A HEALTHY OREGON: 21ST CENTURY HEALTH EQUITY INVESTMENTS

OHEA
Oregon Health Equity Alliance

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- Causa
- Native American Youth and Family Center (NAYA)
- Oregon Latino Health Coalition
- Unite Oregon
- Upstream Public Health
- Urban League of Portland

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EXECUTIVE SUMMARY

Too many Oregonians are sick and die prematurely due to preventable disease. The time is now to close the gap on persistent and historic health disparities. Oregon owns a long, and sometimes unique, history of marginalizing and under-serving Communities of Color, immigrants and refugees. These inequities, including racial bias, resource distribution, and systemic exclusions, have been institutionalized for generations. Oregon is better when all her residents are well and have the opportunity to contribute and thrive.

Oregon has made significant progress over the last decade with a fresh commitment to health equity, expansion of Medicaid, and new community-driven public policy for data equity, cultural competency and community health workers. These budding efforts give hope, and yet the legacy of health inequities requires long-term dedication to address their root causes. The Oregon Health Equity Alliance (OHEA) and member organizations are leading the way to improve access, affordability and innovation to mend the gap for the thousands of families left behind as Oregonians continue to pursue healthcare transformation. OHEA understands the need to improve the social determinants of health, and have taken concrete steps through advocating to raise the minimum wage and guaranteeing paid sick leave for working Oregonians. Together, OHEA and a range of community partners are changing the landscape of health.

Oregon is at a crossroads. We have promising, new, and increasingly diverse leaders, who are creating concrete solutions to Oregon's health disparities. Yet, we lack an equitable revenue system to support this work long term. This limits our ability to realize our full potential. After decades of disinvestment in our public services, Oregon requires a more significant and sustainable source of revenue to realize our shared values of health and prosperity. Our communities are growing and becoming more racially and culturally diverse, and profound new investments are needed to ensure all our children and our grandchildren, regardless of where they were born and who they are, have the rights, resources, and recognition, needed to thrive.

> The legacy of health inequities requires long-term dedication to address their root causes.

INTRODUCTION

This report provides a roadmap to key priorities that, with critical new investments, will improve outcomes and health equity in Oregon. We have the wealth to ensure all Oregonians can experience good health, and we cannot allow some in our communities to suffer and die prematurely. OHEA was formed in 2009 to provide a powerful, organized, community driven alliance that has the capacity to address the root causes of health inequities, create solutions, and improve life for all Oregonians.

The research is clear, racial disparities persist in all aspects of health in Oregon, from healthcare access, illnesses and chronic disease, to premature death. This should be concerning for all public officials; and we must act to address this crisis. For example, African American and Native Americans populations lose more potential years of life in Oregon than other groups.[1]

The research is clear, racial disparities persist in all aspects of health in Oregon, from healthcare access, illnesses and chronic disease, to premature death.

Unfortunately, existing revenues are insufficient to close the gaps and eliminate the deep disparities engraved in lives of Oregonians. Proven programs and seasoned health professionals that help prevent diseases, reduce infant mortality, and improve outcomes for Oregonians who experience health disparities are underfunded and unavailable in many communities throughout the state. Despite a legacy of declining resources that have wrecked havoc on the well-being of working families, there is hope. OHEA and many other allies for a healthy Oregon are developing consensus around the key problems and concrete solutions.

Oregon's health transformation has made important strides to achieve the Triple Aim:[2]

1. Improve the lifelong health of all Oregonians
2. Increase the quality, reliability and availability of care for all Oregonians
3. Lower or contain the cost of care so it is affordable for everyone

Yet as this report outlines, we face persistent disparities in health outcomes particularly among Communities of Color, immigrant and refugees, and rural communities in Oregon. Consistent and targeted funding to improve systems of care are needed to fully realize the Triple Aim.

