Policy Matters Ohio

Photo: Piet van Lier

November 19, 2018

Basic Needs

Building a Healthy Ohio

Overcoming barriers to health stemming from poverty, segregation and racism

Amanda Woodrum
Deanna Krokos

Contents

Introduction & Executive Summary

Photo: Shutterstock

Introduction & Executive Summary

In 2017, Ohio ranked 44th among states for our overall well-being, according to the Gallup Sharecare Well-Being Index.[1] High rates of disease and chronic conditions contribute to low well-being in Ohio, as does financial insecurity, poor community health, low social support and lack of life purpose.[2] For our overall physical and mental health, Ohio ranks 43rd in the nation, according to the Health Policy Institute of Ohio.[3]

Ohio can be a state where people - whether black, white or brown – or whether they live in a city, a suburb or rural area – can live healthy, happy lives. Ohio's poor health is tied to structural problems that affect all aspects of society, such as poverty, racism and income inequality—problems that can be addressed with policy solutions.

Ohio's poor health relates in part to a divide between lower- and upper-income Ohioans. In its "disparity index," the 2018 Commonwealth Scorecard on State Health System Performance ranked Ohio 47th in the nation for how poorly the health of our lower-income residents compared to that of our higher-income residents."[4] Low-income Ohioans are far more likely to report having fair/poor health, losing teeth, smoking, and being obese than their wealthier counterparts in the state. Access to health care for low-income households is an important piece of solving the health divide puzzle, but it is not the whole picture.

Poverty is a barrier to health. Poverty is stressful. Chronic poverty is toxic. In 2017, nearly 1.6 million Ohioans lived in poverty, more than 700,000 of them in deep poverty (with incomes less than 50 percent of the federal poverty level, or $10,210 for a family of three in 2017). Frequent or prolonged adversity from poverty often creates "toxic stress."

Living in an area of concentrated poverty is a roadblock to health. Housing segregation in Ohio, by race and income status, exacerbates the health divide by creating areas of concentrated poverty. Roughly 10 percent of Ohio's neighborhoods are in areas of concentrated poverty (more than double the share in 2000).[5] Impoverished communities tend to feel less safe, residents are more likely to be exposed to air, water, noise pollution and highway dangers, housing is lower quality, there is less green space, and access to healthy foods is more limited, among other issues. Poor communities also have fewer resources to counteract health-damaging conditions.

Ohio can reduce barriers to health with smart economic policy

First, state leaders must include health equity impact assessments in the policymaking process, so that we can better understand the role public policy plays in promoting health or building barriers to it. Second, policymakers can use three main economic levers to dislodge some of the most vexing poverty-related impediments to health:

1. Break the cycle of poverty by investing in education and opportunity for young people.
2. Promote income security for Ohio families by increasing the minimum wage and access to public benefit programs.
3. Target state investments in areas of concentrated poverty and maximize the benefits to the community through local hire policies.

1 https://bit.ly/2CJyrXJ

2 Compared to the national average, Ohioans are more likely to die of cancer (breast and colorectal), more likely to die of suicide, alcohol and drug use, and we have higher rates of infant mortality.

3 Health Policy Institute of Ohio, Health Policy Brief: Connections Between Income and Health https://bit.ly/2ylO8An.

4 Commonwealth Fund Scorecard on State Health System Performance, 2018, at https://bit.ly/2P6RFMN.

5 2016 American Community Survey, Ratio of income to poverty level in the past 12 months.

Policy Matters Ohio

Barriers to Health

Photo: Shutterstock

1. POVERTY IS A BARRIER TO HEALTH

Research consistently demonstrates that income level affects health. According to the Health Policy Institute of Ohio, almost 40 percent of Ohioans living in households with incomes less than $15,000 report their health to be "poor" or "fair," compared to only 6 percent of households with incomes of $75,000 or more. Low-income Ohioans are more than twice as likely to report depression than higher-income Ohioans, 1.75 times more likely to have diabetes (14 percent of Ohioans in low-income households compared with only 8 percent in higher demographics); and, very low-income Ohioans are more than three times as likely to have two or more chronic health conditions together. Death rates from heart disease among low-income people, white or black, are double and triple their middle-income counterparts.[6]

Wealthy people live longer. In a 2016 study published by the National Institutes of Health, researchers found a widespread, consistent, and continuous link between income and life expectancy.[7] The authors came to several conclusions:

1. Life expectancy increases with income. Men in the top 1 percent of income live 15 years longer than men in the bottom 1 percent. Women in the top 1 percent live 10 years longer than their bottom 1 percent counterparts.

2. The difference in life expectancy between the rich and poor has gotten worse over the past two decades. Thanks to innovations in health care from 2001 to 2014, the richest 5 percent gained three years in life expectancy. However, the bottom 5 percent gained zero ground over the same time period.

3. Location matters. Among the bottom 25 percent, life expectancy varies by region by up to five years.

Life expectancy also varies by race.[8] According to a researcher from the Institute for Social Research at the University of Michigan and one from Indiana University in Bloomington, the overall death rate for black Americans is equivalent to that of white Americans from 30 years prior.[9] In examining the leading causes of death—heart disease, cancer, flu, pneumonia, homicide and suicide—over a 50-year time period from 1950 to 2000—they found major differences and a meaningful contribution to mortality in two of the leading causes:[10]

- Death from heart disease was 30 percent higher for black Americans than for whites. Income plays a role. Death rates from heart disease are two to three times higher among low-income black and white Americans than their middle-income counterparts. However, black Americans at every income level have higher death rates from heart disease than comparable white Americans, suggesting there is more to the health divide story, among different races, than differences in income alone.
- Black Americans have a higher cancer death rate than whites. Rates were equivalent in 1950, but increased dramatically in the black community from 1950 to 2000 (by 40 percent). Income plays a major role here.

6 Williams, David R., and Pamela Braboy Jackson. "Social sources of racial disparities in health." Health affairs 24, no. 2 (2005): 325-334, at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.325.

7 Chetty, Raj, Michael Stepner, Sarah Abraham, Shelby Lin, Benjamin Scuderi, Nicholas Turner, Augustin Bergeron, and David Cutler. "The association between income and life expectancy in the United States, 2001-2014." Jama 315, no. 16 (2016): 1750-1766 at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4866586/ (While controlling for race and ethnicity, and looking at data on access to medical care, medical spending, and health behavior statistics).

8 See Williams, David R., and Pamela Braboy Jackson, sources of racial disparities, above.

9 Id.

10 Id.

Policy Matters Ohio

2. POVERTY IS STRESSFUL, CHRONIC STRESS IS TOXIC

Researchers across disciplines—from psychology to medicine to social science—have described the physical, and medical toll taken on people struggling to get by. In a seminal study from 1994, researchers established not only a clear link but also a continuous association between health and socioeconomic status.[11] Rates of infant mortality, life expectancy, and disease-based death are worse for people at the lowest income levels and far better for the upper-income echelons. In fact, according to research, every increase in economic situation, whether through better education, higher income, or better occupational status, was linked to a healthier life.

