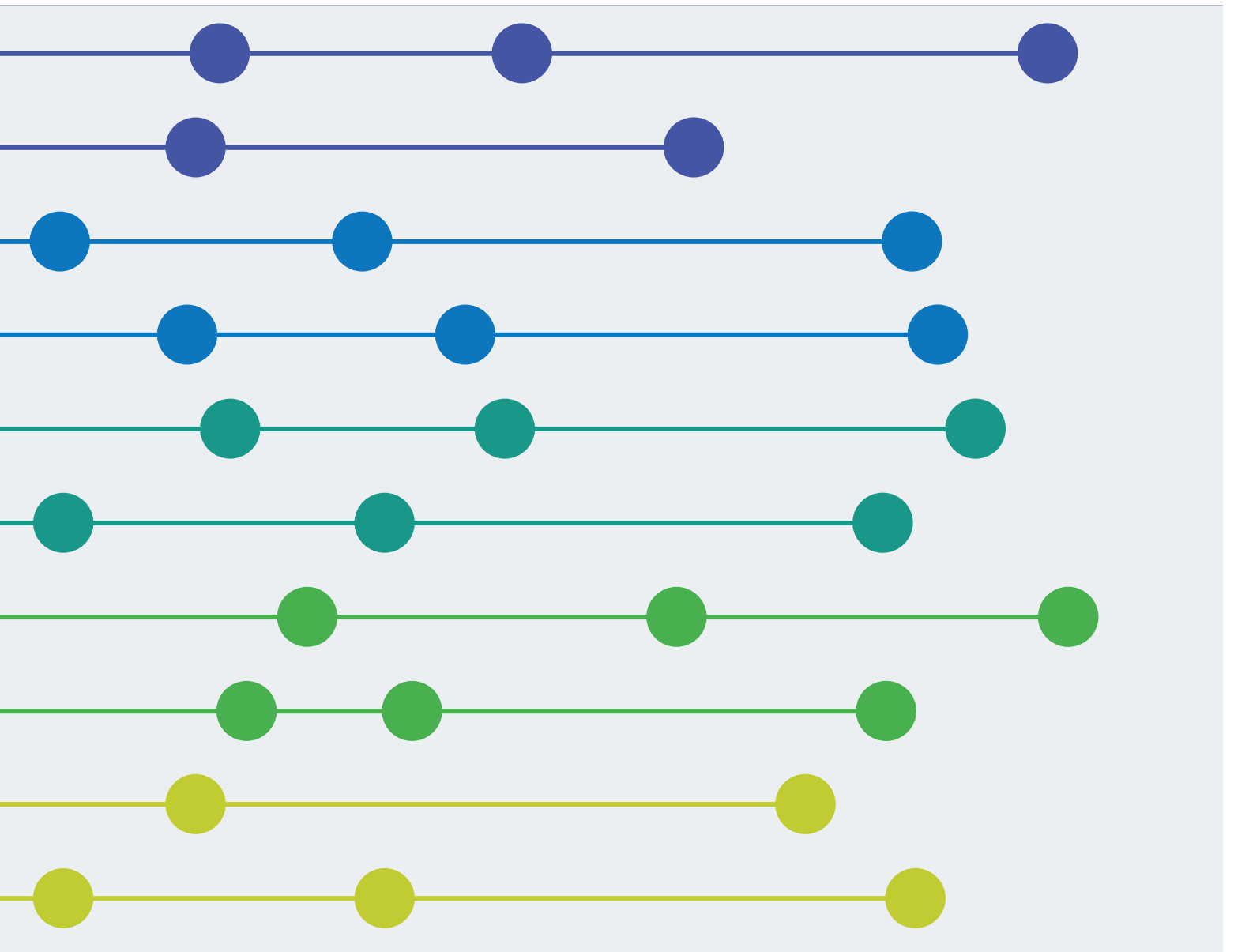


Advancing Health Opportunity and Equity Across the United States: A State-By-State Comparison

NATIONAL COLLABORATIVE FOR
HEALTH EQUITY

TEXAS HEALTH INSTITUTE

VIRGINIA COMMONWEALTH UNIVERSITY
CENTER ON SOCIETY AND HEALTH



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Lead Authors

Naima Wong Croal, Brian Smedley, Dennis Andrulis, Steven Woolf, Nadia Siddiqui, Kim Wilson, Matt Turner, and Anna Stelter

The HOPE Initiative Staff

NATIONAL COLLABORATIVE FOR HEALTH EQUITY

Brian D. Smedley, PhD, Principal Investigator

Naima Wong Croal, PhD, MPH, Project Director

Jalisa Whitley, MPP

TEXAS HEALTH INSTITUTE

Dennis P. Andrulis, PhD, MPH, Co-Principal Investigator

Nadia Siddiqui, MPH

Kim Wilson, DrPH, MPIA

Anna Stelter, LMSW, MPH

Matt Turner, PhD, MPH

Meghan Cocking, MSSW

VIRGINIA COMMONWEALTH UNIVERSITY CENTER ON SOCIETY AND HEALTH

Steven H. Woolf, MD, MPH, Co-Principal Investigator

Derek A. Chapman, PhD

Latoya Hill, MPH

Sarah Blackburn, MS

Lauren K. Snellings, MPH, CHES

This work was made possible with the valuable contributions of the following individuals:

National Advisory Committee (NAC)

David R. Williams, PhD, MPH, Harvard University, Chair of The HOPE Initiative NAC

