

INCOME SECURITY

Income creates access to resources that promote better health, including access to health care, nutritious food, recreation, and safe housing.¹ It is well-documented that income poverty is a risk factor for premature mortality and increased morbidity¹⁶. In the United States, the richest 1 percent of households owns 37 percent of all wealth, and most strikingly is the enormous wealth gap between white households and households of color.¹⁵ The large inequalities in income between the rich and the poor are correlated with lower overall life expectancy and higher risk of social isolation, stress, and poor health outcomes.⁹ Evidence has shown a strong correlation between low-income and cardiovascular disease, low birth weight, hypertension, arthritis, and diabetes.^{1,4,5,6,12,14} One-third of United States deaths can be linked to income inequality, and it is estimated that 883,914 deaths would have been prevented each year if the level of inequality was lowered.^{8,10}

During a period of economic downturn, between 2009 and 2010, rates of poverty and low-income status increased across a wide spectrum of families in the United States, particularly among those headed by women.¹³ Although the gender wage gap has narrowed since the Equal Pay Act became law 50 years ago, it has not disappeared and has been persistent over the past decade. Equal pay is not simply a women's issue, it is a family issue.¹⁷ For working mothers who are their families' sole breadwinner, the gender pay gap can contribute greatly to poor living condition, poor nutrition, and fewer opportunities for their children.² Two fifths of single mother families are poor, triple the poverty rate for the general population, and a majority of poor children live in a female-headed household.¹¹ Low family income can impede children's cognitive development and ability to learn. It can also contribute to behavioral, social, emotional problems, and poor health.^{3,7} Economists estimate that child poverty costs the U.S. about \$500 billion a year.³

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Uneven Distribution Of Household Wealth Across Race/Ethnic Groups In California.

Figure 1a. Households in California by Race/Ethnicity, 2010

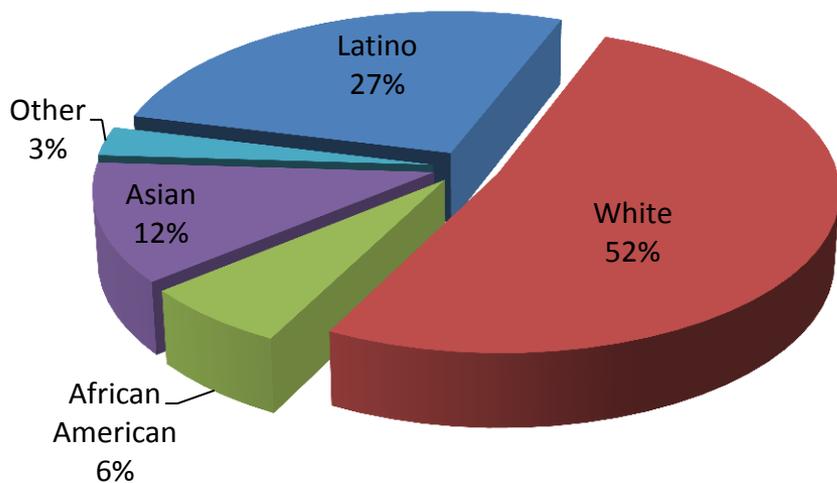
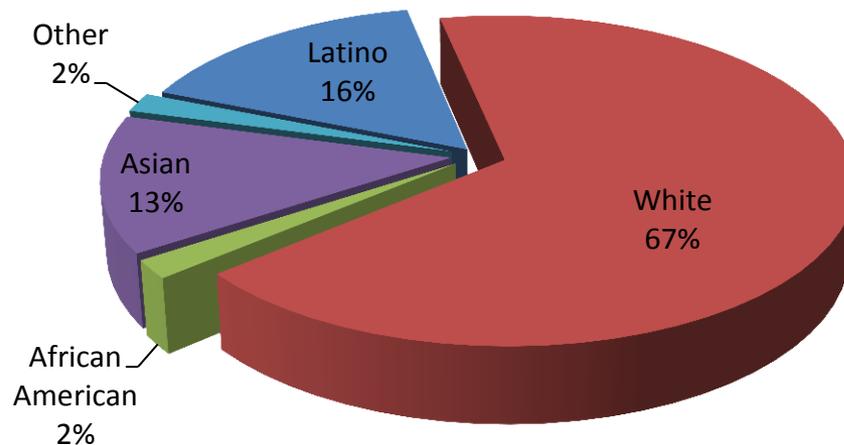


Figure 1b. Household Wealth in California by Race/Ethnicity, 2010



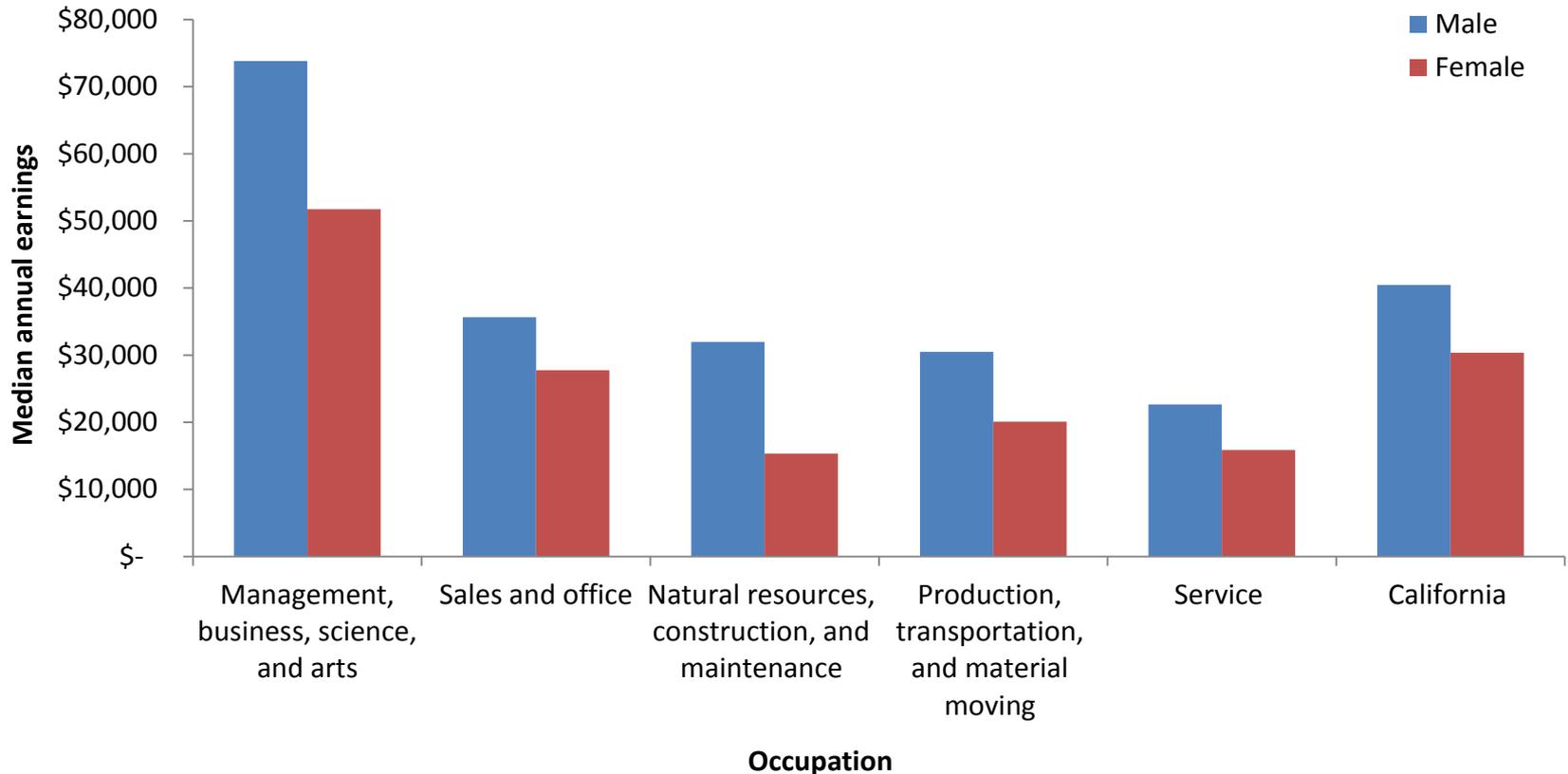
Sources: Survey of Income and Program Participation (Panel 2008, Wave 7), American Community Survey, 2010 Census.

Definition: Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owed by household members. A household consists of all the people who occupy a housing unit.

Data methodology and limitation are available at: <https://www.census.gov/programs-surveys/sipp.html>, https://www.census.gov/acs/www/methodology/methodology_main/

Women Earned 75 Cents On Every Dollar Paid To Men.