Stress is a side-effect of poverty. Numerous researchers have found an association between low socioeconomic status, high stress and poor health.[12] There are two kinds of stress, according to researchers: (1) exposure to life events that require adaptation (i.e. divorce, job loss) and (2) a state occurring when demands appear to exceed a person's abilities to cope with those demands. People at low-income levels are more likely to encounter these kinds of negative events, and encounter them more often. They also feel less control over the outcome when they do occur, and have fewer social and psychological resources to cope with them. Wealthier people, on the other hand, have greater opportunity to form, maintain, and access social networks that can buffer the effects of stressful life events.[13]

For low-income individuals, "survival" or "scarcity" stress is chronic.[14] Having few personal financial resources or living in a community that lacks basic services can lead to worry and instability. Small hiccups can become personal catastrophes for people already struggling.

Car problems, for instance, can turn into loss of a job. This sort of worry isn't just another inconvenience—it makes people sick. "Survival" stress experienced by low-income individuals is biologically distinct from other sorts of stress, and brings about toxic hormonal responses and metabolic changes that leave people susceptible to disease and poor health.[15] Stress alters neuroendocrine and immune responses. Chronic stress—frequent or prolonged adversity—can put people at greater risk for illnesses such as gastrointestinal disorder, heart attacks and susceptibility to infectious agents. It can also lead to poor mental health, depression and obesity.[16]

11 Adler, Nancy E., Thomas Boyce, Margaret A. Chesney, Sheldon Cohen, Susan Folkman, Robert L. Kahn, and S. Leonard Syme. "Socioeconomic status and health: the challenge of the gradient." American psychologist 49, no. 1 (1994): 15.

12 Id. See also sources from text box on next page and Food Research & Action Center, Why Low-Income and Food Insecure People are Vulnerable to Poor Nutrition and Obesity.

13 See Adler, Nancy E. et al., Socioeconomic status and health, above.

14 Carol Graham, Brookings Institution, The rich even have a better kind of stress than the poor (2016) at https://brook.gs/2RKnadX.

15 Carol Graham, Brookings Institution, The high costs of being poor in America: Stress, Pain, and Worry (2015) at https://brook.gs/2hiKH59. See also HPIO, A new approach to reduce infant mortality and achieve equity (2017).

16 FRAC, Why Low-Income and Food Insecure People are Vulnerable to Poor Nutrition and Obesity.

Toxic stress has lifelong impacts on kids

Twin interventions can help break cycle of poverty and poor health

Ohio ranks 12th in the nation for share of children growing up in poverty (one in five). Children who grow up in poverty are more likely to experience toxic stress.

While practicing as a pediatrician in San Francisco's low-income, resource-poor Bayview Hunters Point area, Dr. Nadine Burke Harris noticed a trend among her poorer patients. They often exhibited several, seemingly unrelated signs of poor health, including asthma, behavioral issues, eczema and a general "failure to thrive." This led her to the Centers for Disease Control and Prevention and a Kaiser Permanente study on Adverse Childhood Experiences (ACE).

Stressors that occur within the first 18 years of life, like abuse, neglect, instability in the home, parental drug dependence, incarceration, or mental health issues are called adverse childhood experiences. The study proved a direct correlation between stressful childhood experiences and negative health outcomes later in life like heart disease, lung cancer, depression and suicidality. Each negative life experience acts as an additional "dose" of childhood stress, increasing the likelihood of poor health later in life.

Dr. Harris attributes this link to a physiological response that neurologically and hormonally changes a person's health over time. The hypothalamic-pituitary-adrenal axis, commonly known as a "fight-or-flight" reflex, floods the body with intense hormones preparing a person to survive. However, for children whose brains are still developing, the repeated activation of this response brought on by stressful, volatile or frightening situations alters their cognitive growth, brain response patterns, and their immune system.

A similar study by Stanford University found that children who are frequently exposed to poverty conditions are more likely to experience the sort of intense, internalized stress "capable of damaging areas of the brain known to underlie cognitive processes—such as attention, memory, and language—that all combine to undergird academic success." They also found low-income children were 38 percent more likely to have experienced three or more stress factors than their middle-income counterparts and identified several biophysical markers indicative of poor health. Low-income nine-year-olds fared worse in body mass index, resting blood pressure and rate of stress-released hormones compared to their middle-income counterparts. They also had measurably slower cognitive responses and higher blood pressure.

A researcher at the Harvard Center on the Developing Child found that income-related stress takes hold of entire families, and it plays "an important causal role in the intergenerational transmission of disparities in education…and health outcomes."

Researchers suggest public investments that increase people's income while relieving stress for low-income communities will help children enter the workforce as more productive, less volatile employees. People with stable childhoods are better able to contribute to the economy and their community. These twin interventions can help break the cycle of poverty and poor health.

Sources: America's Health Ranking 2017. Tough, Paul. "The poverty clinic." The New Yorker 25 (2011); Felitti, Vincent J. "The relation between adverse childhood experiences and adult health: Turning gold into lead." Perm J6, no. 1 (2002): 44-7. Felitti, Vincent J., Robert F. Anda, Dale Nordenberg, David F. Williamson, Alison M. Spitz, Valerie Edwards, Mary P. Koss, and James S. Marks. "Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults." American journal of preventive medicine 14, no. 4 (1998): 245-258; "How Childhood Trauma Affects Health Across a Lifetime." Evans, Gary W., Jeanne Brooks-Gunn, and Pamela Kato Klebanov. "Stressing out the poor." Pathways (2011): 22-27; Shonkoff, Jack P., Andrew S. Garner, Benjamin S. Siegel, Mary I. Dobbins, Marian F. Earls, Laura McGuinn, John Pascoe, David L. Wood, Committee on Psychosocial Aspects of Child and Family Health, and Committee on Early Childhood, Adoption, and Dependent Care. "The lifelong effects of early childhood adversity and toxic stress." Pediatrics 129, no. 1 (2012): e232-e246.

Policy Matters Ohio

FIGURE 1: THE CYCLE OF POVERTY & POOR HEALTH

Financial instability
Eviction
Neighborhood violence
Experience with racism
Abuse or Neglect
Parental Stress
- divorce / separation
- drug use
- incarceration

Affects brain development & immune system, ability to concentrate, memory, body mass index, and blood pressure

Policy Matters Ohio

3. LIVING IN HIGH-POVERTY AREA IS A ROADBLOCK TO HEALTH

The community people live in affects their health. Community conditions either assist or detract from a person's health opportunities, often depending on the level of wealth in the community. For example, low-income individuals are far more likely to feel they live in less safe neighborhoods and to have adverse childhood experiences (i.e. traumatic events during childhood).[17] This adds to already high levels of stress brought on by economic instability. Health-shaping neighborhood conditions include:[18]

1. The physical or built environment (such as transportation system and neighborhood walkability, housing quality, green space, healthy food access, recreational facilities);
2. Level of violence and aggression versus social support and resources;
3. The prevalence of health behaviors in the community that are likely to be passed from parents to their children (known as generationally "sticky" behaviors).

