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Position paper

Promoting Equity and Reducing Health Disparities Among Racially/Ethnically Diverse Adolescents: A Position Paper of the Society for Adolescent Health and Medicine

The Society for Adolescent Health and Medicine

The Society for Adolescent Health and Medicine (SAHM) is an international and multidisciplinary organization whose mission is “committed to improving the physical and psychosocial health and well-being of all adolescents through advocacy, clinical care, health promotion, health service delivery, professional development and research.” As a leader in adolescent health, SAHM recognizes the need to specifically address racial/ethnic disparities and inequity that can negatively impact adolescent development, health, and achievement.

The terms *health disparities* and *health equity* are concepts that have developed globally since the 1980s. Many definitions of each of these terms exist and the orientation to and level of the discussion has varied between the United States and other regions of the world [1]. It is important to clarify the definitions and frameworks for health disparities and health equity to be used in this position paper. The definition of health equity is from Margaret Whitehead for the World Health Organization in 1991 “Principles and Basic Concepts of Equity and Health,” in which the basic pillar supporting health equity is the concept of fairness and inequity is defined as “differences in health that are unnecessary, avoidable, unfair and unjust” [2]. This definition has as its underpinning a social justice stance that reflects unequal distribution of resources resulting from power differentials that can be impacted on by societal will. Social justice is very closely related to principles of human rights and medical ethics such as nondiscrimination, beneficence, nonmaleficence, and autonomy [3]. These inequities lead to differences in health among more and less advantaged social groups. To reflect the relationship between health equity and health disparities, the definition of health disparities used in this position paper comes from Paula Braverman, which is, “a particular type of difference in health... in which disadvantaged social groups systematically experience worse health or greater health risks than more advantaged groups” [1,4]. Health disparities can be addressed by examining the root causes of the disadvantage and investing in solutions that help to eliminate this difference. Much evidence shows that social determinants of health are key root causes of disparities that must be addressed [1,4–6]. The World Health Organization, in its 2008 document “Closing the gap in a generation: Health

equity through action on the social determinants of health,” defines social determinants of health as the “structural determinants and conditions of daily life... (that) are responsible for a major part of health inequalities between and within countries.” The three overarching recommendations from the report are to improve daily living conditions; tackle the inequitable distribution of power, money, and resources; and measure and understand the problem and assess the impact of action [7]. These social determinants are particularly important for adolescents and young adults as they are often entering the workforce, having children, are a large part of immigrant populations and are learning to make decisions in social contexts.

Although race and ethnicity are social constructs that vary by context and therefore will vary according to the global context of where the adolescent resides, multiple social dynamics such as discrimination, bias, institutionalized racism, unequal provision of resources, poverty, and unequal environmental challenges in communities and educational institutions disproportionately affect the well-being of less advantaged racial and ethnic groups in many countries [1,2,4,5]. Other dimensions of differences such as socioeconomic status, geography, religion, sexual orientation, educational attainment, family structure, immigration, and health beliefs are equally important to address. However, given the unprecedented changing demographics in many countries in the world and the evidence that many health disparities and inequities correlate with race and ethnicity independent of other factors, this position paper specifically addresses this concern [1,5].

Background

Adolescents account for 20% of the world's population, more than half of whom live in Asia, and the fastest growing population of adolescents being from sub-Saharan Africa [8]. By 2040 in the United States, the projected percentage of non-Hispanic whites in the adolescent population will drop below 50% [9]. In Europe, it is predicted that the population from age 15 to 39 years will be composed of more than double the current level of foreign background persons by 2061 [10]. These continuing dramatic racial and ethnic demographic shifts globally demand that the unique health needs of this diverse population be addressed to ensure that the health

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needs of all adolescents are being met. Typically, the health profile of “minority” or “foreign” racial and ethnic populations has been poorer than their European ancestry counterparts. There is a growing body of literature, most notably the Institute of Medicine’s 2002 report “Unequal Treatment” in the United States, which documents the negative impact of health disparities on population health and the economic burden to the entire health care system. Current “minority” and “foreign” populations suffer from less access, lower quality, and worse outcomes of health care [5,10]. As the world’s youth become increasingly composed of populations that we currently refer to as “minority” or “foreign,” and these groups have poorer health, the adolescent and young adult health profile will have a negative impact on the overall health of these countries.