Dolores Acevedo Garcia, PhD, MPA-URP, Brandeis University

Jeanne Ayers, MPH, Minnesota Department of Health

Rajiv Bhatia, MD, MPH, US Department of Veterans Affairs

Paula Braveman, MD, MPH, University of California - San Francisco

Renee Canady, PhD, MPA, Michigan Public Health Institute

Janet Corrigan, PhD, MBA, Moore Foundation

Rachel Davis, MSW, Prevention Institute

Tom Eckstein, MBA, Arundel Metrics

Ed Ehlinger, MD, MSPH, Minnesota Department of Health (formerly)

Glenn Flores, MD, Connecticut Children's Medical Center

Marjory Givens, PhD, University of Wisconsin, Population Health Institute

Doug Jutte, MD, PhD, University of California - Berkley

Ernest Moy, MD, MPH, Centers for Disease Control and Prevention (CDC), National Center for Health Statistics

Ana Penman-Aguilar, PhD, MPH, CDC, Office of Minority Health and Health Equity

Malia Villegas, EdD, National Congress of American Indians (formerly)

Robert Wood Johnson Foundation

Dwayne Proctor, PhD, Senior Adviser to the President

C. Tracy Orleans, PhD, Senior Program Officer and Senior Scientist

Nicole Collins Bronzan, Communications Officer

J. Michael White, MPH, Program Associate

Elaine Arkin, Consultant, Special Adviser on The HOPE Initiative

Burness

Sara Knoll, Vice President, Health & Social Policy
Janet Firshein, Principal and Co-Director, Health & Social Policy
Shannon Ryan, Vice President and Co-Director, Creative (formerly)

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Robiel Abraha, MPH, Episcopal Health Foundation
Laudan Aron, MA, BSc, Urban Institute
Breannon Babbel, PhD, MPH, MPP, National Indian Health Board
Julia Berenson, MSc, Columbia University
Ashley Brown, MPP, Center for Global Policy Solutions
Juanita Chinn, PhD, CDC, National Center for Health Statistics
Stacy Cunningham, MS, National Network of Public Health Institutes
Jennifer Hadayia, Harris County Public Health
Julia Holmes, PhD, CDC, National Center for Health Statistics
David Huang, PhD, MPH, CDC, National Center for Health Statistics
Marjorie Innocent, PhD, NAACP
Anthony Iton, MD, JD, MPH, The California Endowment
Ginger Jacinic, LMSW, MPAff, City of Austin, Texas
Iyanrick John, JD, Asian & Pacific Islander American Health Forum

Michael Knapp, PhD, Green River Consulting
Kathy Ko Chin, MPH, Asian & Pacific Islander American Health Forum
Vincent Lafronza, EdD, National Network of Public Health Institutes
Leandris Liburd, PhD, MPH, CDC, Office of Minority Health and Health Equity
Adrienne McFadden, MD, JD, Virginia Department of Health (formerly)
Ramal Mooneshinghe, PhD, CDC, Office of Minority Health and Health Equity
Linda Rae Murray, MD, MPH, (retired)
Julie Nelson, Government Alliance on Race and Equity / Race Forward
Sarah Norman, MPP, NeighborWorks America
Brion Oaks, MPA, City of Austin, Texas
Mary Pittman, DrPH, Public Health Institute
Eiman Siddiqui, Chief of Staff, Texas State Representative Tom Oliverson
Shao-Chee Sim, PhD, MPA, Episcopal Health Foundation
Makram Tahlih, PhD, CDC, National Center for Health Statistics
Phil Tegler, JD, Poverty and Race Research Action Council
William M. Tierney, MD, Dell Medical School, University of Texas at Austin
Hieu Truong, MUP, NeighborWorks America

Introduction

Many circumstances in our homes, neighborhoods, schools, workplaces, and society at large affect whether we have a fair shot at living a healthy life. The opportunities for good health and well-being vary depending on our race or ethnicity, our level of education and income, and where we live, among other factors. But, it does not have to be this way. What drives health is more about the resources we have access to and the conditions in our neighborhoods, and less about medical care. Health behaviors like exercise and diet matter a lot, but our behaviors and even our ability to get quality health care depend on the opportunities and resources we can access. The good news is that we can create better opportunities for all Americans—especially for the most vulnerable among us—by expanding health equity. As Braveman (2017) states, “Health equity means that everyone has a fair and just opportunity to be as healthy as possible... measuring the gaps in health and in opportunities for optimal health is important not only to document progress but also to motivate action and indicate the kinds of actions to achieve greater equity.”

To expand opportunity, we must first understand where opportunity thrives, and for whom, and where we have gaps. The Health Opportunity and Equity (HOPE) Initiative offers a new way to measure our national and state-level progress toward expanding opportunity across all racial, ethnic, and socioeconomic groups. We do so by tracking 28 indicators that span the life course, including health outcomes and indicators related to opportunity such as socioeconomic factors, the physical and social environment, and access to health care. For each measure, we set benchmarks that are aspirational but achievable—based on populations and states that have already obtained the best outcomes. We intentionally set the HOPE Initiative’s measures at the national and state levels not only to track progress, but also because we understand the power held by states to create and further opportunities through policies that improve the lives of their residents.

