2021

HEALTH VALUE DASHBOARD

Executive summary

47 Ohio ranks 47 on **health value** out of 50 states and D.C.

BOTTOM LINE ▶ **Ohioans are living less healthy lives and spending more on health care than people in most other states**

Why does Ohio rank poorly?

Ohio's healthcare spending is mostly on costly downstream care to treat health problems. This is largely because of a lack of attention and effective action in the following areas:

1 CHILDREN

Childhood adversity and trauma have long-term consequences

More than four in 10 Ohio children (42%) have **experienced trauma and adversity**.

2 EQUITY

Ohioans with the worst outcomes face systemic disadvantages

Many Ohioans experience **poorer outcomes** and live **shorter lives** because of policies, systems and beliefs that discriminate against and unfairly limit access to resources.

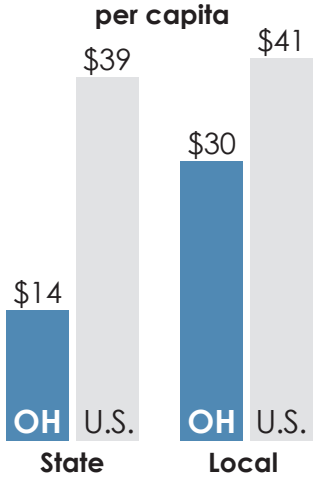
There is a 29-year gap in life expectancy within Ohio

3 PREVENTION

Sparse public health workforce leads to missed opportunities for prevention

Ohioans spend a lot on downstream medical care, but **investment in public health infrastructure is limited** and prevention policies could be stronger.

Public health spending, per capita



Health value is calculated by equally weighting population health and healthcare spending metrics. For more information, see **methodology**.

Data sources are available in data appendices posted on the **HPIO *Health Value Dashboard* web page**

Nine policies that work
to improve health value

By adopting evidence-informed policies and working with private-sector partners, policymakers can make Ohio a leader in health value. Below are examples of policy opportunities for the state.

1 CHILDREN

- **Close widening academic gaps** by prioritizing federal COVID-19 relief funds for high-intensity tutoring, chronic absenteeism interventions and school-based trauma counseling for children who have experienced adversity, disruption and learning loss
- **Strengthen K-12 student wellness** by allocating funds to evidence-based drug prevention, social-emotional learning and school-based mental health
- **Expand access to quality early childhood care and education** by increasing eligibility for Ohio's child care subsidy to at least 200% of the federal poverty level, paying childcare workers more, and streamlining rapid access to child care

2 EQUITY

- **Advance anti-racist and anti-discriminatory policies** by promoting diversity, equity and inclusion in leadership; engaging in training on racism, discrimination and its impacts; and improving access to culturally and linguistically competent information and services
- **Level the playing field,** starting with increasing funding and/or allocating one-time federal COVID-19 relief funding to lead hazard mitigation; construction of accessible, affordable, quality housing for people with very low incomes; rental assistance initiatives and eviction prevention
- **Identify gaps in outcomes and evaluate policy impacts** by building systems and capacity across the public and private sectors to collect and break out data on systematically disadvantaged Ohioans (e.g., race and ethnicity, disability status, education and income)

3 PREVENTION

- **Strengthen the public health workforce and data systems** by ensuring that the state and local health departments have diverse and adequate staffing for epidemiology, communicable disease control and communications, and by fully implementing the recommendations of the March 2021 **Ohio Auditor of State Performance Audit**
- **Prevent addiction and overdose deaths** by dedicating a portion of future revenue from tobacco and alcohol taxes, opioid settlements and pandemic relief toward smoking prevention, addiction treatment, recovery supports, harm reduction and overdose reversal
- **Prevent chronic disease through improved access to healthy food** by streamlining access to SNAP and WIC for eligible Ohioans and expanding Produce Perks and Produce Prescriptions