Statement of the Problem

Health disparities affecting disadvantaged racial and ethnic groups of adolescents globally lead to health inequities that are adversely affecting health care quality, cost, and outcomes for a growing number of adolescents and young adults. These systematic differences can be impacted to improve the health and well-being of all adolescents. Given the growing racial and ethnic diversity within the global adolescent population, it is imperative that health care providers, educators, advocates, researchers, and policy makers be responsive in acknowledging and addressing health disparities to move toward health equity. These constituents can influence changes in how our communities invest in different types of human capital that will help equalize differentials in social determinants that affect adolescent and young adult health. These aspects of human capital are conceptualized in the 2010 American Academy of Pediatrics Policy Statement “Health Equity and Children’s Rights” as social, economic, environmental, educational, and personal capital [3]. As recommended in the Institute of Medicine’s 2008 report, “Adolescent Health Services: Missing Opportunities,” context, need, family, community, skill, and policy matter for optimal adolescent health services, and matter that much more so for racially and ethnically diverse adolescents [11].

SAHM supports frameworks for adolescent health that address the importance of all youth having equal opportunities to make choices that lead to good health and that promote the idea of health starting where adolescents live, play, work, and learn [12].

Positions/Recommendations

SAHM recommends the following positions and recommendations to improve the health of diverse adolescent populations and reduce racial and ethnic health inequities. These positions relate to the areas of the SAHM mission.

1. Advocacy: Policy makers should establish health policies and best practices that promote health among diverse populations of adolescents in order to reduce racial/ethnic health inequities

Powerful social determinants of health include poverty, racism, community violence, quality education, and vocational

opportunities. Disparities as they pertain to health care delivery include: resource allocation, time pressures on health providers, geography of health care access, cultural and linguistic barriers, payment systems and incentives, and health insurance access [5]. Adolescents are particularly vulnerable to these social determinants and health care delivery barriers, and as such require special consideration from advocates and policy makers working to improve health equity. Several major bodies such as the World Health Organization, the National Research Council and Institute of Medicine, and the U.S. Department of Health and Human Services have proposed models of public policy and adolescent health services that aim to reduce disparities [3,6,12,13].

Recommendations

Health policy:

1. Health and public policy to reduce disparities and achieve health equity for all adolescents requires a long-term, coordinated, interdisciplinary, and intersectoral strategy, with adequate resources to study, implement, evaluate, and sustain the strategy.
2. Health-related data collection and monitoring at all levels should include measures of racial/ethnic disparities and be able to measure progress towards health equity.

2. Clinical care and health promotion: Providers should consider the influence of social determinants on the health of adolescents in patient encounters and foster linkages between youth and available resources as part of an overall strategy to promote positive youth development and equity in health outcomes

Recommendations

Health care providers:

1. Health care providers should promote health equity through the consistent application of evidence-based, culturally competent practice guidelines across care settings and populations.
2. Health care providers are encouraged to recognize the impact of social determinants of health on well-being and connect adolescents with resources as part of an overall strategy to promote positive youth development [12–14]. This includes affirming the normative nature of the developmental task, reinforcing positive racial and ethnic identities, displaying openness to discuss tensions and challenges, and assisting youth in finding positive ways to deal with bias and discrimination [12].

Health systems:

1. There needs to be recognition of the disproportionate impact of barriers to care on diverse adolescents and an emphasis on the delivery of affordable, accessible, integrated, and coordinated adolescent health services.
2. Programs should promote culturally relevant patient education, empowerment, and leadership to build capacity for self-advocacy and participation in health care decision making.