At the center of communities experiencing health inequities are the 383,000 uninsured Oregonians, and thousands of working families who are under-insured and lack access to culturally competent healthcare. We have created comprehensive new systems such as Coordinated Care Organizations and the Marketplace to streamline and deliver quality healthcare, yet with so many left behind due to exclusions and high costs, we have an opportunity to finish the job. Too many Oregonians are still left out of health reform, and we all pay the price for health disparities.

John Hopkins University and the University of Maryland have reported that direct costs in the United States related to lost productivity, lost wages, absenteeism, family leave and premature death total more than $230 billion over a four year period, and when you add the indirect cost of health inequities the tab comes to $1.24 trillion.[3] It is not only crucial as Oregon becomes more racially diverse but also in our long-term economic interest to target resources to end health disparities and improve health for all Oregonians into the 21st century.

One example of how Oregon can improve is in public health resources, particularly in rural counties of the state. Many countries lack basic infrastructure to protect and promote good health, to respond to epidemics, and to fully understand and address the root causes of health disparities in their communities. Oregon currently ranks 31 in state public health funding, 21% below the median state. Another $105 million a year is needed to fully fund a modern public health system. The lack of resources for population-level health promotion ensures that disparities will persist as many Oregonians are still uninsured or underinsured.

Mental health is another area of concern, with Oregon facing a $320 million dollar a year shortfall needed to provide essential mental health and substance abuse services to people enrolled in the Oregon Health Plan. A final area given our changing demographics is the need for significantly improved culturally and linguistically appropriate services for primary care, mental health, and dental health providers. These healthcare gaps create disparities that last across generations.

Oregon has an opportunity to turn things around. By increasing available funds to promote healthcare access and disease prevention, Oregon will be able to reduce disparities and move closer to health equity. We need to ensure equitable contributions and investments from large corporations to do this. Our communities must not continue to suffer and die due to inequitable health care coverage and access just so Oregon can have the country's lowest corporate taxes.

In addition to adequate funding, there are many reasonable and attainable policy solutions that would also improve Oregonians' health and reduce disparities. The topics in this report review health disparities in the areas of data equity, culturally and linguistically appropriate services, access to healthcare, health promotion and chronic disease prevention, and mental health services. This report identifies deep inequities in health outcomes and access to care in order to highlight important policy and funding opportunities. Together we can achieve a healthier, better Oregon and achieve 21st century health equity for everyone.

NOTES ON THE REPORT

- This report is an overview of the critical disparities facing Oregonians, and key state investments needed to improve health equity for communities of color, immigrants and refugees.
- Recommendations are based on currently available information, subject to change.
- The cost estimates accompanying each policy recommendation are projected for the 2017-2019 state biennial budget. These are general estimates and may represent only a minimum investment needed.

HEALTH INEQUITIES IN OREGON

The need to address racial and ethnic health disparities is essential to give every child and every person the opportunity to live and thrive. Given Oregon's changing demographics, this mission is even more critical. People of Color comprise more than 23.4% of the state, more than 1 in 5 Oregonians.[4] The Latino population has almost doubled from 275,000 in 2000[5] to more than 500,000 in 2015, and is now the largest ethnic population in the state. Likewise, the Asian American and Pacific Islander population in Oregon continues to grow, now numbering around 200,000.[6]

The data are clear, People of Color in Oregon are sicker and die younger than white people in Oregon. Non-white Oregonians face an increased risk for chronic disease, cancer, reduced life-expectancy, and are disproportionately susceptible to the social determinants of health that hinder the ability to seek, utilize, and sustain public and personal health services. Nearly every ethnic group, for which data exists, experiences a health disparity in one or more critical area. For instance;