The surrounding community, if built or developed poorly, can negatively impact both mental and physical health, as can the community's exposure to air, water and noise pollution, highway dangers, and lack of access to quality food and nutrition.[19] The level of public resources in a community also matters. High-poverty areas often lack the resources necessary to ameliorate health-damaging conditions and promote health-enhancing opportunities.

Neighborhood safety is a problem in low-income communities. According to the Health Policy Institute of Ohio, low-income Ohioans are almost 10 times more likely to report their children live in unsafe neighborhoods than their higher-income counterparts.[20] As noted previously, adverse childhood experiences from trauma and violence contribute to toxic stress levels and have lifelong impacts on health. Plus, where neighborhood safety is questionable, people in that neighborhood will engage in less physical exercise.[21]

Poor people are more exposed to air, water and noise pollution. Low-income individuals tend to be segregated into areas that are high in unhealthy environmental factors.[22] Poor people often live near highways, industrial zones, landfills and toxic waste sites, both because property costs near those locations are cheaper and because these businesses receive fewer complaints from preoccupied residents too busy surviving to complain.[23] They also live in neighborhoods with less access to green space and deal with lower quality housing, lead and mold hazards, overcrowding and noise pollution, issues that can interfere with memory as well as reading skill development for young children. Substandard housing is also linked to childhood asthma levels. These disadvantages work cyclically with poverty; they create further barriers to improving a family's economic situation, and those financial difficulties keep them in the neighborhood.

17 Health Policy Institute of Ohio, 2017 Health Value Dashboard (Health equity profiles, p. 30-37).

18 Adler, Nancy E., Thomas Boyce, Margaret A. Chesney et al. "Socioeconomic status and health: the challenge of the gradient." American psychologist 49, no. 1 (1994): 15.

19 Havranek, Edward P., Mahasin S. Mujahid, Donald A. Barr, Irene V. Blair, Meryl S. Cohen, Salvador Cruz-Flores, George Davey-Smith et al. "Social determinants of risk and outcomes for cardiovascular disease: a scientific statement from the American Heart Association." Circulation 132, no. 9 (2015): 873-898.

20 Health Policy Institute of Ohio, 2017 Health Value Dashboard (Health equity profiles, p. 30-37).

21 Williams, David R., and Pamela Braboy Jackson. "Social sources of racial disparities in health." Health affairs 24, no. 2 (2005): 325-334, at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.325.

22 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

23 Havranek, Edward P., Mahasin S. Mujahid, Donald A. Barr, Irene V. Blair, Meryl S. Cohen, Salvador Cruz-Flores, George Davey-Smith et al. "Social determinants of risk and outcomes for cardiovascular disease: a scientific statement from the American Heart Association." Circulation 132, no. 9 (2015): 873-898. Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

Food deserts in low-income communities contribute to poor nutrition and obesity.[24] Low-income people have limited access to healthy foods, due to cost and availability in areas of concentrated poverty. High-poverty areas frequently lack access to full-service grocery stores and farmer's markets where healthier foods are available.[25] When communities lack grocery stores, they are often flooded with convenience stores and fast food restaurants which provide cheap and easy options that are less nutritious. Due to these food-related issues deriving from the built environment, poor people are more likely than higher-income people to skip meals and overeat when food becomes available. This "feast or famine" approach to eating increases obesity rates. The issue is both a rural and urban one.[26]

Transportation is a barrier to food, doctors, treatment, education, training and jobs. According to the U.S. Department of Agriculture, transportation is the most important factor in whether a family can access affordable and nutritious food (particularly outside the neighborhood).[27] Transportation can also be a barrier to seeing a doctor, getting to dialysis or opioid treatment centers, accessing vocational schools or higher education facilities, as well as securing and retaining a stable job that comes with health benefits.

Cars are expensive to own and operate. Cars can be prohibitively expensive for low-income households, and driving may not be an option at all for elderly people and those with disabilities. At the same time, the state of Ohio has underinvested in public transportation, the more affordable and accessible transportation option. Walking can be dangerous in our road-centric communities, and our car-centered transportation system leads to less walking, biking and other physical activities.

Childhood Asthma in Cincinnati

Neighborhood differences in asthma rates

Researchers at Cincinnati Children's medical center saw a number of children in their community suffering from severe asthma and investigated. The asthma admission rate to hospitals was on average 5.1 per 1,000 children in Hamilton County. However, in some neighborhoods it was as low as zero, while in others it was as high as 27 per 1,000 children—a very large health inequality. Using neighborhood-level data within Hamilton County, the researchers designated "hot" and "cold" zones where the disease was widespread or rare. They studied differences between these neighborhood-level zones looking at measures of income and quality of the surrounding environment (i.e. substandard housing).

The hot spots were in neighborhoods where the median household income level hovered around the poverty line. Hospital admissions rates for asthma declined as median neighborhood incomes increased. Asthma hot zones also had significantly lower property values, higher numbers of vacant and rental properties, more dense populations and less access to cars. Researchers suspected high asthma rates were, in part, linked to substandard housing conditions and recommended community-based interventions.

Sources: Beck, Andrew F., Terri Moncrief, Bin Huang, Jeffrey M. Simmons, Hadley Sauers, Chen Chen, and Robert S. Kahn. "Inequalities in neighborhood child asthma admission rates and underlying community characteristics in one US county." The Journal of pediatrics 163, no. 2 (2013): 574-580.

24 Food Research & Action Center, Why Low-Income and Food Insecure People are Vulnerable to Poor Nutrition and Obesity at https://bit.ly/2xagUW7.
25 Id.
26 USDA Food Desert Atlas: https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/.
27 USDA, Report to Congress: Access to Affordable and Nutritious Food (2009) at https://bit.ly/2CM7BhB.

Poverty can lead to less healthy behaviors that are generationally "sticky." Due to an array of stress factors, poor coping skills, and other systemic issues such as food deserts, adults in low-income communities have higher rates of smoking, are more likely to engage in unhealthy use of drugs and alcohol, and have issues associated with poor diets. Stress and poor mental health are tied to unhealthy eating habits and physical inactivity. These are practices known to increase the risk of heart disease and cancer.[28] Over the past few decades, it has been shown that economically disadvantaged groups are also less likely to reduce these risky health practices in response to public health marketing efforts.[29]

- Ohio has the highest rate in the nation for smoking among low-income adults (37 percent). Ohioans with less than $15,000 in income are three times more likely to smoke than those earning greater than $50,000.
- More than four of every 10 low-income adults in Ohio are obese, making Ohio the 45th worst in the nation for obesity rates among poor people. Very low-income Ohioans are 1.8 times more likely to have adult diabetes than those with modest incomes.[30]
- Low-income Ohioans suffer from addiction at higher rates, and are more likely to die from suicide, and drug and alcohol abuse, ranking Ohio 48th worst among states.[31]

These behaviors are generationally "sticky," likely to be passed from parents to children, perpetuating a cycle of poor health.[32] Economic disadvantage in early life can leave children without the necessary knowledge and skills to prevent toxic overactive stress reactions and cardiovascular disease. Lack of resources in low-income communities also influences the development of certain high-risk behaviors.[33]

Poor communities have few resources available to overcome health barriers. Poverty barriers to health are amplified because poorer communities have few public resources to deal with community-wide problems.[34] The physical condition and resource deprivation in poor neighborhoods exacerbate the challenges faced by residents. Residents don't have access to vital services and supports—like reliable transportation and safe public spaces—that counteract health barriers. Access to recreational facilities and green space helps lower stress levels and increase physical activity, but impoverished communities often lack the public resources to own and operate them.[35] In a study published by the New England Journal of Medicine, *Neighborhoods, obesity, and diabetes—a randomized social experiment*, researchers found that when people from low-income neighborhoods were able to move to higher-income areas, there were fewer incidences of extreme obesity and diabetes.[36]

28 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

29 Williams, David R., and Pamela Braboy Jackson. "Social sources of racial disparities in health." Health affairs 24, no. 2 (2005): 325-334, at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.325.