Policies Can Create Opportunities for Better Health & Well-Being

Health and well-being are determined at multiple levels. On one level, people make individual choices about their health on a routine basis. This morning, you chose whether or not to eat breakfast; and, if you ate breakfast, you decided what and how much you ate. These types of daily decisions have a profound impact on individual health. Your personal health decisions, however, are not fully under your own control. Eating a banana for breakfast is a healthy choice but doing so presumes you have access to a store that sells produce and the money to purchase the banana. A human and historical chain affects the opportunity to make that decision—from the grocer, to the distributor, to the farmer, to the politicians setting trade policy, to the history and practices for cultivating the banana, among many others. For all too many, weak links or breaks in that chain greatly impede the opportunity to access affordable healthy food. This is just one, small example of the many systems that intersect beyond our individual choices that shape opportunities for health. And while the systems may be complex, they are malleable and we can construct them to reflect our values.

The opportunities to increase health and well-being are abundant. They exist in every place we live our lives—our homes, where our children go to school, where we work, where we shop, and where we socialize—as many of the social and economic factors that determine opportunities for health, and affect our quality of life, are interconnected. The factors that shape the stability of families, also determine educational attainment, employment, and retirement savings—and together shape the economic vitality and social well-being of neighborhoods across the nation. These circumstances and dynamics lead to one conclusion: good socioeconomic policy is good health policy. Improving educational opportunities is good health policy. Taking care of our environment is good health policy. And so on.

The Health Opportunity and Equity (HOPE) Initiative

Led by the National Collaborative for Health Equity (NCHE) and Texas Health Institute (THI), in partnership with Virginia Commonwealth University’s Center on Society and Health (VCU-CSH), and with support from the Robert Wood Johnson Foundation (RWJF), The Health Opportunity and Equity (HOPE) Initiative begins with a set of state and national metrics designed to spur action to improve health and well-being for all, regardless of race and ethnicity or socioeconomic status (SES). Key to HOPE is that we use measures that illuminate opportunities for everyone to flourish. Specifically, the indicators allow states to see where they are doing well and where they can do better on a broad range of factors that influence health and well-being. The indicators tracked by HOPE show us where babies are more likely to live past their first birthday, where residents can more easily access a doctor, where air quality is healthier, where young children are more likely to enroll in pre-k, or where housing is more affordable. We identify states with the best outcomes and ask, “What are they doing right, how did they get there, and how can it work in my

state?” Further, the data are broken down race, ethnicity, and socioeconomic status to help us better understand what it would take for members of all population groups to reach the benchmarks. Groups that have been systematically disadvantaged by racial discrimination or poverty—two key root causes of inequity (Braveman, 2017)—often have a greater distance to go, but these gaps differ by state suggesting policy and context matter.

What Is Unique About the HOPE Initiative?

HOPE is not the first or only national effort to furnish indicators on the determinants of health and equity. Other notable initiatives include *America’s Health Rankings*,¹ *County Health Rankings and Roadmaps*,² *Health of the States*,³ *National Equity Atlas*,⁴ and the *Opportunity Index*,⁵ among many others. What makes HOPE unique is that

HOPE Features

OPPORTUNITY FRAMING provides an asset-based orientation to replace measures that typically call attention to deficits rather than highlighting achievements or opportunities for improvement. We measure income, not poverty; employment, not unemployment; housing quality, not housing problems.

ASPIRATIONAL, YET ATTAINABLE GOALS for achieving equity across health and broader well-being indicators. We use “HOPE Goals” to set benchmarks that we know are reachable because they are based on actual rates we can observe among certain populations.

NATIONAL AND STATE DATA BY RACE, ETHNICITY, AND SOCIOECONOMIC STATUS, allowing for a deeper understanding of health equity and opportunity for specific population groups.

MEASURES OF PROGRESS, also referred to as “Distance to Goal,” for specific population groups. This tells states, and the nation, how far they must go to achieve the goal of greater equity in health outcomes and the determinants of health for their populations.

we have reoriented our focus from health inequities to a positive frame of opportunity, focusing whenever possible on assets rather than deficits. To make progress on health equity, we need to understand who is doing well and why. We have developed a new way for the nation and states to measure opportunities for better health and well-being, to learn from where population groups are doing well, and to take action based on metrics that are rooted in an opportunity framework. The HOPE Initiative intentionally presents data not only at the national level, to track the country's progress, but also for each state and the District of Columbia. This is because the opportunity landscape differs dramatically across the 50 states. And we stratify the data by race, ethnicity, and socio-economic status, allowing for a deeper understanding of how opportunity varies among subpopulations across the states. This kind of stratification of data in a nation-wide resource breaks new ground. Previous efforts have emphasized national averages to describe inequities among population groups. HOPE shows that the story varies considerably from one state to another.

It allows states to examine where they are in the progression toward equity, where they can celebrate wins, and where to look to other states for model solutions and policies to improve opportunities for health and well-being for all.

The Domains & Indicators of the HOPE Initiative

HOPE tracks 28 indicators of child and adult health outcomes and the key resources that produce opportunities for health and well-being. These outcomes and resources, which we call *domains*, include: health outcomes, socioeconomic factors, the social environment, the physical environment, and access to health care. For each indicator within a domain, we have calculated a national benchmark which we refer to as the HOPE Goal and ranked states on their performance related to the benchmark.⁶ National and state data are provided by race, ethnicity, and SES.

Measuring gaps in health and well-being is an important first step toward documenting progress and motivating action to achieve greater equity.

⁶ A technical summary on our methods is available at www.nationalcollaborative.org/our-programs/hope-initiative-project/

HEALTH OUTCOME INDICATORS

HOPE's six health and well-being indicators are intended to capture the overall physical and mental health of a population across the life cycle. These indicators measure the presence or absence of health and wellness, as well as mortality.