- Infant mortality in Oregon is highest among American Indian/Alaska Natives (10.2 deaths per 1,000 live births) and African Americans (8.3 deaths per 1,000 live births). Rates are much lower for white (4.7/1,000), Asian/Pacific Islander (4.1/1,000), and Latino populations (4.8/1,000).[7] Infant mortality is higher for teen mothers compared to mothers between the ages of 20 and 44;[8]
- African Americans, American Indians/Native Alaskans, Pacific Islanders in Oregon are more likely to experience chronic disease and chronic disease-preconditions and die younger when compared with their white peers;[9]
- 10% of African American children are likely to be born with low-birth weights, a higher prevalence than any other race/ethnicity;[10]
- Latino, American Indians/Native Alaskans, Pacific Islanders, and African Americans, all are less likely to receive critical prenatal services versus white peers;[11]
- People of Color, immigrants and refugees are more likely to be uninsured or underinsured that can lead to untreated disease and a delay in care;[12] we see increased utilization of expensive emergency room services for many of these populations.[13]

Communities of Color are also most at risk of living in subpar housing, experience discrimination, feel unsafe in their homes and neighborhoods, experience crippling poverty, homelessness and overcrowding.[14 15] This daily risk creates toxic stress that permeates the home. Parents who experience ongoing toxic stress have a harder time shielding children from their environment. Maternal stress can put a child at physical risk; research by OHSU found the first 1,000 days of a child's life to be as much a determinate of chronic disease as genetics.[16] For new parents, toxic stress affects a child's ability to develop cognitive skills, leading to behavioral issues, and ultimately affects a child's ability to perform well in school.[17 18 19]

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The cycle of displacement, homelessness, poor physical and mental health, on the adult risks creating generations of sick children, unable to access their full potential in school and life due to conditions beyond their control. Studies show one forced in-district move can set a child's education behind as much as 3-4 months.[20] For immigrant students, English language learners and students with disability, this creates a cliff almost impossible to climb, perpetuating the cycle of poverty and ultimately increasing the risk of poor health in early adulthood.[21]

We can and must address these disparities utilizing a comprehensive approach to reduce health disparities by focusing not only on access and affordability of care, but the stability and condition, economic opportunity of the environments in which our communities live. Critical investments are needed to improve direct healthcare services and the social determinants of health.

HEALTH EQUITY INVESTMENTS FOR OREGON

DATA EQUITY

Oregon's current data collection policies are insufficient and too inconsistent to identify and support the needs of Oregon's diverse communities. Crucial information needed to address disparities and ensure efficiency and quality improvement is not currently available. The traditional metrics used to categorize people into racial or ethnic categories are based on discredited 18th century science.[22] Not only do these categories do a poor job at distinguishing different groups of people, but they perpetuate stereotypes. Consistent standards are needed to ensure Oregon's data practices allow health providers to identify costly disparities, increase effectiveness of culturally and linguistically appropriate care, and maintain compliance with evolving national standards and leverage financial incentives.

> Improving data collection and analysis now will drive cost savings in the future by identifying and supporting our health system to address disparities in a timely manner.

Current practices of simply using aggregated racial categories creates liability for the healthcare system as significant differences in populations are masked. For example, lumping Micronesians and Native Hawaiians together as Pacific Islanders or Cambodians and Chinese as Asians fails to recognize substantially different cultural contexts and needs that are necessary for quality care. HB 2134B created the strongest and most effective standards in the US in 2013.[23] A baseline

assessment done in 2014 of nearly 100 health and human service database systems covered by HB 2134B revealed over 80% failing to meet national and state standards.[24] Current practices of simply using aggregated racial categories creates liability for the healthcare system as significant differences in populations are masked.

Improving data collection and analysis now will drive cost savings in the future by identifying and supporting our health system to address disparities in a timely manner. Resources are needed to ensure local and state health and human service databases are in full compliance with HB 2134B as technology systems go through routine upgrades, data is made publicly accessible, and the data policy standards are updated periodically. Funding constraints have limited current efforts "data integration effort"[25] whereas significant systems development may be needed.

POLICY RECOMMENDATIONS

- Coordinated and comprehensive implementation of HB 2134 standards in all health and human services databases, training for frontline staff, and research and recommendations of updated standards for disability, gender and sexual orientation. Estimated cost: $2 million.
- Technical assistance to Oregon counties to implement HB 2134 standards. Estimated cost: $2 million.
- Establish updated metrics and provide technical assistance for Coordinated Care Organizations (CCOs) on delivering culturally appropriate care and assessing differences in treatment and healthcare experience based on racial identity. Estimated cost: $1 million.

CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Cultural and Linguistically Appropriate Services, also known as CLAS, is about interacting effectively with people of different backgrounds. When health professionals lack important information or understanding of the health of a patient, we all pay for it. Ineffective patient communication leads to misdiagnosis, incorrect treatment, and are a drive health inequities. According to health experts, effective health care providers need to recognize and address the unique culture, language and health literacy of diverse consumers and communities.[26]

Improvements in this area are needed to increase utilization of Communities of Color, who are more likely to delay seeking health care and end up in the emergency department.[27] This is particularly a concern for vulnerable children and families. For example, African American children are less likely than white children to have received immunizations.[28] Native American women are 30 percent more likely to have kidney/renal pelvis cancer as non-Hispanic White women.[29]

Fourteen of fifteen studies in a recent systematic review article found evidence that health care professionals are biased against People of Color.[30] Health care professionals associated African Americans with being less cooperative, less compliant, and less responsible in a medical context compared to whites. Latinos were associated with being noncompliant and having risky behavior. Some of these studies found that People of Color experienced discrimination in patient-provider interactions, treatment decisions, patient treatment adherence, and patient health outcomes. People of Color are also less likely to receive appropriate pain medications compared to white patients. The result is more disability from their original injury.[31]

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It is also important for Oregon to build a stronger pipeline for a more racially and culturally diverse health profession. Workforce development with communities experiencing health disparities is a concrete way to ensure providers bring expertise and context to the root causes of poor health and are often best positioned to create effective, affordable solutions.

Oregon's Coordinated Care Organizations (CCOs) are responsible for approximately 1 million Oregonians enrolled in the Oregon Health Plan, our state's Medicaid. Despite measurable health disparities by racial group, CCO metrics currently fail to incentivize CCOs to address those most affected despite repeated recommendations.[32] The state should take a leadership role in crafting those incentives and accountability measures.

Culturally and Linguistically Appropriate Services improves the foundation of our health care delivery system, positioning our workforce to work effectively with a diversifying and globalizing Oregon and decreases liability of health care professionals, further reducing costs. It is in Oregon's best interest to drive down these costs, and establish basic minimums for Cultural Competency training as one proven tool.

POLICY RECOMMENDATIONS

- Full implementation of HB 2611 with technical assistance provided to all licensed health professional associations. Estimated cost: $2 million.
- Development of new cultural competency training curriculum and opportunities that meet the HB 2611 standards. Estimated cost: $2 million.

ACCESS TO HEALTHCARE

Many Oregonians lack health insurance and cannot pay for unaffordable medical care.[33] These gaps disproportionately impact rural Oregonians, Communities of Color, immigrant children and adults, women, LGBTQ people, people with chronic conditions and low-wage working families.

Oregon's strength lies in our communities and the success of our children. Our state has made major advancements to ensure more Oregonians the care that they need to be productive and healthy. Over 840,000 Oregon children are eligible for health coverage and since 2009, 100,000 uninsured kids have received coverage.[34] These are all substantial gains, and yet lack of health care coverage persists for some of Oregon's children.

In Oregon 17,600 children are categorically excluded from coverage from Health Care for All Oregon Children Act.[35] Children without health insurance are less likely to see a doctor and get the care they need. Having health insurance promotes health, while preventing needless suffering, economic hardship and even death for some children. An extension of the Oregon Health Plan up to 300% FPL for the remaining children would ensure that all children have the care they need to learn in school.

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Disparities continue to persist in cash strapped households and communities that are excluded from state based coverage and options on the Oregon Exchange. A workgroup is currently exploring Basic Health Plan options to ensure everyone can be covered; investing in their recommendations will be critical to equitable access to care. A Basic Health program would offer more affordable coverage than marketplace plans to low-income Oregonians who make too much to qualify for the Oregon Health Plan. Basic Health could also fill gaps in vision and dental coverage.