Figure 2. Occupation by Sex and Median Annual Earnings† Among Civilian Employed Population 16 Years and Over, California, 2007-2011



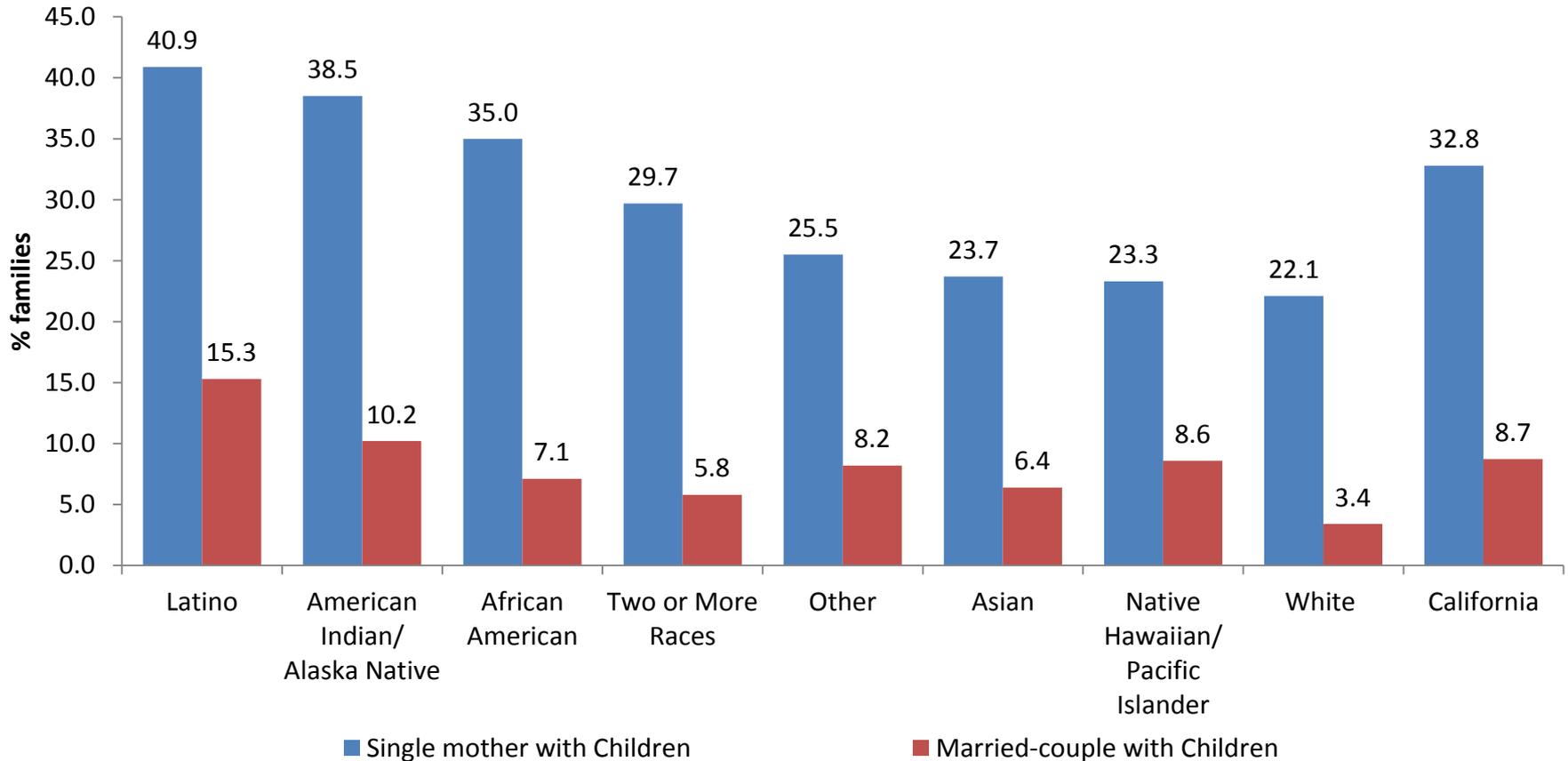
Source: American Community Survey, 5-year estimate.

† Individual earnings

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/

About 33% Of Female-headed Households And 9% Of Married-couple Households Live Below Poverty Level.

Figure 3. Percentage of Families With Annual Income Below Poverty Level by Race/Ethnicity, California, 2006-2010.



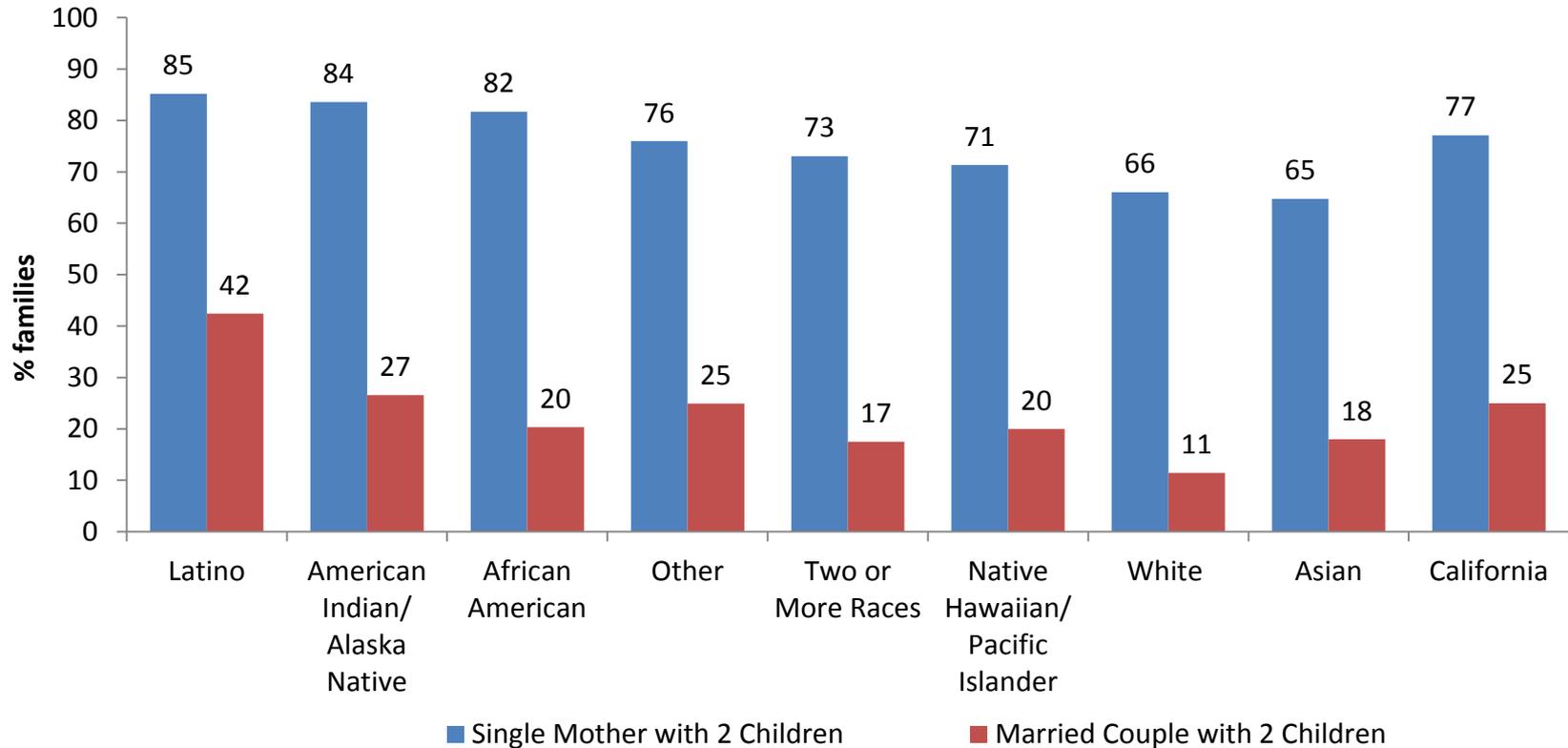
Source: American Community Survey, 5-year estimate

The U.S. Census Bureau determines poverty status by comparing pre-tax cash income against a threshold that is set at three times the cost of a minimum food diet in 1963, updated annually for inflation using the Consumer Price Index, and adjusted for family size, composition, and age of householder. For more information, please visit: <http://www.irp.wisc.edu/faqs/faq2.htm>

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/

About 77% Of Female-headed Households And 25% Of Married-couple Households Don't Earn Enough Income To Meet Basic Needs.