Adult Health Status	Portion of adults who say their health is very good or excellent
Mental Health Status	Portion of adults who say their mental health was not good for 14 or more days in the past 30 days
Child Health Status	Portion of children whose parents rate their health as very good or excellent
Premature Mortality	Number of annual deaths due to any cause per 100,000 population age 25-64
Infant Mortality	Number of infants who die before their first birthday annually per 1,000 live births
Low Birth Weight	Portion of infants weighing less than 2,500 grams at birth

SOCIOECONOMIC INDICATORS

The six socioeconomic factors tracked by HOPE reflect systemic circumstances that promote or constrain opportunities to enjoy good health. These indicators broadly measure financial, educational, and occupational conditions influencing the standard of health people and households can achieve.

Livable Income	Portion of people living in households with income greater than 250% FPL
Affordable Housing	Portion of households spending no more than 30% of monthly household income on housing and related expenses
Post-secondary Education	Portion of adults with at least some college education after graduating from high school
Connected Youth	Portion of young people age 16-24 enrolled in school or working, including military enlistment
Preschool Enrollment	Portion of children age 3-4 enrolled in preschool
Employment	Portion of people in the labor force who are employed

SOCIAL ENVIRONMENT INDICATORS

HOPE's five social environment indicators measure elements of one's social surroundings with implications for health, such as living in an environment without concentrated poverty or violence. Differences in social conditions between groups often reflect historical practices or policies that privileged certain people over others and contribute today to limited health opportunity among socially disadvantaged groups. Here, the surrogate measure for safety is low crime rates.

Low Poverty Concentration	Portion of people in neighborhoods with less than 20% of residents living in poverty
Low Murder Rate	Portion of people living in counties with fewer than 5.1 murders per 100,000 population annually
Low Assault Rate	Portion of people living in counties with fewer than 283 reported cases of aggravated assault per 100,000 population annually
Low Rape Rate	Portion of people living in counties with fewer than 36.9 reported cases of rape per 100,000 population annually
Low Robbery Rate	Portion of people living in counties with fewer than 52.1 reported cases of robbery per 100,000 population annually

PHYSICAL ENVIRONMENT INDICATORS

HOPE identified five physical environment indicators to measure dimensions of health opportunity embedded in people’s physical surroundings. Together, these indicators are meant to capture the physical conditions that either promote or discourage health and wellbeing in the places where people live, work, play, and perform activities of daily living.

Home Ownership	Portion of households living in a home they own
Housing Quality	Portion of households living in homes with no severe housing problems (i.e., homes that have complete kitchens, functioning plumbing, and are not overcrowded or severely cost-burdened)
Air Quality—Particulate Matter	Portion of people living in counties with average daily density of fine particulate matter (PM _{2.5}) below 12 micrograms per cubic meter
Low Liquor Store Density	Portion of people living in counties with fewer than 1.736 liquor stores per 10,000 population
Food Security	Portion of people living in census tracts that are not food deserts (i.e., census tracts not designated low income and low food access)

ACCESS TO HEALTH CARE INDICATORS

HOPE’s six measures of access to health care are intended to capture conditions to ensure that people can engage with clinical services when needed. Accessible and affordable health care are essential to protect people’s opportunities to maintain the highest possible standard of health across the lifespan.

Access to Primary Care	Portion of people living in counties with a population-to-primary care physician ratio of less than 2,000:1
Access to Psychiatric Care	Portion of people living in counties with a population-to-psychiatrist ratio of less than 30,000:1
Health Insurance Coverage	Portion of people under age 65 with any kind of health insurance
Affordable Health Care	Portion of adults who did not delay or forego any medical care they needed due to cost in the past year
Usual Source of Care	Portion of adults who have someone they consider their personal health care provider
Colorectal Cancer Screening	Portion of adults age 50–75 receiving recommended colorectal cancer screenings

Key HOPE Findings: What Did We Learn?

Detailed charts and data on all of HOPE's measures can be found in *The HOPE Initiative: Data Chartbook* and an in-depth description of our methods can be found in *The HOPE Initiative: Technical Summary*.⁷ Several key takeaways emerged from our analysis revealing how the 50 states and District of Columbia vary in terms of health and the domains that shape health. First, we learned that the racial and ethnic disparities we see nationally hide important differences that exist across the states. As shown in Figure 1, the health status described by whites, Blacks, and other populations of color are not uniform across the country. For example, some minorities in the healthiest states—particularly those with less diversity, such as New England or the Northern Great Plains states—report better health status than do whites in other states such as West Virginia.

Second, we observed—as many others have—that the relationship between socioeconomic status and health operates as a gradient; that is, health improves progressively with greater levels of education or income. Many reports have documented this gradient in national data, but we also observed it in each state as well as variation in the size of the gradient by state. Figure 2, for example, shows that despite some variation between states on their performance in comparison to the HOPE benchmark, higher levels of educational attainment are associated with higher percentages of home ownership.

National data show that these gradients also exist within racial and ethnic groups; for example, Blacks, whites, and other racial groups with advanced degrees on average have better health than members of their racial group with less education. However, we find that education or income do not confer equal benefits to all racial and ethnic minorities, as the health profiles of the most educated people of color often resemble those of whites with less education. In Figure 4, using the health care affordability indicator, we see that Hispanics with some college education face

a greater distance to reach the HOPE goal than do whites with less than a high school degree.