Basic Health could help people get the care they need by reducing high out-of-pocket costs that deter some from seeing a doctor. By lowering or eliminating co-payments, coinsurance and deductibles, individuals needing reproductive services and chronic disease management care would be more likely to get it.

Access to reproductive health care is critical for the health and economic security of all Oregonians. Thousands of Oregonians still lack coverage for the full range of reproductive services, including postpartum care, contraception and abortion.

In Oregon, up to 48,000 women of reproductive age are categorically ineligible for plans on the exchange and the Oregon Health Plan due to their documentation status, leaving them without coverage despite income eligibility. While the Emergent Medical (CAWEM) Plus program ensures medical coverage for these women during pregnancy and delivery, their prenatal care coverage drops immediately after childbirth and does not include coverage for postpartum services. By extending the CAWEM Plus program into the postpartum period, women would be able to ensure a healthy start to motherhood for themselves and their families.

In addition, for Oregonians who have the option to purchase on the exchange there are barriers to essential family planning services. The ACA requires most insurance plans to pay for the full range of FDA-approved contraceptives at 100%. In Oregon, however, approximately 18,600 women of reproductive age receive healthcare coverage from grandfathered plans,[36] which means they are forced to pay out-of-pocket costs for preventive health services, including contraception.

Furthermore, 30,000 women of reproductive age who purchase insurance on the Exchange, as well as an unknown number of women with employer-sponsored coverage, have policies with deductibles of $2,500 or more.[37] While most plans cover abortion, the cost of the procedure must first come out of this deductible, leaving the procedure unaffordable and inaccessible for many.

Finally, transgender and gender-nonconforming Oregonians need access to services typically categorized as "women's" health care, including family planning, abortion and postpartum care. Unfortunately, when coverage is dependent on one's gender marker, procedural barriers can hinder access to this necessary and time-sensitive care.

Every county where Latino residents make up at least 20% of the population is a designated medical provider shortage area.

Access to insurance is the key in the door to get seen by a provider, yet the need in rural and urban communities goes beyond coverage. Now more than ever Oregonians need a robust medical

network to achieve timely and preventative care. There are provider shortages of primary care, dental, and mental health in nearly every county in Oregon. Every county where Latino residents make up at least 20% of the population is a designated medical provider shortage area.[38 39]

Oregon's health workforce incentive programs reduce health care provider shortages in underserved areas. Health care training for people in underserved communities is especially important, as they are more likely to remain there to work.[40] Livable wage jobs in the healthcare sector will also boost incomes in the community, improving the economy. Loan repayment is another powerful incentive to encourage providers to stay in underserved areas. Currently the state is not funding any specific loan repayment for providers who come from Communities of Color. As part of HB 3396 that passed in 2015, the OHA Health Workforce Committee is in the process of making recommendations on how to strengthen these programs.[41] Inadequate resources are a barrier to funding these programs and making healthcare more available.

POLICY RECOMMENDATIONS

- Expand state health insurance options, such as a Basic Health Plan, to cover approximately 90,000 Oregonians under 200% of the federal poverty level. This includes an estimated 10,000 Legal Permanent Residents and COFA Pacific Islanders who are excluded from federal Medicaid. Estimated cost: $26 million.
- Ensure all children in Oregon have access to the Oregon Health Plan on day one of school up to 300% FPL. Estimated cost: $55M per biennium.
- Extend income eligible adults on to a state based medical assistance program. Estimated cost: $78 million.
- Ensure that Oregonians receive the full range of preventive reproductive health services at zero out-of-pocket cost, fill gaps in reproductive health coverage for those categorically excluded from health programs due to citizenship status, and prohibit discrimination in reproductive health care. Estimated cost: Fiscal was unavailable at the time of printing.