Figure 4. Percentage of Families Who Do Not Earn the Minimum Income Necessary to Meet Their Basic Needs (Living Wage), by Race/Ethnicity, 2006-2010



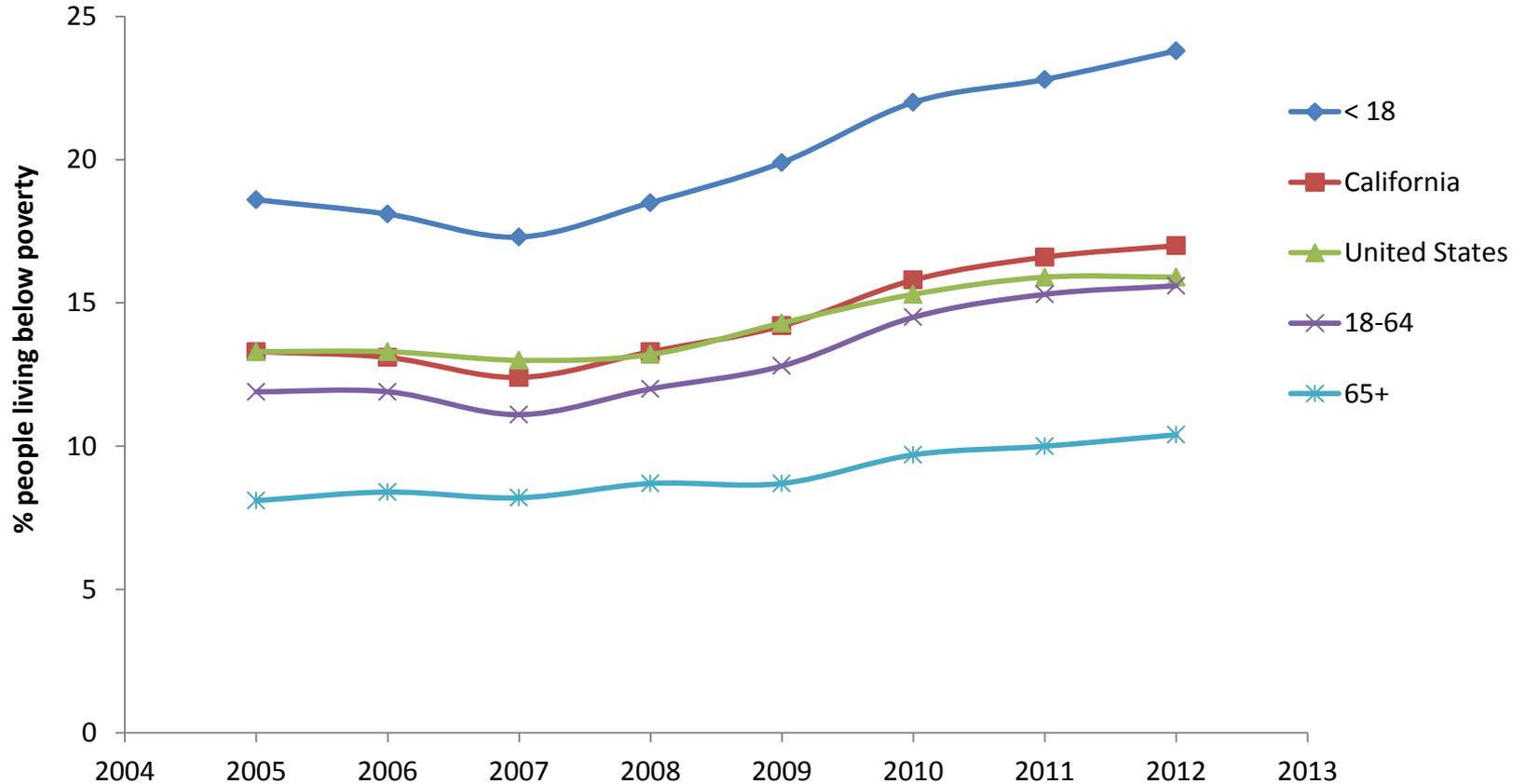
Source: Living Wage Calculator (www.livingwage.mit.edu) and American Community Survey, 2006-2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

Definition: Living wage is hourly rate or annual income that a sole provider working full-time (2080 hrs/year) must earn to provide his/her family a minimum standard of living, covering costs of food, child care, housing, and other necessities. Minimum wage is the lowest hourly wage an employer is required to pay an employee (CA current minimum wage is \$9.00, federal is \$7.25).

Data methodology and limitation are available at: http://www.cdph.ca.gov/programs/Documents/HCI_Living_Wage_770_Narrative_and_examples_9-30-13.pdf

1 In 4 California Children Living In Poverty In 2012.

Figure 5. Percentage of People Living Below Poverty Level by Age, California, United States, 2005-2012.



Source: American Community Survey, 1-year estimate

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/

FOOD SECURITY AND NUTRITION

Food insecurity has been defined as the inability to afford enough food for an active, healthy life in socially acceptable ways.⁶ While stable access to enough food is a basic human need, nearly 50 million Americans (about 16% of the U.S. population) lived in food insecure households in 2010, and that's 12 million more people than those who faced hunger before the recession in 2007.⁹ Most adults living in food-insecure households report being unable to afford balanced meals, worrying about the adequacy of their food supply, running out of food, cutting the size of meals or skipping meals, and being hungry because there was not enough money for food.⁸ There is clear evidence suggesting that food insecurity contributes to a wide range of detrimental effects on the physical and mental health of adults and children.⁴

Numerous studies have found that adults who are food insecure have poorer health and are at risk of major depression as well as chronic diseases such as heart disease, diabetes, and hypertension.⁵ Women living in food insecure households are more likely to be overweight or obese. They tend to overcompensate for periods when food is scarce by overeating when food is available.² Food insecurity may also be detrimental to the health of expectant mothers. Food insecure mothers may receive fewer nutrients and experience long term physical health problems, experience birth complications, and are at greater risk of depression and other mental health problems.⁴

Good nutrition is important in establishing a foundation for a child's future physical and mental health, academic achievement, and economic productivity. Food insecurity, unfortunately, is an obstacle that threatens such a foundation.⁴ Food insecurity among children has been linked to adverse health effects, including increased rates of iron-deficiency anemia, acute infection, chronic illness and developmental and mental health problems⁸. Children in food-insecure households tend to have poorer cognitive development and stunted growth, and can affect children's behavioral, social, and educational development.³

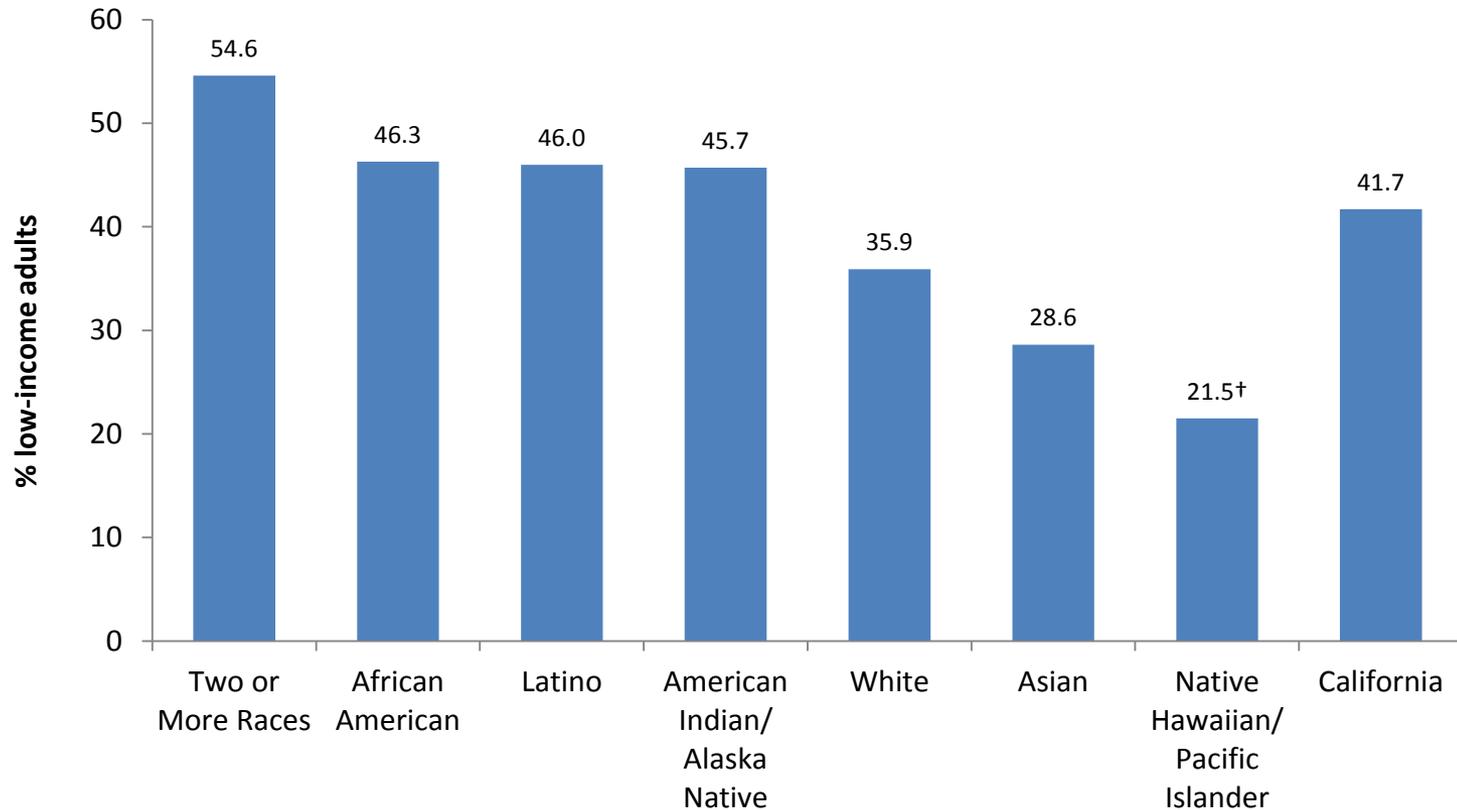
When food access becomes severely limited, adults and children in food-insecure households may experience hunger,⁸ and hunger has a disproportionate impact on particular communities.⁷ Hispanic and Black households, for instance, are especially hit hard by hunger and poverty.⁷ The limited healthy food available within low-income communities, an abundance of fast-food restaurants and convenience stores, higher cost of fresh and healthy foods, and the costly or unavailable transportation to supermarkets or grocery stores can keep people in underserved communities from purchasing healthy food necessary for good health.^{1,10} Hunger costs the United States about \$168 billion due to the combination of lost economic productivity per year, rising costs of poor education outcomes, avoidable health care costs, and the cost of charity to keep families fed. This \$168 billion does not include the cost of the Supplemental Nutrition Assistance Program and other federal nutrition programs, which runs at about \$94 billion per year.⁹ These nutrition programs are essential in reducing food insecurity and hunger for millions of low-income people in the nation.