Third, the HOPE Goals help us to better understand the degree of equity within and across states. Using the example of adult health status in Figure 3, the HOPE rankings show that among four southern states, Virginia is closest to the HOPE Goal at 18th, North Carolina is a bit further back at 33rd, and Alabama and Mississippi are among the farthest at 46th and 47th respectively. Despite Mississippi being relatively far from the Goal at 47th, race and ethnicity groups within the state rate themselves on health similarly, whereas, in North Carolina the degree of inequity between groups or the opportunity gap is much wider.

Finally, we have much to learn from bright spots—that is, states that are positive outliers and exhibit surprising data. While infant mortality among U.S. Blacks nationally, for example, is much higher than among whites, infant mortality in Washington State is lower among Blacks (7.1 per 1,000 live births) than among whites in Alabama (7.3), Hispanics in South Dakota (8.6), and Asian and Pacific Islanders in Utah (7.6). We have much to learn from these unexpected findings. These kinds of positive outliers raise questions about which contextual factors at the state level are driving outcomes that are different from national trends. Where we find these bright spots, we should scrutinize the social, economic and environmental conditions in that particular state because they can offer important clues for policy change.

Taken all together, these findings show that higher levels of socioeconomic status are associated with better health and opportunity, but the protective effects of SES do not fully apply to all populations or facilitate health to the same degree in all states. That is, the health of Americans is shaped not only by their personal characteristics and lifestyles but also by the places in which they live.

⁷ Available at www.nationalcollaborative.org/our-programs/hope-initiative-project/