HEALTH PROMOTION AND CHRONIC DISEASE PREVENTION

The leading causes of death in Oregon are chronic diseases like cancer, diabetes and heart disease.[42] There are deep disparities in who is most affected.13.5% of Native American and 22.5% of African American adults in Oregon have diabetes compared to 7.4% of white adults. 7.1% of white adults have heart disease while 10.0% of Native American and 11.9% of African American adults have heart disease.[43] Chronic disease risk factors tend to be more common among People of Color. In Oregon 35% of Native American adults and 33% of African American adults smoke, compared to 20% of white adults.[44]

> State funding for public health in Oregon is 21% lower than the median state. The Public Health Advisory Board identified a $105 million annual gap to deliver public health programs at a level at which they can cover all Oregonians.

These disparities require targeted interventions with public health programs that are culturally and linguistically appropriate. Public health programs that prevent tobacco use, promote healthy eating and physical activity, and create safer neighborhoods can all reduce chronic disease rates and disparities. Yet limited prevention dollars too often perpetuate disparities by failing to strategically address the needs of rural communities, LGBTQ, Communities of Color and other communities experiencing health disparities. State funding for public health in Oregon is 21% lower than the median state.[45] The Public Health Advisory Board identified a $105 million annual gap to deliver public health programs at a level at which they can cover all Oregonians.[46]

A robust public health system should benefit all Oregonians. For example, in response to tobacco companies targeting Communities of Color and in particular children, the Centers for Disease Control and Prevention recommends $39.3 million per year be spent in Oregon on tobacco prevention. Oregon only spends one-quarter of that amount, allowing disparities to persist.[47 48 49]

Environmental and school public health programs are additional areas that remain underfunded. Lead-based paint, mold, and industrial pollution threaten the health of many Oregonians. Some communities in Oregon face regular exposure to pesticides, while in others people live near factories that release toxins and heavy metals into the air. As the climate changes, toxic algae blooms, higher pollen counts, and forest fires will be more common. In Oregon schools, lead and radon are serious risks, and infrastructure for adequate physical education and cafeterias will help reduce risks of chronic disease.

POLICY RECOMMENDATIONS

- Fund the state's six Regional Health Equity Coalitions that identify community priorities for improving health outcomes that increase health equity, reduce health disparities and address the social determinants of health. Estimated cost: $2 million.
- Increase public health funding and ensure all 36 counties develop a strategy to increase public health services to uninsured Oregonians including refugee and immigrant communities. Estimated cost: $105 million.
- Increase funding for the Oregon Tobacco Prevention and Education Program which has been shown to save five dollars for every one dollar invested in the program. Estimated cost: $30 million.
- Increase funding to schools in order to create school environments that better promote physical activity, nutrition and protect children from environmental toxins. Estimated cost: $75 million.

MENTAL HEALTH

Mental health is inextricably linked to physical health. In high-income countries, men with serious mental illnesses tend to have a 20 year lower life expectancy than the rest of the male population. A difference in life expectancy of 15 years is seen in women with mental illnesses.[50] People with severe mental illness have higher rates of chronic diseases, infectious diseases, suicide and substance abuse.[51] In Oregon, African Americans and Latinos are more likely to report poor mental health status than whites.[52]

Mental and behavioral health services are underfunded and understaffed in Oregon. Among the people enrolled in the Oregon Health Plan in 2015, 160,000 weren't getting the mental health care they needed, and 87,000 weren't receiving care for their substance abuse issues. In order to meet the mental health and substance abuse needs of Medicaid patients alone, Oregon would need to spend another $316 million a year.[53]

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These investments would avert other costs. For example, out of the 14,721 people incarcerated in Oregon jails in 2016, 71% have a substance abuse or addiction problem and 23% have severe mental health problems in need of treatment.[54] Oregon needs to invest in community mental health systems to assist people with mental health and substance abuse disorders before they are incarcerated or hospitalized. Other states that have invested in addictions treatment and jail diversion programs have seen a $2.05 return for each dollar invested.[55]

People of Color are underserved by the mental health system.[56] Whites are 50 – 70% more likely than African Americans and Latinos to access mental health services. People of Color often go undiagnosed or untreated. Among the people that do receive mental health care, whites are more likely to receive adequate care while African Americans and Latinos are more likely to have a shorter duration of care.[57]