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More Than 40% Of Low-income Adults (<200% FPL) Are Unable To Afford Enough Food.

Figure 6. Percentage of Adults Whose Income is Less Than 200% of the Federal Poverty Level That Reported Having Food Insecurity by Race/Ethnicity, California, 2011-2012



Source: UCLA, California Health Interview Survey, 2011-2012

† Statistically unstable

Definition: Food insecurity refers to USDA's measure of lack of access, at times, to enough food for an active, healthy life for all household members and limited or uncertain availability of nutritionally adequate foods.

Low-income, according to UCLA Health Policy Brief, is defined as income less than 200% of the federal poverty level (FPL)

Data methodology and limitation area available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

One Third Of California Children Are Food Insecure.

Figure 7. Child Food Insecurity Rate, California, 2011.

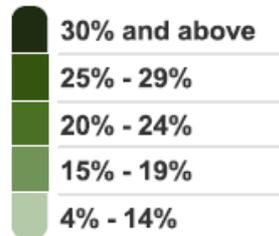
San Mateo County

\$111,250 Median family income†
17.1% Child food insecurity rate
8.8% Children living in poverty
65.5% Non-white children
60.1% Children age 3-4 enrolled in school
84.2% Graduation rate

Fresno County

\$42,278 Median family income†
33.7% Child food insecurity rate
33.3% Children living in poverty
79.3% Non-white children
41.7% Children age 3-4 enrolled in school
76.0% Graduation rate

Child Food Insecurity Rates



Child Food Insecurity Rate
California: 27.3%
United States: 22.4%

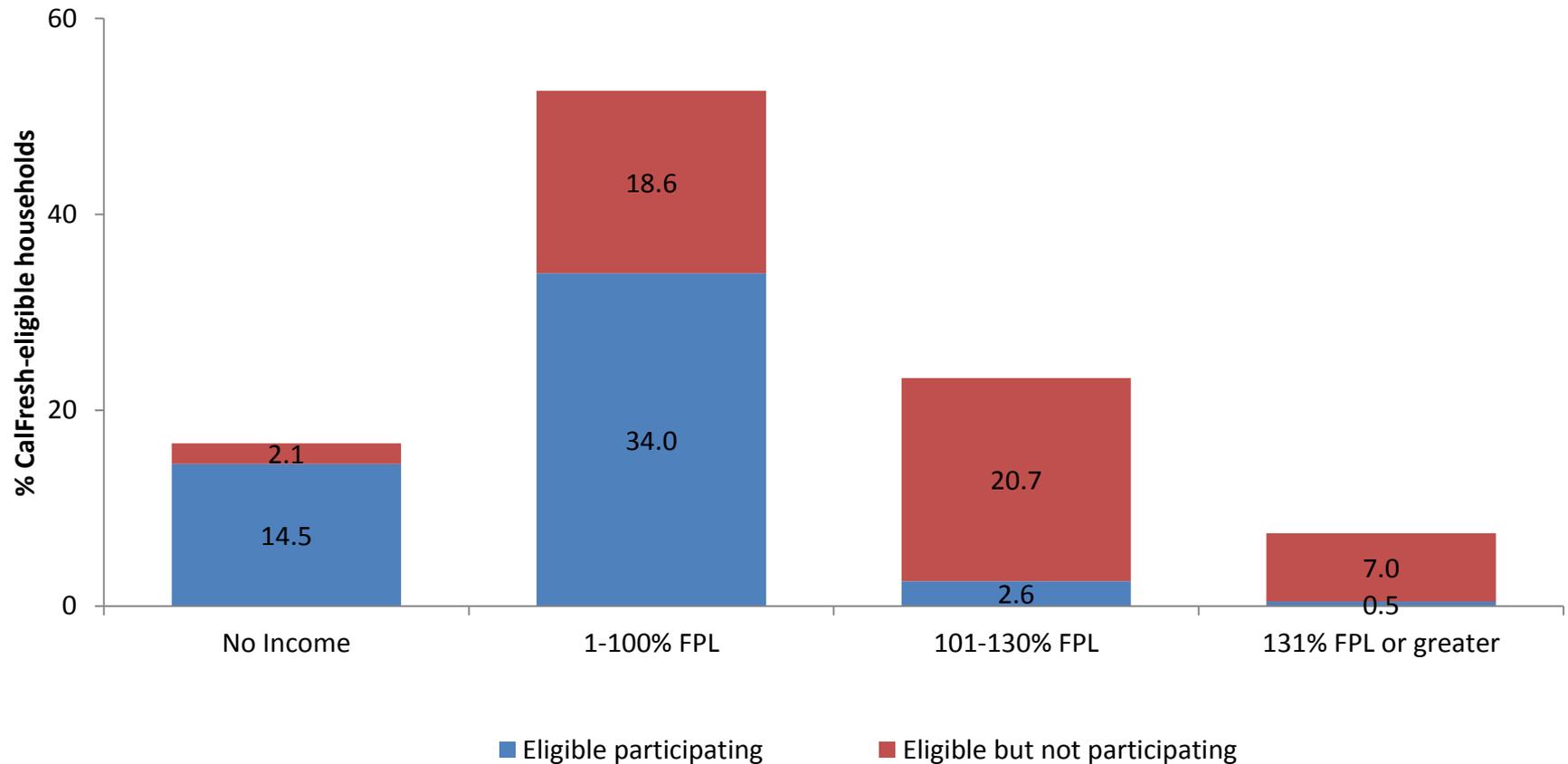
Sources: Map the Meal Gap, Feeding America 2011. American Community Survey, 3-year estimate (2009-2011) and 5-year estimate (2008-2012). California Department of Education, 2011-2012.

†Median family income with own children under 18 years.

Data methodology and limitation are available at: <http://feedingamerica.org/hunger-in-america/hunger-studies/map-the-meal-gap.aspx>, https://www.census.gov/acs/www/methodology/methodology_main/, <http://www.cde.ca.gov/ds/>

Majority Of CalFresh-Eligible Households With An Income >100% FPL Do Not Participate In CalFresh.

Figure 8. Percentage of CalFresh-Eligible Households and their Levels of Participation by Gross Income as a Percentage of Federal Poverty Level (FPL), California, 2012.