FIGURE 1

ADULT HEALTH STATUS

By Race and Ethnicity

- White ● Black ● Hispanic
- Asian/PI ● AI/AN ● Multiracial

Percent of Adults with Very Good or Excellent Health

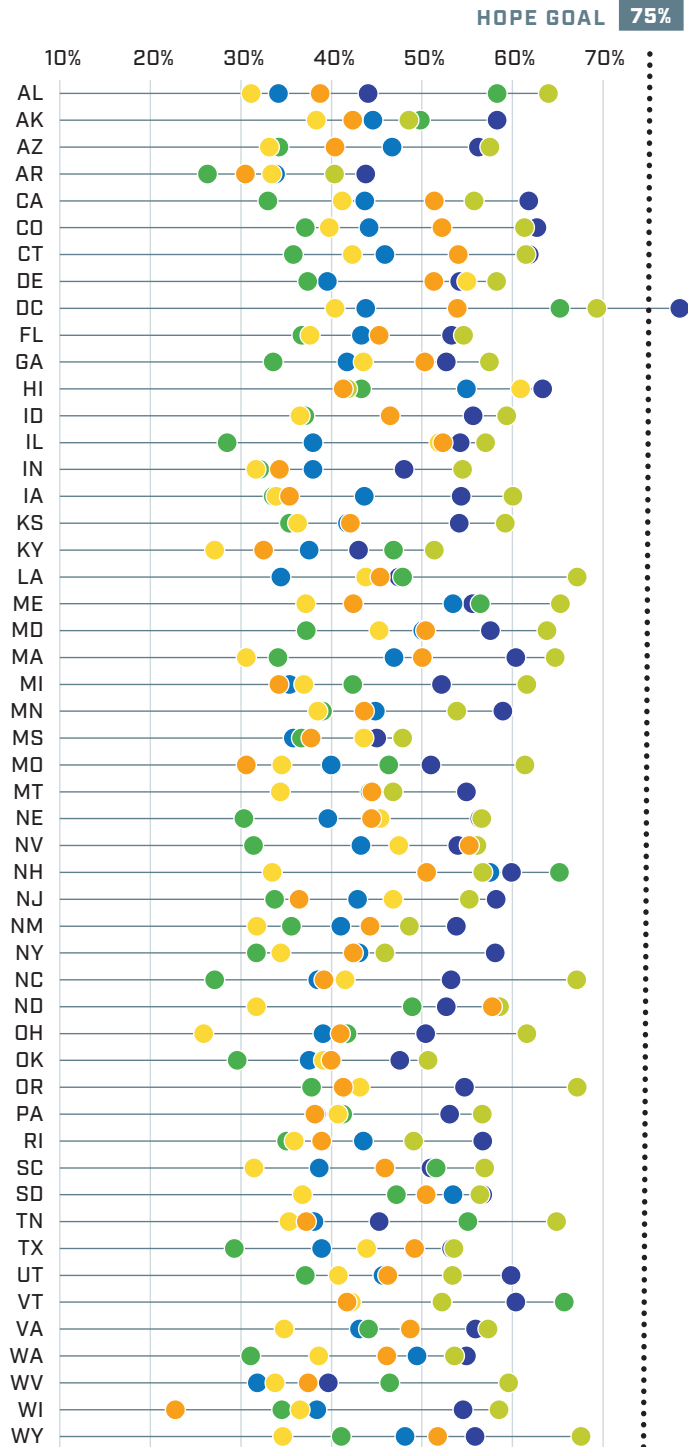


FIGURE 2

HOME OWNERSHIP

By Education Attainment

- Less than HS ● HS Grad ● Some College ● College Grad

Percent of Households Owning Homes

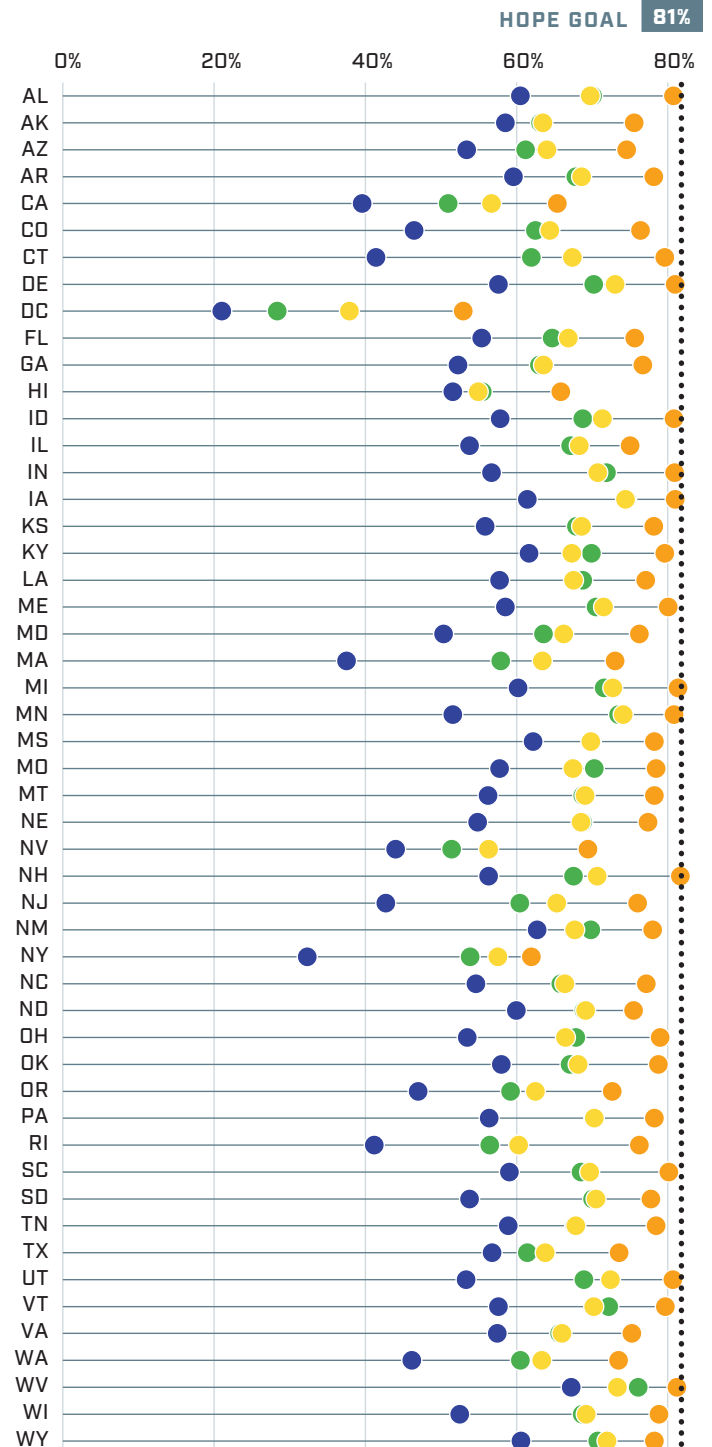


FIGURE 3
DEMONSTRATING THE DEGREE OF EQUITY WITHIN AND BETWEEN STATES USING HEALTH STATUS

By Race and Ethnicity for AL, MS, NC & VA

- White ● Black ● Hispanic
- Asian/PI ● AI/AN ● Multiracial

Percent of Adults with Very Good or Excellent Health

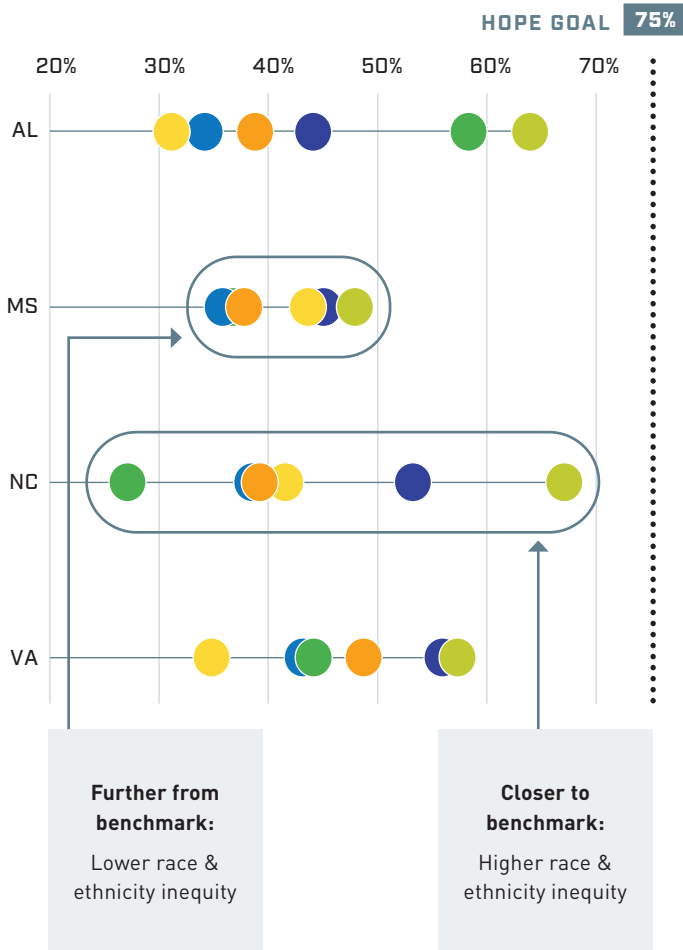
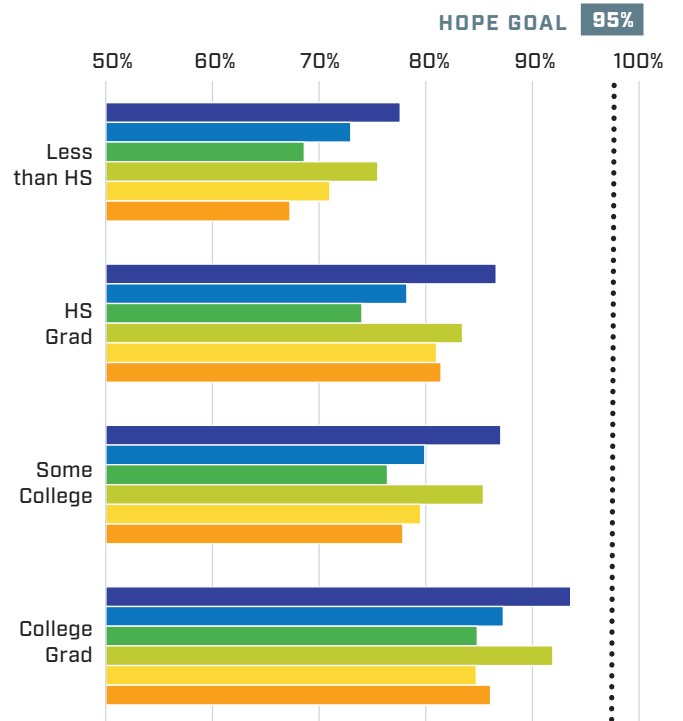