30 Health Policy Institute of Ohio, 2017 Health Value Dashboard (Health equity profiles, p. 30-37) (Ohioans with less than $15,000 annual income 1.8 times more likely to have adult diabetes than Ohioans with more than $50,000).

31 Commonwealth Fund Scorecard on State Health System Performance, 2018, and Health Policy Institute, 2017 Health Value Dashboard.

32 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

33 Havranek, Edward P., Mahasin S. Mujahid, Donald A. Barr, Irene V. Blair, Meryl S. Cohen, Salvador Cruz-Flores, George Davey-Smith et al. "Social determinants of risk and outcomes for cardiovascular disease: a scientific statement from the American Heart Association." Circulation 132, no. 9 (2015): 873-898.

34 Health Policy Institute of Ohio, Health Policy Brief: Connections Between Income and Health at https://bit.ly/2ylO8An.

35 See note supra, Havranek et al., Social determinants of cardiovascular disease.

36 Jens Ludwig, Lisa Sanbonmatsu, Emma Adam et al., "Neighborhoods, obesity, and diabetes—a randomized social experiment," New England Journal of Medicine (2012) at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3410541/.

Policy Matters Ohio

4. RACISM AND SEGREGATION EXACERBATE THE HEALTH DIVIDE

Black Ohioans have lower life expectancies than white Ohioans. They are far more likely than other races to die prematurely (before the age of 75), and to die of heart disease or stroke, according to the Health Policy Institute of Ohio.[37] Black Ohioans also have higher levels of infant mortality, lower birth weights, are more likely to be overweight or obese, have adult diabetes, and have long-term complications from diabetes.[38]

Given the connections between poverty and health, and that poverty rates for black Ohioans are 2.6 times higher than white poverty rates, it is no surprise African-Americans in Ohio are less healthy, on average, than white Ohioans.[39] However, the difference between the health of black and white Ohioans is often greater than the difference between lower- and higher-income Ohioans, suggesting there is more to the health story than just poverty itself.[40] The health divide between black and white Americans has been attributed not only to economic disadvantages but also racial barriers faced by the black community.[41]

Ohio has a serious housing segregation problem. As a state, Ohio ranks 8th worst in the nation for black-white residential segregation.[42] Cleveland and Cincinnati are two of the most segregated communities in the nation. High rates of concentrated poverty in racially-segregated communities create a feedback loop for generational poverty that is amplified by lack of resources in those communities to ameliorate health-damaging conditions and create health-enhancing opportunities.[43]

Segregated neighborhoods are less safe.[44] Segregation produces health-damaging neighborhood conditions, including those that promote violence and limit educational and employment opportunities.[45] In turn, segregated areas have high rates of unemployment and low wages, and the chronic stress associated with those factors. Stress and neighborhood violence in segregated communities also lead to riskier health practices.[46] Where neighborhood safety is questionable, for instance, people engage in less physical exercise. Studies have shown residential segregation, by race, is associated with unhealthy weight gain for African-Americans.[47]

Stress from racism leads to hypertension, and hypertension leads to heart disease. In their review of the existing scientific literature, Hicken et al. found numerous studies show elevated blood pressure and cardiovascular activity in response to racism, and that continued subtle experiences of racial and ethnic bias correlate to chronic stress and hypertension.[48] Hypertension is a leading cause of heart disease.

37 Health Policy Institute of Ohio, 2017 Health Value Dashboard (Health equity profiles).

38 Id.

39 2016 American Community Survey, 1-year estimates, Selected Characteristics of People at Specified Levels of Poverty in the Past 12 Months (31 percent black poverty rate versus 11.5 percent white poverty rate).

40 Williams, David R., and Pamela Braboy Jackson. "Social sources of racial disparities in health." Health affairs 24, no. 2 (2005): 325-334, at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.325, and Health Policy Institute of Ohio, 2017 Health Value Dashboard (Health equity profiles).

41 https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70446

42 William H. Frey, Brookings Institution and University of Michigan Social Science Data Analysis Network's analysis of 2005-9 American Community Survey and 2000 Census Decennial Census tract data.

43 Williams, David R. & Pamela B. Jackson, Social Sources of Racial Disparities in Health, Health Affairs: 24(#2)(2005).

44 Id.

45 Id.

46 Id. at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.24.2.325.

47 Center for Health Equity Research and Promotion, Racial Residential Segregation and Weight Status Among U.S. Adults (2006) at https://www.ncbi.nlm.nih.gov/pubmed/16707199/.

48 Hicken, Margaret T., Hedwig Lee, Jeffrey Morenoff, James S. House, & David R. Williams, Racial/ethnic disparities in hypertension prevalence: reconsidering the role of chronic stress, American journal of public health 104, no. 1 (2014).

5. GOOD PUBLIC POLICY CAN PROMOTE BETTER HEALTH

Ohio can reduce barriers to health through better economic policy.[49] The health of our citizens depends not only on the overall wealth of a state like Ohio, but also how the government allocates public resources to various segments of the population and treats people in poverty.[50] States with strong policies to reduce income inequalities have better health outcomes than their weaker-policy neighbors.[51]

An effective public health spending plan requires a broad policy agenda implemented at the federal, state, and local levels. From child care to public transportation, a number of public expenditures can improve health. The Urban Society and Center on Society and Health identify three target policy areas most likely to impact health outcomes for people at low- or moderate-income levels:[52]

1. Policies designed to break the cycle of poverty and poor health for young people;
2. Policies promoting income security and reducing toxic stress;
3. Investing in areas of concentrated poverty.

Spending on public health produces large returns on investment. Despite cost-saving and cost-effective benefits, however, these programs are often underfunded.[53] The state of Ohio does a particularly bad job.[54] Ohio ranks 45th in the nation for its public health funding, spending just $53 per state resident on public health, compared to the national average of $86 per person.[55] Weak spending on public services is an important part of why Ohio's health continues to rank low despite improved health care coverage.

We need to rethink what constitutes public health policy. First, we need to better understand the health impact of public programs.[56] A consistent recommendation from academic researchers is to require contemplation of the impact on health during the policy making process. Good economic policies can promote better health, while ill-considered policies can create barriers to good health for certain communities. A health equity impact analysis can empower policymakers by measuring the effect of proposed public policies and public sector programs on health, paying particularly close attention to income levels and race.[57] At its core, it is a way to ask questions about proposed programs or initiatives: Who will this affect? What forces will it challenge or counteract? How will it change the landscape of health for the people affected by it?