3. Education and health services delivery: Training programs should ensure that trainees and professionals in the field of adolescent health have the knowledge and skills to effectively care for diverse adolescent populations and should seek/employ new curricula and methodologies to deliver that education

Health service and outcome implications linked to provider competence in cross-cultural care underscore that training need not only be for those entering a health profession, but also for current providers who trained before the need was widely recognized [15]. Thus, institutionalizing education to address demographic-driven needs supports effective care of diverse populations and concurrently strengthens adolescent care in general.

Recommendations

Health systems:

1. Leadership in health professional training institutions, academic medical centers, and service agencies should buy in and commit to invest resources into training, retraining, and evaluation of cross-cultural competencies at all provider levels.
2. Training in cross-cultural care should combine cultural awareness, beginning with self-awareness, knowledge of community demographics and prevailing customs, and development of specific skills such as open inquiry. As part of an integrated training experience, this approach lays the foundation for building a provider workforce increasingly competent in caring for diverse adolescent populations in diverse settings.

Professional education and funders:

1. Cross-cultural education not only pertains to clinicians but also to educators and researchers of adolescent health. Without protected time and space for educators and researchers to engage in self-reflection, they may only perpetuate stereotypes and biases unknowingly affecting generations of learners and health policy, respectively.
2. Dialogue around health equity and the dynamics of power, legacy, and privilege as it pertains to the nuances of what and how content is taught and researched needs to be included in the training, retraining, and evaluation of educators and researchers.

4. Professional and workforce development: Professional organizations should work collaboratively with stakeholders from multiple disciplines and settings to construct and execute workforce development plans that ensure outreach, recruitment, and retention of trainees and providers from diverse backgrounds

There have been several studies that show that racial and/or language concordance between health care provider and patient leads to greater patient satisfaction and health outcomes [5]. Disparities in the health care workforce not only have implications for clinical service, but also for the academic medicine and research enterprises of adolescent health.

Recommendations

The pathway to health careers and professional education:

1. The pathway to health careers involves making young students aware of the possible jobs and assists them in preparing academically and socially to pursue the educational path to health career professions. Fostering the development of a diverse health professional workforce must start at the beginning of formal education, with a specific emphasis to reach the underrepresented students at early to middle adolescent years when many start to consider professional careers. These students need specific mentorship around health careers, science, and math education.
2. Professionals from traditionally disadvantaged racial and ethnic groups should be encouraged to pursue careers in academia in order to diversify perspectives in the delivery of health services training and promote innovative health services, policy, and research. They must also be specifically supported and mentored around career development and advancement.

5. Research: Funders should support the discovery and dissemination of knowledge that reflects racial and ethnic diversity of the population

Because health behaviors and conditions established during adolescence have implications for adulthood, research including adolescents is essential to advance well-being along the life course.

Writing on research ethics often uses the term *justice*, which is concerned with assuring that the benefits and burdens of research are shared equally (Belmont report) [16]. Likewise, the National Institutes of Health has policies requiring *inclusion* of children, women, and minority groups within research, again to ensure justice in the benefits of research [17]. Promoting full scientific participation by groups that historically have been excluded and/or underrepresented ensures excellence in diversity of thought and inquiry and better solutions for today's gaps in evidence-based practices [5,18].

Recommendations

Research:

1. Effective partnerships in community-academic research should be strongly encouraged so that the perspective of diverse populations continues to be included in the discovery and dissemination of new knowledge.
2. Adolescents and their families should contribute toward all aspects of research including development of pertinent research questions, the design of studies, recruitment, implementation, retention, data analysis and interpretation, dissemination of study findings, and setting a relevant future research agenda for their racial and ethnic community [5,16].

Summary

With this paper, five key domains of advocacy, clinical care and health promotion, education and health services delivery, workforce and professional development, and research are

identified. All five require attention in order to reach the overarching goal of health equity for adolescents and young adults. SAHM believes that achieving health equity is related to its organizational mission and vision and is a key factor in driving excellence in adolescent health and medicine. SAHM will continue to expand its capacity, being introspective as an organization as well as make recommendations to others, in an effort to be collaborative and inclusive of professionals, programs, and systems that represent and serve the diverse populations for whom the Society advocates.

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