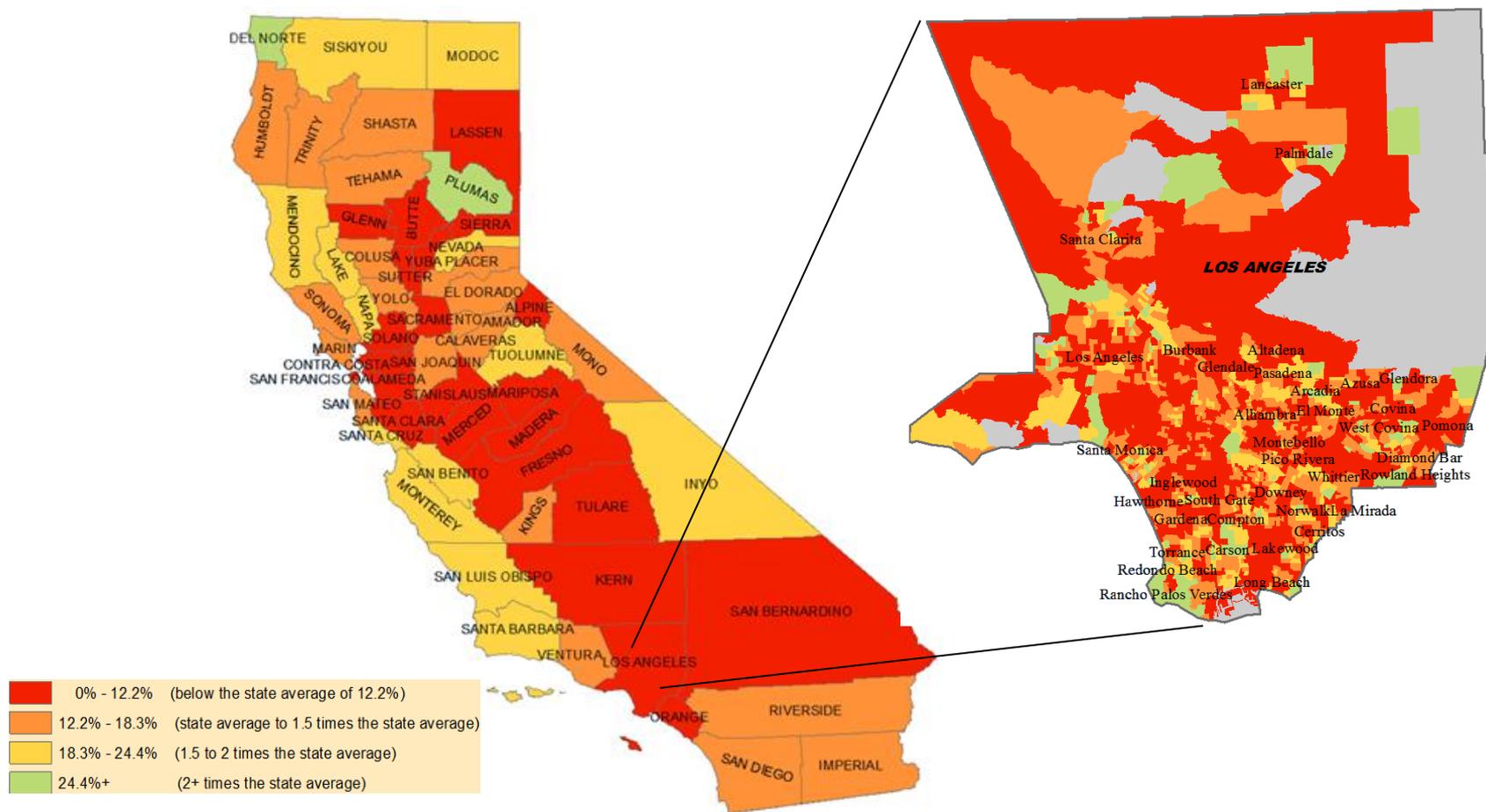


Source: California Food Policy Advocates, CalFresh Characteristics Report 2013.

Data methodology and limitation are available at: <http://cfpa.net/CalFresh/CFPAPublications/CalFresh-Characteristics-FullReport-2012.pdf>

For Most Of California Only 1.2 Out Of Every 10 Food Retailers Have Healthier Food Options Available.

Figure 9. Percentage of Healthy Food Retailers (Modified Retail Food Environment Index), California, 2009.



Sources: Centers for Disease Control and Prevention; Division of Nutrition, Physical Activity, and Obesity. U.S. Census Bureau, Decennial Census 2000. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicator Projects.

Data methodology and limitation are available at: http://www.cdph.ca.gov/programs/Documents/HCI_RetailFoodEnvironment_75_Narrative_and_examples_11-8-13.pdf

CHILD DEVELOPMENT

Policy, research, and clinical practice communities recognize that early childhood provides the physical, cognitive, and social-emotional foundation for lifelong health, learning, and well-being.¹ A number of adult health and medical conditions have their origins in early childhood. How a child develops during the first years of life affects future cognitive, social, emotional, and physical development, which influences school readiness and later success in life.² More than any other developmental period, early childhood sets the stage for health literacy, self-discipline, the ability to make good decisions about risky situations, eating habits, conflict negotiation.¹ Although adolescence are generally healthy times of life, several important public health and social problems either peak or start during these years.¹ The leading causes of illness and death among adolescents are largely preventable and the financial burdens of preventable health problems in adolescence are large.³ Health outcomes for adolescents are grounded in their social environments and are frequently mediated by their behaviors influenced at the individual, peer, family, school, community, and societal levels.⁴

Much of the current research on disparities among children has focused on the preschool years leading into the transition to kindergarten.⁵ As mothers with young children have entered the labor force, families have shifted a greater portion of early child care from parents to non-parental babysitters, family day care providers, and early education centers such as preschools. These care arrangements differ by income, race/ethnicity and other socio-economic characteristics in the type and quality of care children receive. Children in less advantaged families have a lower rate of attending preschools and they receive less formal or lower quality care. The quality of these arrangements influences child development and health, as well as inequalities in children's early care.⁶

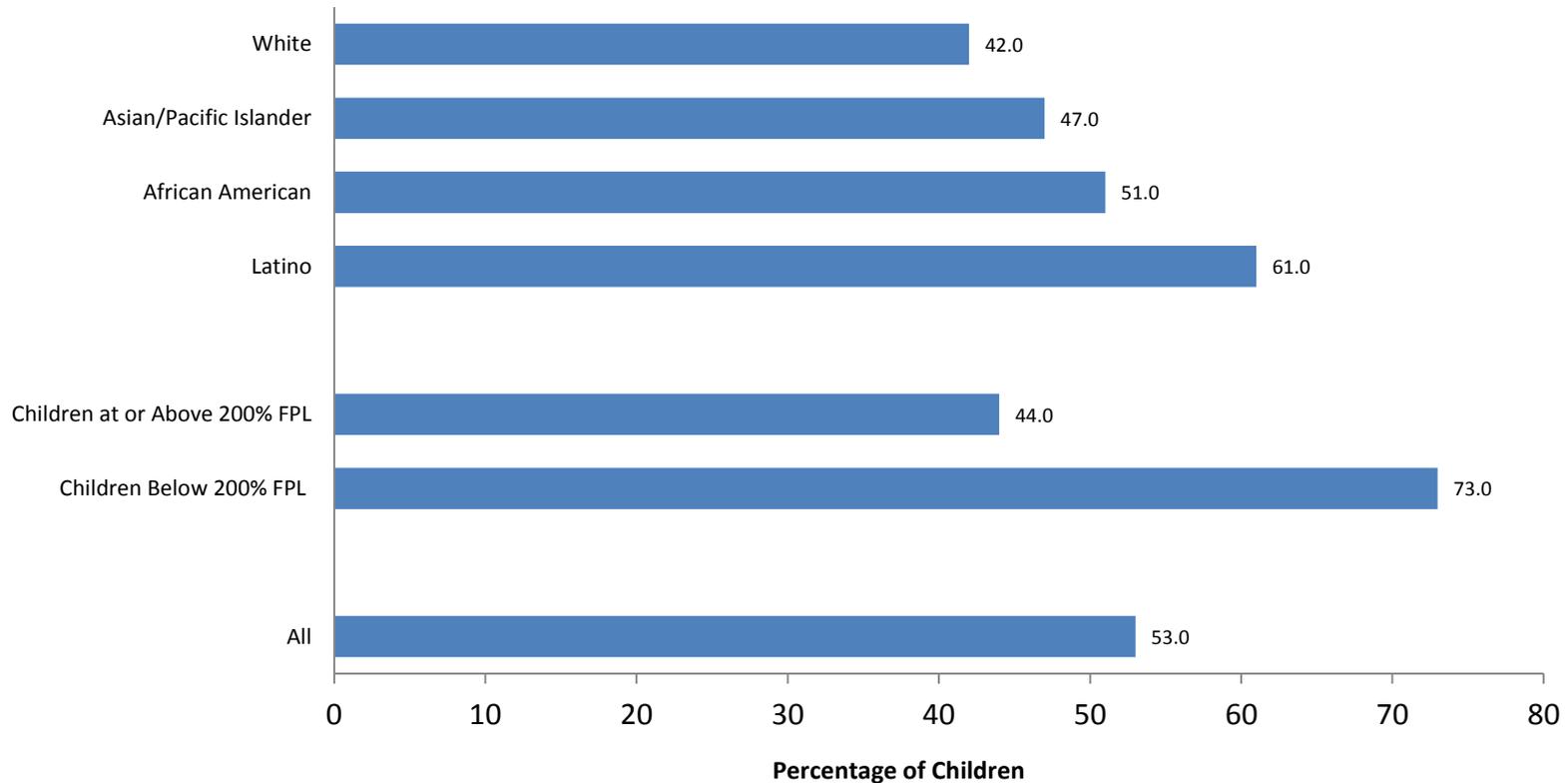
Third grade reading levels are a strong predictor of future academic success, individual earning potential, global competitiveness, and general productivity of a child.⁷ In California, only 31-34 percent of American Indian/Alaska Natives, Hispanic, and African American 3rd graders read at or above the proficiency level, while 71 percent of Asian American children do. In addition, these three racial ethnic groups have a much higher graduate dropout rates and less rates of completing courses required for higher education compared with Asian American students. Also a study showed that socioeconomic factors were related indirectly to children's academic achievement through parents' beliefs and behaviors but that the process of these relations was different by racial group. Parents' years of schooling were found to be an important socioeconomic factor on child's education achievement.⁸

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More Than Half Of African American And Hispanic Children Are Not Attending Preschool. 73% Are In Below 200% Poverty Level.