49 Berenson, Julia, Yan Li, Julia Lynch, and José A. Pagán. "Identifying policy levers and opportunities for action across states to achieve health equity." Health Affairs 36, no. 6 (2017): 1048-1056. https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0004

50 Kim, Ae-Sook, and Edward T. Jennings Jr. "Effects of US States' social welfare systems on population health." Policy Studies Journal 37, no. 4 (2009): 745-767.

51 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

52 Laudan Arn, Lisa Dubay, Emily Zimmerman, et.al., Urban Society and Center on Society and Health, "Can Income-Related Policies Improve Population Health?" at https://societyhealth.vcu.edu/media/society-health/pdf/IHIBrief2.pdf.

53 AcademyHealth, The return on investment of public health system spending (2018) at https://bit.ly/2CPlb3I.

54 Masters, Rebecca, Elspeth Anwar, Brendan Collins, Richard Cookson, and Simon Capewell. "Return on investment of public health interventions: a systematic review." J Epidemiol Community Health (2017): jech-2016.

55 United Health Foundation, America's health rankings 2017: Ohio

56 See Elizabeth H. Bradley et al., The role of spending on social services (2016), above.

57 Povall, Susan L., Fiona A. Haigh, Debbie Abrahams, and Alex Scott-Samuel. "Health equity impact assessment." Health promotion international 29, no. 4 (2013): 621-633.

Implementing health equity assessments should be a standard part of Ohio's policymaking process. By conducting these analyses, we can gain a better understanding of the holistic impact of programs, from education to public transit. With increased understanding of health impacts from economic policies, we can proactively and deliberately develop a policy agenda that counteracts barriers to health from poverty and race. The state of California went a step further than just requiring health equity assessments during the policy-making process. The Governor of California created an inter-agency taskforce devoted to promoting health equity.

California's Health-in-All Taskforce

The creation of an inter-agency health equity taskforce

In 2010, California's Governor Arnold Schwarzenegger issued an executive order creating a new system of collaboration across state agencies. In establishing the "Health-in-All Taskforce" he challenged various state agencies to consider promoting health as part of their work. The taskforce, housed within the Department of Public Health, considers health impacts of policies related to "air and water quality, natural resources and agricultural land, affordable housing, infrastructure systems, public health, sustainable communities, and climate change." It has the power to "review existing state efforts, consider best/promising practices used by other jurisdictions and agencies … and propose … programs, policies, and strategies."

By providing tools and support to agencies, policymakers, and a network of third-party organizations, the task force created greater health-awareness and collaboration across sectors, in the decision-making process and codified health equality as a priority that will persist into the future. Recognized opportunities included:

- Promoting safe and active transportation by improving both public transit and physical routes… to make waking or biking safer and more feasible;
- Re-evaluating food procurement contracts in state buildings, schools, and correctional facilities to improve nutrition;
- Re-evaluating siting practices for housing near high-traffic roadways;
- Grant-making for improving safe access to green space to promote physical activity;
- Prioritizing health equity in grant-making guidelines. Setting aside funds for disadvantaged communities, and eliminating the match requirement for those communities; and,
- Engaging and strengthening local public health departments to initiate a broad health policy agenda.

Source: Executive Order: http://sgc.ca.gov/programs/hiap/docs/20100401-Executive_Order_S_04_10.pdf

Health Equity Levers

Photo: Zach Schiller

LEVER 1: BREAK THE CYCLE OF POVERTY

To break the cycle of poverty and poor health for young Ohioans, we need to better invest in education and opportunity in high-poverty areas. Public spending on education and opportunity for low-income communities is one of the best ways to increase life expectancy.[58] Skilled workers earn more and achieve a higher standard of living over the long run. Too many children in Ohio are already behind before they even get started. In 2017, fewer than one in three of Ohio's economically-disadvantaged kindergarteners demonstrated readiness for kindergarten, according to the state of Ohio's annual report on the Kindergarten Readiness Assessment. Even among kindergarteners that are not economically disadvantaged, only 58 percent were kindergarten ready.

Quality child care and pre-k are major equalizers for young children, ensuring that regardless of income level, they don't get left behind.[59] Schools and community learning centers play a pivotal role for children affected by the trauma of poverty.[60] Trauma-informed education teaches cognitive skills to better cope with events that harm health. Quality, accessible early childhood education, including pre-school, is essential for socialization and well-being. It also helps ensure proper nutrition, promote healthy behavior, and allow early detection of mental and physical health issues.

State investments in quality child care and universal pre-k make it easier for working parents to get by, reducing the costs of care and promoting income stability. Ohio's current system burdens families, demanding large portions of their income to secure quality child care. When these services are not affordable, retaining jobs becomes more difficult and both children and parents miss out on important opportunities.[61]

Break the cycle of poverty and poor health

Increase access to quality early care and education and provide universal pre-k

Boost eligibility for Ohio's childcare assistance program to twice the federal poverty level (200 percent), a generally accepted level of what it truly takes to meet a basic family budget. Quality child care is expensive. Public assistance for quality child care not only helps parents work, it also expands educational opportunities for low-income children. To be eligible for Ohio's child care assistance program, currently, low-income households must have household income that is at or below 130 percent of poverty (approximately $27,000 for a family of three). This limit is too low.

Ohio should follow the lead of West Virginia, Georgia, Oklahoma and Florida and adopt universal pre-kindergarten, as well as full day kindergarten. We can expand Ohio's school funding formula to include pre-k in order to cover them.

58 Id.
59 Berenson, Julia, Yan Li, Julia Lynch, and José A. Pagán. "Identifying policy levers and opportunities for action across states to achieve health equity." Health Affairs 36, no. 6 (2017).
60 Children's Defense Fund – Ohio, Addressing children's trauma: A toolkit for Ohio schools (2015) at https://bit.ly/2yCvQdy.
61 Id.

LEVER 2: PROMOTE INCOME SECURITY

As of 2014, the top 1 percent in Ohio brought in 19 times more than the average of the rest of earners.[62] The state's most common occupations overwhelmingly pay low wages and offer a limited number of hours per week, leaving too many families struggling to get by despite working.[63] For this large portion of the population, better wages could lower barriers to health, as could greater public income support.

What it takes to meet a basic family budget. Basic household costs include housing, utilities, food, health care, child care, transportation, other necessities and taxes.[64] A household earning less than what it takes to meet basic living expenses lives in hardship. Nationally, four in 10 adults report they or their family were unable to meet at least one basic need in 2017, despite the economy being at full employment, according to the Urban Institute.[65]

Ohio families need jobs with better wages and benefits or better access to public income supports. Good public policy can promote income stability and reduce hardship. In a state-level analysis with data from United Health Foundation's America's Health Rankings, academic researchers Megan Hatch and Elizabeth Rigby found a clear relationship between health of a state's residents and a state's adoption of public policies that improve conditions for low-income families by increasing wages or providing income support.[66] The most effective policies in academic literature for promoting economic security and, in turn, the health of the population, include a strong minimum wage, policies supporting workers' right to collectively bargain for better wages, the Earned Income Tax Credit, and the Supplemental Nutrition Assistance Program (SNAP).