FIGURE 4
AFFORDABLE HEALTH CARE: NATIONAL PROGRESS TOWARD HOPE GOAL
By Race, Ethnicity, and Education

- White ■ Black ■ Hispanic
- Asian/PI ■ AI/AN ■ Multiracial

Percent with Affordable Health Care



How Can I Use HOPE's Measures?

HOPE's measures forge the way for states and the nation to:

- Identify each state's areas of strength and of greatest need
- Learn from states that are leading on our measures of equity and opportunity
- Assess policy priorities and potential health impacts that may be linked to opportunity status within each state
- Identify key drivers of health opportunity and equity
- Use data in conversations within states and communities to understand what is happening and what is working well
- Understand the degree of equity within a state and compared to other states against a national benchmark

The policies of states and communities affect the environment and socioeconomic circumstances in which residents live and contribute to divisions in access to opportunities to thrive.

Research has documented evidence of equity-focused policies that have proven effective in enhancing health opportunities for all. For example, with its long history of work to achieve universal coverage, Massachusetts ranks at or near the top on many HOPE measures of health and well-being, as well as health care access. Notably, all income and racial and ethnic groups in the state possess high rates of health insurance coverage and primary care access. Thus, equitable state level policies across the multiple sectors that shape health are a promising point of intervention. What can we learn about the context and potential policies and investments that are producing the outcomes we seek? We believe these kinds of data offer promising clues about what works for improving opportunity and equity.

Future HOPE research will delve more deeply into "positive outliers" to identify common characteristics and strategies. We will also conduct more analyses to examine how states in different regions of the country, or those with similar demographic profiles, fare on HOPE measures, again to identify important commonalities that can assist others in furthering construct programs and policies.

EVERY STATE CAN DO SOMETHING TO IMPROVE THE HEALTH AND WELL-BEING OF ITS RESIDENTS. A review of state policies can offer important clues for strategies that could be helpful for states that want to close opportunity gaps. In so doing, our team recognizes the rich and growing literature documenting promising strategies to expand opportunity, health and well-being. While an exhaustive review of this literature is not possible here, below we cite examples from this body of research, with the goal of informing discussions and actions among state policymakers and identifying research questions that HOPE will address in future work.

Socioeconomic Factors

States can expand economic opportunities, particularly for low-income families and communities, through a combination of macroeconomic, labor market, housing, and education policies, among other strategies to boost family incomes and economic security. State tax policy, for example, can help low-income families retain more of their income and encourage savings. Several states have implemented earned income tax credit (EITC), Child Tax Credit (CTC), and/or Child and Dependent Care Credit (CDCTC) policies, which provide a tax refund to eligible low-income families.⁸ These policies have been shown to increase employment and income, especially for single mothers, and improve health and access to health care among poor working families (Centers for Disease Control and Prevention, 2014). Such policies are also associated with improvements in child health, including reductions in infant mortality (Arno et al., 2009; Marr et al., 2013) and low birth weight (Strully et al., 2010).

Similarly, there is robust evidence that high-quality early childhood education improves children's educational attainment, as well as health and well-being, across a range of measures. Children who attend high-quality preschool programs are less likely to show behavioral problems, score higher on standardized tests, and achieve higher levels of education relative to children who do not attend pre-kindergarten programs (Barnett et al., 2017). In addition, they are more likely to be employed as adults, and have greater adult earnings (Ruhm & Walfoegel, 2011).

Several states that perform well on HOPE measures of child health, such as Minnesota, Oregon, and Washington, rank high in ratings of quality and accessibility of state-funded pre-k programs.