Figure 10. Percentage of California Children Ages 3 to 4 Who Are Not Attending Preschool by Race/Ethnicity and Federal Poverty Level (FPL), 2008-2011



Source: KIDS COUNT Data Center, Annie E. Casey Foundation, 2011.

Data methodology and limitations are available at: <http://datacenter.kidscount.org/data#CA/2/0>

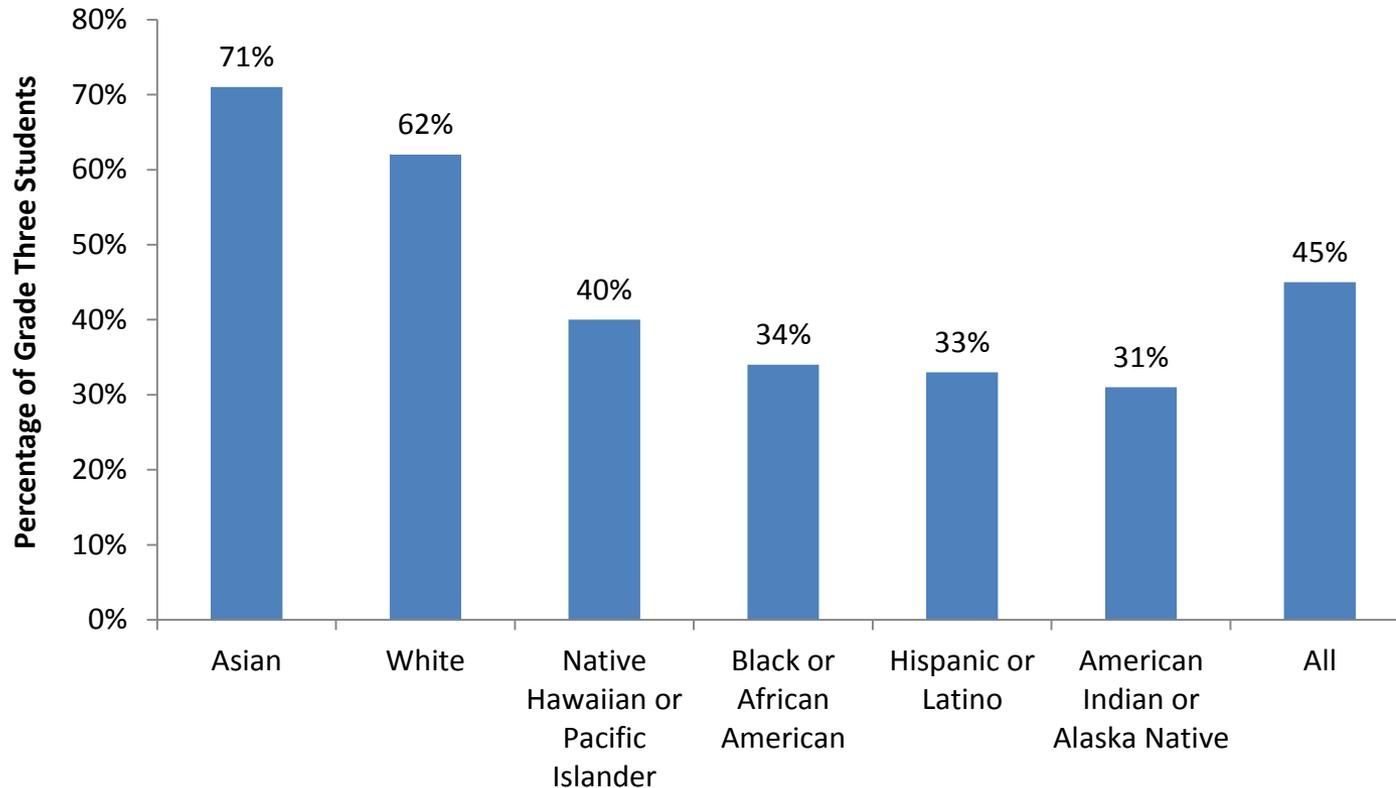
Data Source: Population Reference Bureau, analysis of data from the U.S. Census Bureau, Three-year American Community Survey, 2009-2011.

Preschool includes any group or class of institution providing educational experiences for children during the years preceding kindergarten.

Note: The share of children ages 3 to 4 not enrolled in nursery school or preschool school during the previous two months by their poverty status.

Among Third Graders, Only Asians And Whites Read At Or Above The State Average Proficient Level.

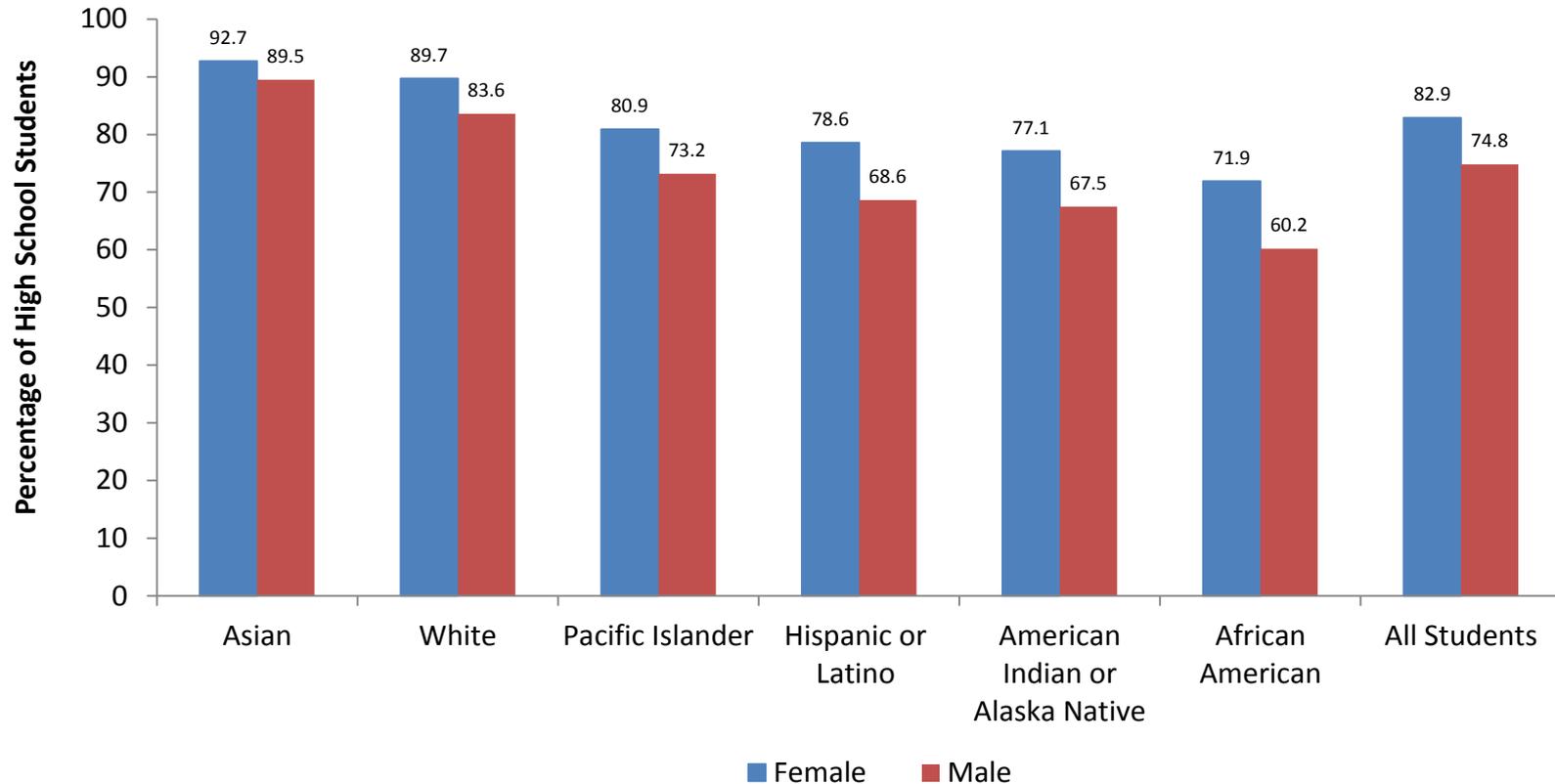
Figure 11. Percentage of Grade 3 Students Whose Reading Skills are at or Above the Proficient Level by Race/Ethnicity - 2013



Source: California Department of Education, English-Language Arts Standardized Testing and Reporting (STAR) Results, 2013. Data methodology and limitations are available at: <http://dq.cde.ca.gov/dataquest/>

Only Asians And Whites Graduation Rates Are Above The State Average. Female Students Have Higher Graduation Rates Than Male Students.