Promoting income security in Ohio

Increase wages & reduce costs of living in Ohio with public benefit programs

Ohio can improve health by increasing our state's minimum wage and supporting worker rights. Increase incomes in Ohio by raising the minimum wage to $15 by 2025 to give 1.8 million Ohio workers a pay bump. We also need to better enforce Ohio's labor laws so that workers get paid for all the hours they work, including for overtime. State policymakers must protect working people's right to organize against low pay and unsafe work conditions.

We can reduce the cost of living and promote economic stability by expanding access to public benefit programs, such as cash and rental assistance, utility bill assistance and home weatherization, food aid, Medicaid coverage, subsidized childcare and universal pre-k, and/or the Earned Income Tax Credit. Ohio's cash assistance program is miserly, serving only one in five poor families. Eligibility should be expanded from 50 to 100 percent of the poverty level.

Source: A. Hanauer, Policy Matters Ohio, State of working Ohio, 2018, https://bit.ly/2CPlk7g.

62 Amy Hanauer, Policy Matters Ohio, 2017 State of Working Ohio.
63 Hannah Halbert, Policy Matters Ohio, Working for less: Too many jobs pay too little (2018) at https://bit.ly/2K94eRk.
64 Amanda Woodrum, Policy Matters Ohio, 2013 Basic Family Budget: What it takes to get by in Ohio.
65 Karpman, Zuckerman & Gonzalez, Urban Institute, Material hardship among non-elderly adults and their families in 2017 (2018) at https://urbn.is/2Ca2Vm8.
66 Rigby, Elizabeth & Megan E. Hatch, Incorporating Economic Policy Into a 'Health-In-All-Policies' Agenda, Health Affairs (November 2016).

The Earned Income Tax Credit (EITC) supports income stability and improves health. A 1993 reform to the federal EITC gave a substantial boost to the income of low-income families with two or more children. In-depth research on the health ramifications of the 1993 EITC expansion show:

1. Cash infusion from the EITC decreases rates of low birth weight, a major indicator of life-long health outcomes.[67]
2. The health benefits of the EITC increase with the size of the tax refund.[68]
3. People whose EITC refunds increased reported significant decreases in stress-related biomarkers and better mental health indicators, both of which are predictive of better health outcomes over time.
4. Additional studies show health benefits not only at the individual level, but neighborhood-wide due to a health "spillover" effect to the entire community from the cash infusion into high-poverty areas.
5. The authors of these reports attribute these improvements largely to reduced stress levels. Researchers also hypothesize that the cash infusion improved access and the ability to use pre-natal care.

In a study on neighborhood-wide impacts of the Earned Income Tax Credit entitled, *Improving Population Health By Reducing Poverty: New York's Earned Income Tax Credit*, researchers Jeannette Licks-Wim and Peter Arno take a closer look at the EITC "spillover" effect.[69] They found greater improvements in the entire community's health for high-EITC filing "poverty areas" than their low-EITC filing moderate-income area counterparts. The authors hypothesize the cash injection into high-poverty areas from the Earned Income Tax Credit counteracts the "double jeopardy" faced by poorer individuals in resource-limited areas—household stress in a community lacking resources to help relieve that stress—by both reducing household stress and spurring economic activity in the community. Even families that do not receive the EITC benefit from a more robust local economy and greater economic security that comes from the cash infusion into the community.

Promoting income security in Ohio

Expand Ohio's EITC and make it refundable

Low- to moderate-income families pay a higher share of their income to state and local taxes than their wealthier counterparts. The state and federal Earned Income Tax Credits (EITC) counteract this, in part, by providing working families who earn too little with a credit toward the taxes they paid. Unlike the federal tax credit, however, Ohio's EITC is very narrow and does not offer a refund for excess taxes paid. As a result, Ohio's EITC only reaches 5 percent of the neediest families and does not provide the much-needed cash infusion into the household budget or the community. The state of Ohio should expand its EITC and make it refundable.

67 Hoynes, Hilary W., Douglas L. Miller, and David Simon. "The EITC: Linking Income to Real Health Outcomes." University of California Davis Center for Poverty Research, Policy Brief(2013) at https://bit.ly/1zYWnO7.

68 Evans, William N., and Craig L. Garthwaite. "Giving Mom a break: The Impact of Higher EITC Payments on Maternal Health." American Economic Journal: Economic Policy 6, no. 2 (2014): 258-90 at https://bit.ly/1ULUNHY.

69 Wicks-Lim, Jeannette, and Peter S. Arno. "Improving Population Health by Reducing Poverty: New York's Earned Income Tax Credit." Political Economy Research Institute: University of Massachusetts-Amherst Working Paper (2015). Together, New York City's EITC, when combined with the state's EITC, adds up to the biggest income-boost in the country for low-income households.

Food assistance promotes income security and nutrition. Ohio ranks 39th worst among states for people experiencing food insecurity, which means they periodically miss meals due to lack of income and other resources.[70] A higher proportion of Ohio residents went hungry at least one time during 2017—due to lack of money or other resources—than residents in most other states.[71] Robust food aid programs like the federal Supplemental Nutrition Assistance Program (SNAP), are public health investments. SNAP not only provides families with vital support to put food on the table, it also alleviates some of the stress of having to choose between paying rent, fixing the car or feeding the family. On average, SNAP keeps more than 400,000 people out of poverty in Ohio, including more than 185,000 children.[72]

SNAP also helps close a nutrition gap between the rich and poor. SNAP helps adults stay in good health, avoiding malnutrition and other related diseases as well as the expensive medical care associated with those conditions. Low-income adults who receive SNAP incur 25 percent fewer health care costs than low-income adults who do not.[73] For families, food aid also reduces the likelihood that simple disruptions like being scheduled fewer hours at work or an unforeseen expense, turns into a hunger crisis.

Nationally, children are the largest group helped by SNAP, with the health benefits extending into adulthood. Food-insecure children whose families received SNAP have lower rates of obesity, heart disease and stunted growth than food-insecure children whose families did not. They also are more likely to complete high school.

SNAP also supports grocery stores in low-income communities. In high-poverty areas grocery stores rely on SNAP-eligible customers to keep their doors open and food on everyone's plate. Cuts to SNAP or restrictive requirements would not only make families and children vulnerable to hunger, but also put entire communities at risk of losing one of their more important health resources.

Protect the Supplemental Nutrition Assistance Program (SNAP)

Tear down barriers to food assistance in Ohio

Under federal law, low-income working-age adults without children are required to work at least 20 hours per week to get food assistance. While the federal government should eliminate these requirements altogether—taking away someone's food for not working enough is not helpful—Ohio can exempt areas with high unemployment or a job shortage from the SNAP's work requirements under existing federal law. The state of Ohio currently employs this exemption, but applies it in a way that helps poor, white, rural Ohioans while ignoring the plight of urban areas with higher proportions of black residents. Until the requirements are eliminated entirely, the state should exempt all areas that meet the exemption guidelines.