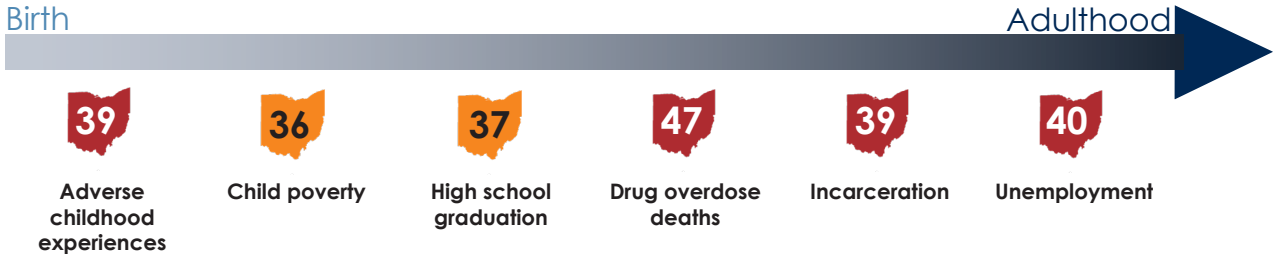
Why does Ohio rank poorly?

1 Childhood adversity and trauma have long-term consequences

- **Many of Ohio's children experience early adversity and trauma**, including exposure to Adverse Childhood Experiences (ACEs) such as child abuse and neglect, living in poverty and experiencing racism.
- **Ohio ranks in the bottom half of states on measures that put children at increased risk of exposure to adversity and trauma**, including adult depression, drug overdose deaths, excessive drinking and incarceration.

Burdens from childhood adversity and trauma carry forward across generations

Childhood adversity and trauma influence health and well-being at all stages of life



If adverse childhood experiences were eliminated...

- **More than $10 billion a year** in healthcare spending could be **saved** in Ohio
- **$319 million in lost wages** could be **eliminated** each year in Ohio

How can we improve through state policy?

- **Close widening academic gaps** by prioritizing federal COVID-19 relief funds for high-intensity tutoring, chronic absenteeism interventions and school-based trauma counseling for children who have experienced adversity, disruption and learning loss
- **Strengthen K-12 student wellness** by allocating funds to evidence-based drug prevention, social-emotional learning and school-based mental health
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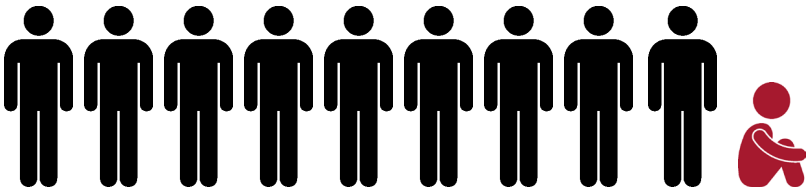
Why does Ohio rank poorly?

2 Ohioans with the worst outcomes face systemic disadvantages

- **Racism and other forms of discrimination drive troubling differences in outcomes across Ohio**. This includes racist and discriminatory beliefs and interactions among Ohioans and structural racism and discrimination embedded within systems and across sectors, rooted in ageism, ableism, xenophobia, homophobia and other "isms" or "phobias."
- **Ohioans experiencing the worst health outcomes are also more likely to be exposed to risk factors for poor health**. These include trauma and adversity, toxic stress, violence and stigma, and inequitable access to resources.

Our systems, policies and beliefs unfairly favor some Ohioans over others

One in 10 Black children in Ohio is treated unfairly due to their race, 17 times higher than the rate for white children



Inequitable distribution of infrastructure, power, resources and dollars result in **obstacles to accessing education, food, transportation, housing, health care and other resources** for Ohio's most at-risk groups.

If these inequities were eliminated:

58,507 fewer Black children and 13,373 fewer Hispanic children would experience food insecurity	**362,917** fewer low-income households would be severely cost burdened for housing	**238,174** more Ohioans with less than a high school diploma would have broadband internet access	**181,488** Ohioans with disabilities would not have to delay health care due to cost

How can we improve through state policy?