Figure 12. Graduation Rates for California High School Students by Race/Ethnicity and Gender, Class of 2011-2012.



Source: California Department of Education, Data Reporting Office.

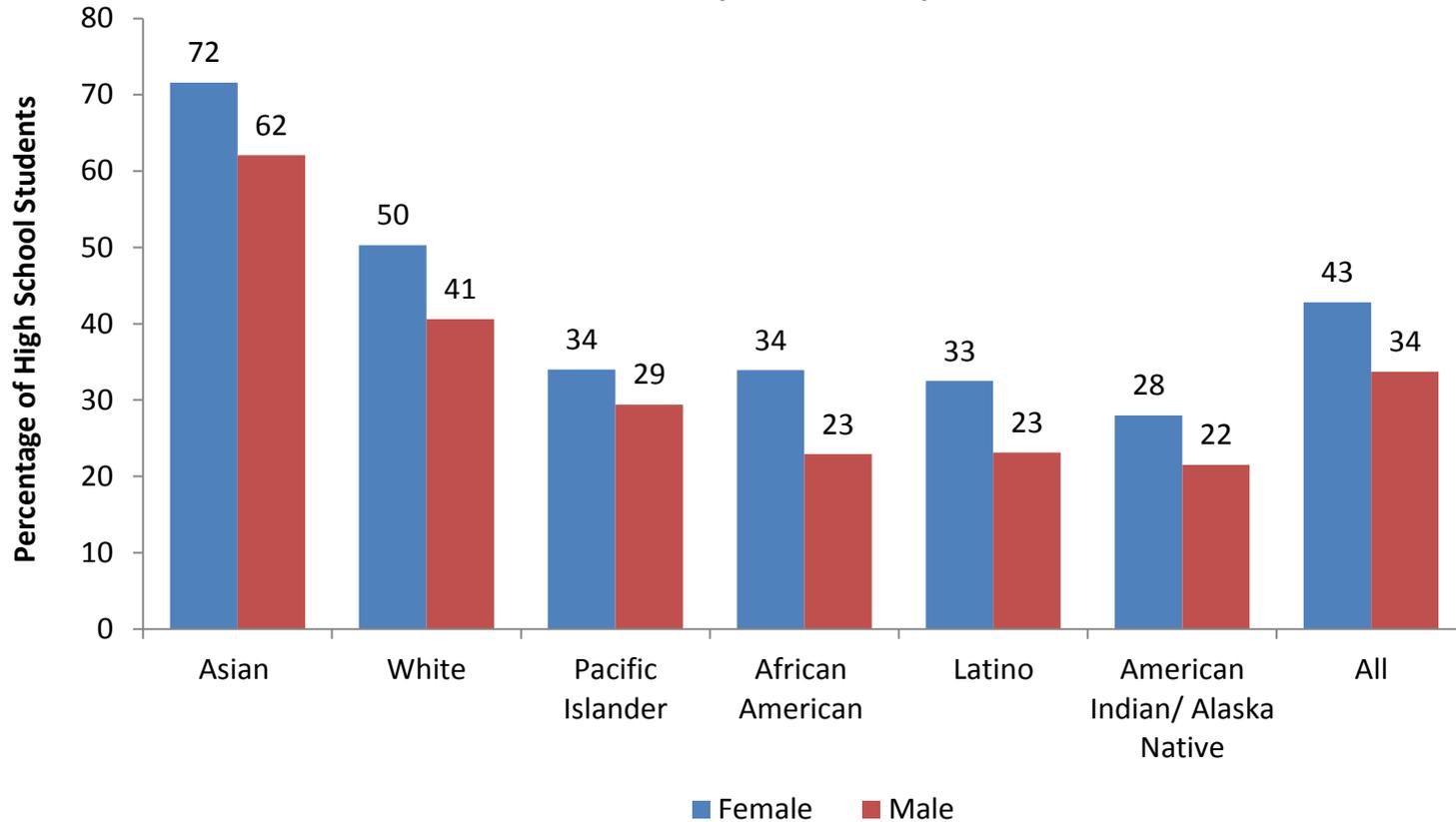
Data methodology and limitations are available at: <http://dq.cde.ca.gov/dataquest/>

Dropout definition: Either 1) was enrolled in grades 7, 8, 9, 10, 11 or 12 at some time during the previous school year AND left school prior to completing the school year and has not returned to school as of Information Day or 2) Did not begin attending the next grade (7, 8, 9, 10, 11 or 12) in the school to which they were assigned or in which they had pre-registered or were expected to attend by Information Day.

Note: Each race and ethnic group excludes percentages of “Still Enrolled high school student Rates” and may not add up to 100%.

Asian And White Students Are More Likely To Complete Required Courses To Enter Higher Education.

Figure 13. 12th Grade Graduates Completing all Courses Required for U.C. and/or C.S.U.* Entrance by Race/Ethnicity and Gender – 2011-2012



Source: California Department of Education, Data Reporting Office, 2011-2012.

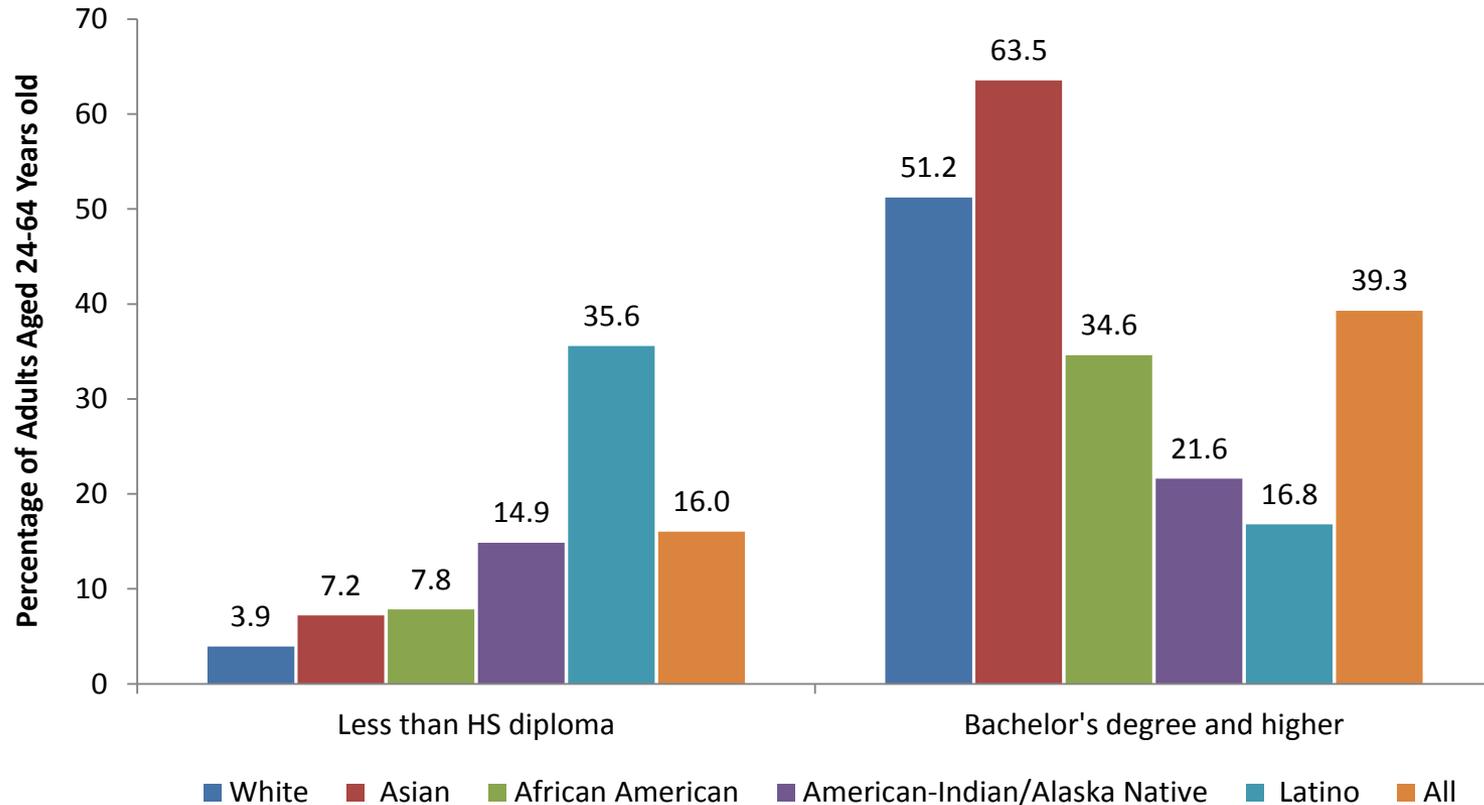
Data methodology and limitations are available at: <http://dq.cde.ca.gov/dataquest/>

Definition: Percentage of public school 12th grade graduates completing courses required for University of California (UC) and/or California State University (CSU) entrance, with a grade of "C" or better.