State policies can also influence family earnings. Slightly less than half (49%) of salaried workers in the United States earn the federal minimum wage, and three-fourths (76%) of these are 20 years or older (Bureau of Labor Statistics, 2013). But in many communities the federal minimum wage

is insufficient to meet needs, especially among families with children. Researchers have developed a “living wage” calculation that takes into consideration regional and community variation in costs related to housing, health care, transportation, food, and child care (Glasmeier, 2004), and some states have enacted minimum wage laws that require employers to pay wages higher than the federal minimum wage (U.S. Department of Labor, 2018).

Many of that states that have the greatest distance to HOPE Goals on socioeconomic factors (e.g., Southeastern) use the federal minimum wage standard while states that are closest to the respective goals (e.g., Northeastern and Pacific Northwest) have set state minimum wages higher than the federal requirement.

Social Environment

A large body of research finds that aspects of the social environment—in particular, neighborhood poverty concentration—powerfully shape opportunities for health and well-being. Children living in high-poverty neighborhoods face greater risk for exposure to adverse childhood experiences such as violence, have less access to healthy food, face greater environmental health risks, and are too often educated in poorly-resourced schools (Kramer & Hogue, 2009; Williams, Priest & Anderson, 2016; Acevedo-Garcia et al., 2014). Policies that encourage mixed-income housing developments—where affordable housing is included with market-rate housing—have resulted in multiple benefits for families with low incomes (Joseph, Chaskin & Webber, 2007). And, the recently-concluded Moving to Opportunity study, a longitudinal, randomized control trial involving over 4,600 low-income families, found that families in an experimental condition who used housing vouchers to move from high- to low-poverty neighborhoods earned higher incomes and experienced lower levels of psychological distress, severe obesity, and diabetes relative to a control group that received no assistance to move to low-poverty neighborhoods (Chetty, Hendren & Katz, 2016).

While housing policy is primarily established by local jurisdictions, states can incentivize inclusionary zoning and the use of portable housing vouchers to combat high levels of neighborhood poverty concentration.

States such as California, Colorado, and Washington have used policy incentives like inclusionary zoning and housing vouchers and by comparison perform much closer to the HOPE Goal of ensuring that no resident lives in a community with high levels of poverty concentration.

Physical Environment

Recognizing that home ownership is key to building wealth and economic opportunity, as well as promoting stable families and communities, many states have implemented policies to assist low- and moderate-income families to purchase homes. These strategies include providing down payment assistance through grants, second mortgages, or premium bonds; direct lending to first-time home buyers; and homeownership counseling.

West Virginia, a relatively poor state, offers all three sources of homeownership support, and is ranked second among all states on HOPE's measure of home ownership. Minnesota and Michigan—ranked 3rd and 4th respectively—offer both down payment assistance and counseling. California and New York are ranked the lowest—49th and 50th—are among the most expensive states to own a home and only offer down payment assistance.

States are also increasingly implementing policy strategies to improve access to healthy food retail, particularly in low-income communities. One of the first such initiatives was launched in the Commonwealth of Pennsylvania in 2004. The Pennsylvania Fresh Food Financing Initiative (FFFI) was designed to attract supermarkets and grocery stores to underserved urban and rural communities, with the goals of stimulating investment of private capital and removing financial obstacles for supermarkets to establish in “food deserts.” The program also sought to reduce the

incidence of diet-related diseases, while creating good-paying jobs for community residents. Preliminary evidence suggests that the initiative is meeting its goals: by 2010, FFFI approved 88 grocery retail projects for funding, which created more than 5,000 jobs and increased health food access to nearly 500,000 Pennsylvania residents. And while many factors influence diet-related health outcomes, researchers found an unprecedented 5% decline in rates of childhood obesity in Philadelphia where the first FFFI funds were implemented (Harries et al., 2014). The success of this effort stimulated creation of the federal Healthy Food Financing Initiative in 2011.

The states that are closest to the HOPE goal of ensuring that 97% of residents live in communities with healthy food retail—including California, New York, New Jersey, Massachusetts, and Pennsylvania—all had adopted fresh food financing programs by 2015 (Opportunity Finance Network, 2015).

Access to health care

States have important opportunities to improve health insurance coverage through Medicaid and the Child Health Insurance Program, as well as other efforts to incentivize private insurance markets. To the extent that states equitably approach the HOPE insurance coverage goal, they will also reduce geographic barriers to care and induce health care providers and institutions to locate in medically underserved communities. But many states—particularly those in the Deep South and Mountain West that elected not to expand the Medicaid program through the Affordable Care Act—remain far from the goal. The federal government remains the primary force determining health care provider supply and distribution, through designating and funding federally-qualified health centers and supporting health care provider training and service programs such as the National Health Service Corps, but states can also create programs and incentives to align health care resources with community need. For example, 34 states have established Certificate of Need (CON) laws to regulate the citing and construction of new health care facilities, but these tools are rarely applied with equity as a guiding principle (National Conference of State Legislatures, 2016).

Conclusion

The HOPE Initiative envisions a nation where state and national policymaking prioritizes health, equity, and opportunity for all, with a particular focus on low-income families, people of color, and others who face currently the widest gaps in opportunity and health. Ultimately, the goal of our work is to promote a Culture of Health that embraces fair and just opportunities to access needed

resources, provides metrics that society can use to track progress, enables forecasting of likely outcomes of state-level policy solutions, and promotes wise, strategic investments in remedying the root causes of inequities. It's in our national interest to nurture the resources that enhance all facets of a good life—for all.

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