POLICY RECOMMENDATIONS

- Mental and behavioral health services are underfunded and understaffed in Oregon. Everyone enrolled in the Oregon Health Plan who needs help with mental health or substance abuse issues should be able to receive care. Estimated cost: $316 million.
- Invest in mental health providers within School-Based Centers: Approximately one out of five adolescents has a diagnosable mental health disorder, and nearly one third shows symptoms of depression. Effective treatments for mental health disorders, especially if they begin soon after symptoms appear, can help reduce its impact on an adolescent's life. Estimated cost: $6 million.
- School counselors and social workers intervene on behalf of kids whose health and ability to learn have been impacted by trauma. Every school in Oregon should have at least one counselor looking after the welfare of students. Estimated cost: $66 million.

SOCIAL DETERMINANTS OF HEALTH

> The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries.
> *-World Health Organization*

Human health status is typically thought to be the result of interactions between an individual's physiology, the person's health-related choices and quality of healthcare. New evidence has clearly linked health to a range of factors that impact a person's health as critically as behaviors, physiological or quality healthcare. Social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Social and economic conditions have significant influence on population health outcomes.

Living wages, safe and affordable housing, quality education, public safety, environments free of life-threatening toxins and accessible food and health services are common examples of the social determinants of health that explain in part why some Oregonians are healthier than others.

Poverty and poor health go hand in hand.[58] In Oregon and across the nation, People of Color are more likely to have incomes below the poverty level. A survey from 2010 to 2014 showed 36% of Blacks, 29% of AI/AN, 16% of Asians, and 28% of Latinos had incomes below the poverty level. 15% of Whites had an income below the poverty level in this survey.[59] From 2011-2012, 92% of Non-Hispanic white children reported their health was excellent or very good, compared to only 62% of Hispanic/Latino children.[60] The Supplemental Nutrition Assistance Program (SNAP) served over 1 million Oregonians in 2015 and over 1.3 million were enrolled in the state Medicaid and Medicare programs.[61] Living wage jobs and stable anti-poverty programs ensure people meet their basic needs.

Education is a pathway out of poverty, but Oregon's underfunded schools are leaving poor kids and People of Color behind. People with more education tend to make more money and be in better health.[62] People who have not completed high school are more likely to have chronic health conditions such as diabetes, cancer, asthma, and high blood pressure compared to people that have a high school education or higher.[63]

In 2007, African American (20.9%) and Latino (11.8%) public school students in kindergarten through high school were more likely than white (8.7%) students to repeat a grade. Latino students are also more likely to experience homelessness as they make up 22.0% of the population and are 27.6% of the student homeless population. Native American students are the most likely to miss school and have the highest dropout rates[64] African Americans represent 2.4% of Oregon students but 5.3% of the homeless student population.[65] Oregon's underfunded schools, including a backlog of $7 billion dollars of deferred maintenance,[66] disproportionately affect Communities of Color, their educational outcomes and worsen health disparities.

CONCLUSION

Oregon can and must do better to achieve health equity. Sustainable and adequate funding is needed to address persistent disparities, and improve our institutions to serve all Oregonians. While Oregon has made great strides in policies to reduce disparities and improve health equity, advocates and healthcare providers alike agree this work has a long way to go. Implementing a core set of the recommendations outlined in this report will have a measurable benefit to communities experiencing health disparities, and will make our state healthier.

The greatest barrier in Oregon to eliminating health disparities is inadequate funding. With greater investments, more Oregonians will have the opportunity to contribute, to have a good education, work a living wage job, and have access to quality public services. Targeted resources are needed to address historic disinvestment, as well as address persistent disparities. New leadership is needed to secure a better, stronger future for all Oregonians.

ENDNOTES

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> "Family and environmental stressors common to many children in poverty, rather than just homeless and doubled-up episodes, were associated with young children's poor health and cognitive development and high health care use. Practitioners need to identify and respond to parental and family needs for support services in addition to housing assistance to

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