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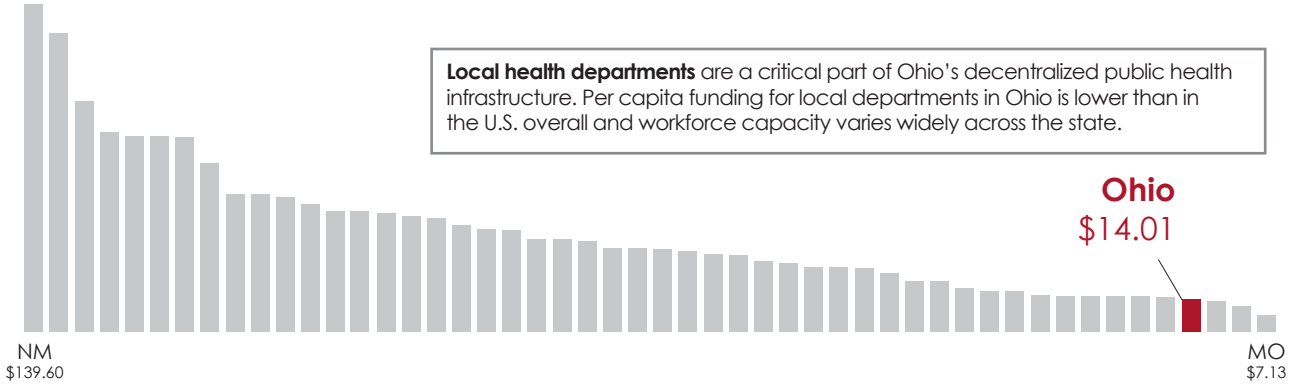
Why does Ohio rank poorly?

3 Sparse public health workforce leads to missed opportunities for prevention

- **Limited investment in public health.** Only three other states spend less on public health than Ohio, limiting public health workforce and ability to proactively implement comprehensive approaches to our state's greatest health challenges.
- **Patchwork approach to community-based prevention.** Ohio struggles on several outcomes that could be prevented, such as addiction and chronic disease. Stretched thin by the many demands of the COVID-19 pandemic, public health departments now have even fewer resources to devote to these issues.

Going upstream to prevent health problems reduces costly sick care later

State public health funding per capita, 2019



Greatest challenges Ohio in the bottom quartile	Missed opportunities for prevention policy Examples
Adult smoking and youth all-tobacco use	Ohio invests 10.6% of what the CDC recommends for state tobacco prevention and control
Drug overdose deaths	Administrative barriers to naloxone distribution and an overly complex Good Samaritan policy
Excessive drinking	Lack of a sustained, long-term approach to school-based alcohol and drug prevention
Heart disease mortality and food insecurity	Limited reach of programs to increase access to healthy food, such as fruit and vegetable incentives and school breakfast

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Acknowledgments

Authors
Reem Aly, JD, MHA (raly@healthpolicyohio.org)
Amy Bush Stevens, MSW, MPH (astevens@healthpolicyohio.org)
Zach Reat, MPA (zreat@healthpolicyohio.org)

Graphic design and layout
Nick Wiselogel, MA

Contributors
Amy Rohling McGee, MSW
Hailey Akah, JD, MA
Carrie Almasi, MPA
Rebecca Sustersic Carroll, MPA
Alana Clark-Kirk, BA
Stephen Listisen, MPA candidate
Jacob Santiago, MSW

Jeffrey Cheng, HPIO intern
Meggie Garry, HPIO intern
Farhiya Hirsi, HPIO intern
Ananya Kalahasti, HPIO intern
Tiana Stussie, HPIO intern

Voinovich School of Leadership and Public Affairs, Ohio University
Data analysis
Anirudh Ruhil, PhD
Zarek Bell, MPA

HPIO Dashboard advisory groups
Health Measurement Advisory Group (HMAG) members contributed expertise on development of the conceptual framework, selection of metrics, and layout and design of the *Dashboard*. A complete list of HMAG members is posted on the **HMAG web page**.

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