Source: Gregory B Mills, "Assessing the Merits of Photo EBT Cards in the Supplemental Nutrition Assistance Program" (Urban Institute, n.d.);
Three kinds of communities now qualify for the waiver: Those categorized as "labor surplus areas" by the U.S. Department of Labor; those with an unemployment rate 20 percent higher than the nation's over a recent 24- month period; or those qualifying for extended unemployment benefits.

70 Victoria Jackson, Policy Matters Ohio, Cuts to SNAP will harm hungry Ohioans.
71 U.S Dept. of Agriculture definitions of food security https://bit.ly/2nkSgcW.
72 https://www.cbpp.org/sites/default/files/atoms/files/snap_factsheet_ohio.pdf
73 https://bit.ly/2HgJZUQ.

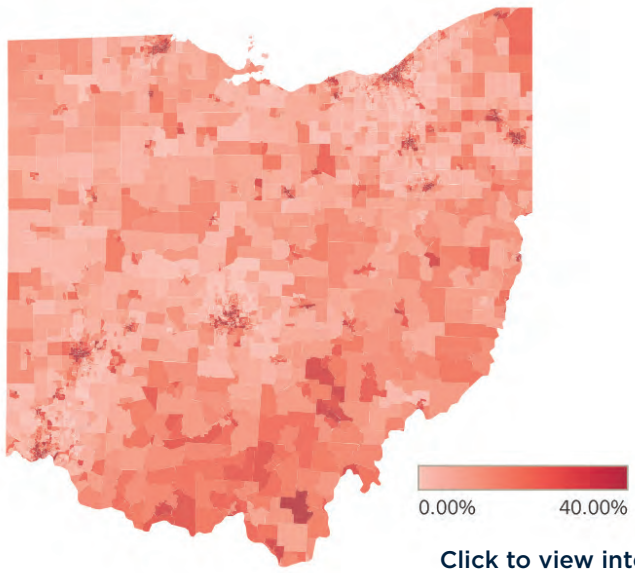
LEVER 3: INVEST IN HIGH-POVERTY AREAS

States making targeted investments in poor communities have better health and lower mortality rates.[74] Improving the health of people living in segregated areas of concentrated poverty requires public investments to improve physical, economic and social infrastructure.[75] While the public health benefits might not be immediately clear, improving the built environment, investing in schools or parks, and giving struggling families a leg up all help counteract the destructive forces of poverty.[76] Improving incomes in poor communities promotes safer environments, lower crime rates, and neighborhoods with developed physical infrastructure and facilities that promote healthy behaviors.[77]

Out of roughly 3,000 census tract divisions in Ohio, about 300 are considered areas of concentrated poverty (10 percent), where at least 40 percent of residents live in poverty (less than $21,000 for a family of three).[78] Since 2000 the share of high-poverty areas in Ohio has doubled.

Figure 2: Areas of concentrated poverty in Ohio

10% of Ohio's census tracts have poverty rates of 40% or more



Click to view interactive map

Source: 2016 American Community Survey, 5-year data, Ratio of income to poverty level.

74 Id.

75 Williams, David R. & Pamela B. Jackson, Social Sources of Racial Disparities in Health, Health Affairs: 24(#2)(2005).

76 Adler, Nancy E., and Katherine Newman. "Socioeconomic Disparities in Health: Pathways and Policies." Health affairs 21, no. 2 (2002): 60-76 at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.21.2.60.

77 Kim, Ae-Sook, and Edward T. Jennings Jr. "Effects of US States' social welfare systems on population health." Policy Studies Journal 37, no. 4 (2009): 745-767.

78 2016 American Community Survey 5-year estimates, Ratio of income to poverty level in the past 12 months.

The health impact of local government spending on public services is measurable.[79] While the income levels of residents play a significant role in the health of that community, research shows that targeted public spending on certain programs helps a community generate better health outcomes than would otherwise be expected. For each percentage point of total spending on community health care and public health activities, health outcomes were 3.7 percent higher than projected based on median income alone.

Using County Health Rankings data from the Robert Wood Johnson Foundation, J. Mac McCullough and Jonathon P. Leider analyzed how different levels of public spending affected a county's health ranking. Counties that aggressively invested over a five-year time period saw significant health improvements. Among the programs found to be impactful were public health initiatives, public hospitals, fire protection, and education. Both general social spending and targeted public health initiatives are important to helping populations overcome barriers to good health. These programs save money in the long run, preventing costly and chronic diseases before they occur. Taking proactive approaches to improving health improves people's lives while stemming growth in health care costs.

Invest in areas of concentrated poverty in Ohio

Address health-damaging neighborhood conditions, promote health-enhancing opportunities

Restore the local government fund. Ohio's local governments have lost more than $1 billion in state aid during the past decade. Recreation facilities were shuttered, roads left unrepaired, and police forces understaffed despite the growing drug epidemic. The loss of state aid strains resources for all public services. The poorest communities, with the lowest property values, have been least able to cope, with deficits in everything from emergency services to child welfare.

Invest in public transit. Ohio's public transit systems provided 37 million rides short of market demand in 2015. Since then their fiscal challenges have grown, in part because of state policy. Ohio has underinvested in public transit for decades. The state should be spending at least $150 million a year to support public transit instead of $40 million, according to their own study. Investments in public transit reduce barriers to employment and health care, among many other benefits. We should also invest in safe pedestrian and cycling infrastructure to promote walkability and bicycling.

Create more green space. The Clean Ohio Conservation Fund provides grants to local governments for a variety of uses to preserve and expand green space in communities. The green space conservation fund should be expanded and targeted toward areas of concentrated poverty to ensure everyone lives within a 10-minute walk of a park. Vacant and abandoned lots can be repurposed into parks and community gardens. Doing so will improve mental health of residents and promote greater physical activity.

Invest to make homes healthy. The state of Ohio needs to increase funding for testing and remediating homes in high-poverty areas facing lead, mold, and other issues. We also need to invest in low-income home weatherization to reduce air leakages and utility bills.

Use community benefit agreements. Local investments should be made in a way that ensures the community gets what it needs, and residents have access to the jobs created. The work force in a community should reflect the diversity of the community.

79 McCullough, J. Mac, and Jonathon P. Leider. "Government spending in health and non-health sectors associated with improvement in county health rankings." Health Affairs 35, no. 11 (2016): 2037-2043.

