken hundreds of years of unjust social policies and practices to create the degree and magnitude of health inequities detailed in this report. Each resident, tribe, community, coalition, organization, institution, corporation, and philanthropy has inherited this legacy – and each has an important part to play as the tide is turned through a concerted, comprehensive, and sustained response. We welcome you to join us.

DRAFT

References

Sources: The President’s 2015 Budget Proposal for Education. U.S. Department of Education Website. <http://www.ed.gov/budget15>. Accessed July 2014. DiCamillo M, Field M. Majority of California Voters supports expanding pre-school to all four-year-olds despite its additional costs and regardless of parents’ incomes. San Francisco, CA: The Field Poll; April 2014. California State Budget 2014-2015. California State Budget Website. <http://www.ebudget.ca.gov/2014-15/pdf/Enacted/BudgetSummary/FullBudgetSummary.pdf>. Accessed November 2014.