Policy Matters Ohio

FIGURE 3: CLOSING OHIO'S GREAT HEALTH DIVIDE

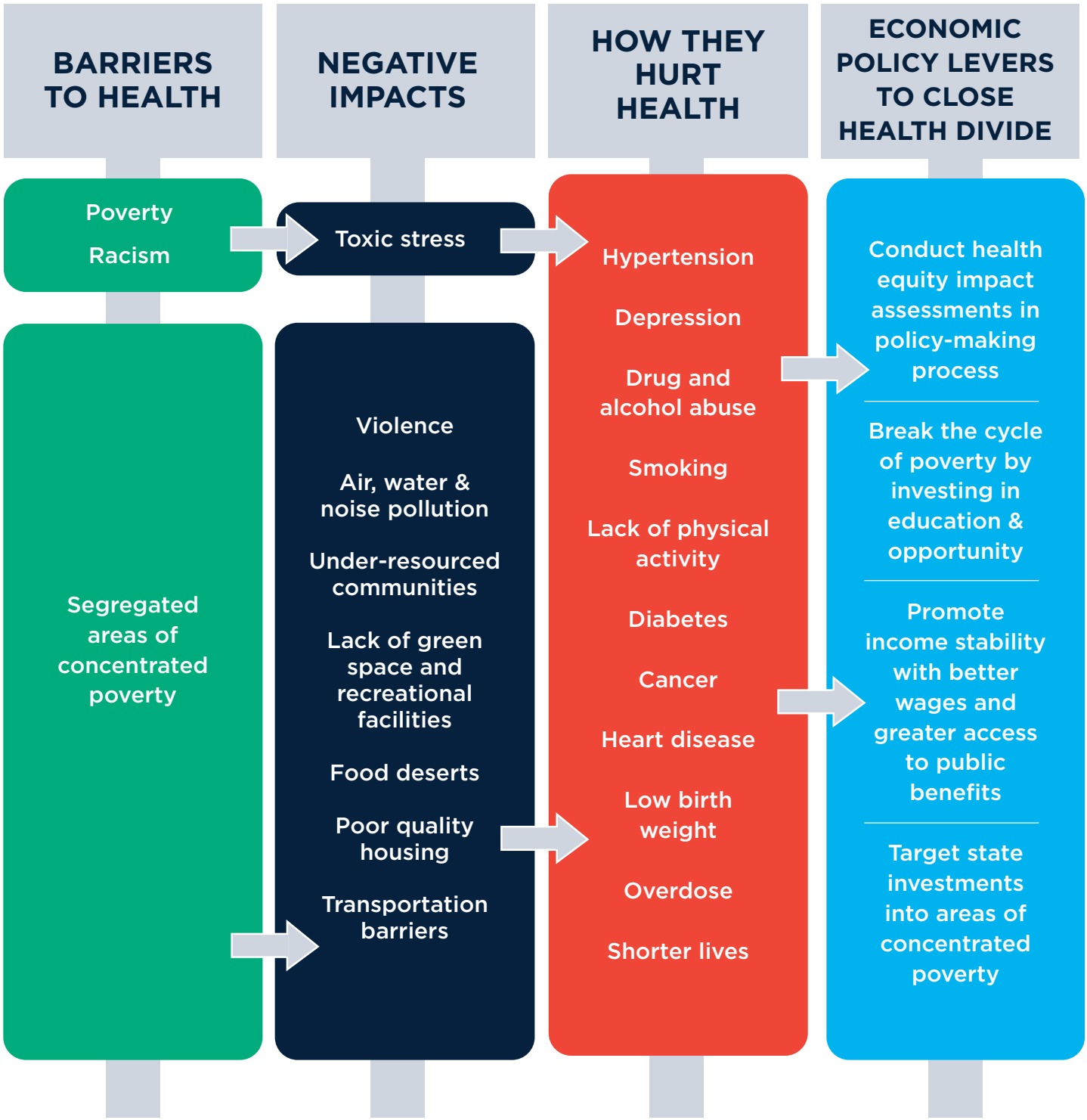


Photo: Shutterstock

Summary of Recommendations & Conclusion

SUMMARY OF RECOMMENDATIONS & CONCLUSION

1

Implement health equity assessments as a standard part of Ohio's policymaking process. Health equity impact analyses empower policymakers with tools needed to understand the effect of proposed public policies and public sector programs on health, paying particularly close attention to health impacts across income levels and by race.

2

Help break the cycle of poverty. Public spending on education and opportunity for low-income communities is one of the best ways to increase life expectancy. Investing in quality, accessible early childhood education is particularly important.

- Ohio should boost eligibility for Ohio's child care assistance program to twice the federal poverty level (200 percent), a generally accepted level of what it truly takes to meet a basic family budget.
- We should also follow the lead of West Virginia, Georgia, Oklahoma and Florida and adopt universal pre-kindergarten, as well as full day kindergarten.

3

Promote income security for Ohio families. Ohio's most common occupations overwhelmingly pay low wages and offer a limited number of hours per week, leaving many families struggling to get by despite working. Better wages would lessen the barriers to health they face due to financial insecurity, as could better access to public benefit programs.

- **Raise the minimum wage to $15 by 2025** and protect working people's right to organize against low pay and unsafe work conditions.
- **Eligibility for Ohio's cash assistance program should be expanded from 50 to 100 percent of the poverty level.** Existing limits to the program are miserly, serving only one in five poor families.
- **The state of Ohio should expand its Earned Income Tax Credit** and make it refundable.
- **Protect Ohio's Supplemental Nutrition Assistance Programs.** Until the federal requirements on work are eliminated entirely, the state should exempt all areas that meet exemption guidelines.

4

Invest in areas of concentrated poverty. Maximize the benefits of those investments through the use of community benefit agreements. States making targeted investments in poor communities have better health and lower mortality rates.

- **Restore the local government fund.** Ohio's local governments have lost more than $1 billion in state aid during the past decade. The poorest communities, with the lowest property values, have been least able to cope.
- **Invest in public transit.** Ohio has underinvested in public transit for decades. The state should be spending at least $150 million a year to support public transit instead of $40 million, according to their own study. We should also invest in safe pedestrian and cycling infrastructure to promote walkability and bicycling.
- **Create more green space.** Ohio's green space conservation fund should be expanded and targeted toward areas of concentrated poverty to ensure everyone lives within a 10-minute walk of a park.
- **Invest to make homes healthy.** The state of Ohio needs to increase funding for testing and remediating homes in high-poverty areas facing lead, mold, and other issues. We also need to invest more in low-income home weatherization to reduce air leakages and utility bills.
- **Use community benefit agreements.** Local investments should be made in a way that ensures the community gets what it needs, and residents have access to the jobs created. The workforce in a community should reflect the diversity of a community.

Conclusion

Poverty, racism and residential segregation into areas of concentrated poverty create barriers to health. Those barriers contribute to a great health divide between rich and poor Ohioans, as well as black and white residents. We can close this divide using economic policy levers to break the cycle of poverty for the next generation, promote income stability for Ohio's families, and target state investments into areas of concentrated poverty. We also need to better understand the link between poverty, policy and health. Health equity impact assessments should be a standard part of the policy making process and evaluation of public programs.

Acknowledgments

Support for this research was provided in part by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

With additional support from:

Center on Budget & Policy Priorities

Saint Luke's Foundation

Sisters of Charity Foundation of Cleveland

George Gund Foundation

Policy Matters Ohio

CONTACT
Amanda Woodrum
Senior Researcher
(216) 361-9801
awoodrum@policymattersohio.org

CLEVELAND
3631 Perkins Avenue, Suite 4C-East
Cleveland, OH 44114

COLUMBUS
125 East Broad Street, 4th Floor
Columbus, OH 43215

policymattersohio.org

@PolicyMattersOH