Note: U.C. – University of California, C.S.U. – California State University

Disparities In Adult Education Exist Across Race/Ethnic Groups In California.

Figure 14. Educational Attainment of California Adults Aged 24 to 64 Years By Race/Ethnicity, 2011-2012



Source: UCLA, California Health Interview Survey, 2011-2012.

Data methodology and limitations are available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

Definition: Adults are in ages 24-64 years excluding seniors age 65 and above.

Note: Each race and ethnic group excludes percentages of HS graduate, no college and some college or associate's degree and may not add up to 100%.

HOUSING

The Department of Health and Human Services has defined housing insecurity as high housing costs in proportion to income, poor housing quality, unstable neighborhoods, overcrowding, or homelessness.¹ Healthy and safe housing protects family members throughout their life stages from exposure to environmental hazards, such as chemicals and allergens, unintentional injuries, and supports mental and emotional health. In contrast, inadequate housing or housing insecurity is associated with a wide range of health conditions, including infectious and chronic diseases, injuries, respiratory infections, asthma, lead poisoning, mental health and can adversely affect child development.²

Housing is important to healthy and sustainable communities. A community is strongest and most successful when members in families, especially children, have safe and affordable homes. Housing and neighborhood conditions can promote or adversely impact health outcomes. Health is especially influenced by housing location, home maintenance and design, and housing costs (affordable housing).³ Housing location affects access to resources such as parks, recreation, grocery stores with healthy food, jobs, schools, transportation, and other community necessities which are related to health outcomes.⁴ Poor home maintenance and design such as risky stairs, balconies, and windows, a lack of safety devices such as smoke detectors, and unhealthy building materials lead to injuries, emergency room visits, and hospital admissions. In addition over-crowded housing can increase exposure to second-hand smoke or infectious disease.⁵

California housing is among the most costly in the nation, so finding affordable housing is a significant challenge for many middle- and low-income families. Housing typically is considered affordable if it comprises 30% or less of a family's income.⁶ According to 2011 estimates, only 34% of low-income children in the U.S. and 24% of low-income children in California lived in affordable housing⁴. Families that spend more than half of their income on housing tend to spend much less than other families on essential items, such as food, health care, and clothing⁶. Low-income parents with high housing cost burdens are more likely to report that their children have fair or poor health than low-income parents in more affordable housing situations¹. Research has also shown that unaffordable or unstable housing can diminish a child's opportunities for educational success by increasing the chance that he or she will have to move, change schools, and disrupt instruction.⁷

Generally, low-income families are more likely to experience the disruption of a residential move than other families. Moves can occur for a variety of reasons, but when they are involuntary or unplanned and frequent, they can have detrimental effects on children's outcomes.⁸ Hyper-mobility can present special challenges to children's well-being, both through direct effects on children (e.g., the stress of being uprooted or difficulty catching up with classmates at school) and as mediated through their parents (e.g., the parents' stress or preoccupation with details related to the move could affect their ability to be supportive of their children).⁹ Frequent moves have also been associated with modest disruptions in access to health-care services, including an increased likelihood of shifts from one provider to another as the number of moves increases, and a lower rate of office visits for immunizations for children.¹⁰

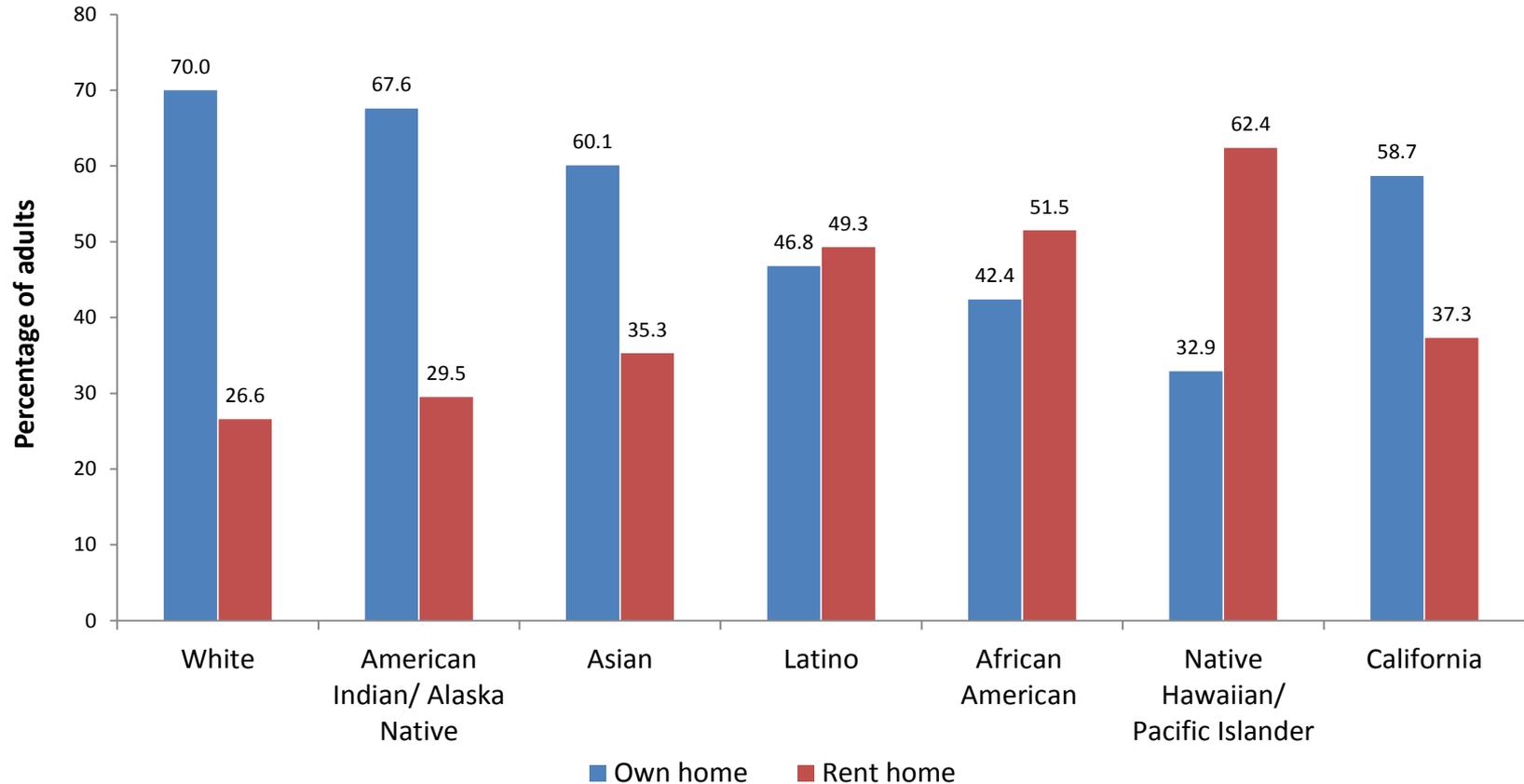
Homelessness remains a major social problem with health consequences. On a single night (Point-in-Time) in 2012, there were 633,782 homeless people in the US, including 394,379 who were homeless as individuals and 239,403 people who were homeless in families. Five states accounted for nearly half of the nation's total homeless population: California (20.7%), New York (11.0%), Florida (8.7%), Texas (5.4%), and Georgia (3.2%). On a single night, California accounted for more than 1 in 5 homeless people in the US (or 20.7%) and was the second highest of unsheltered homelessness in the nation (64.9%) compared to the highest at 73.8% in Wyoming.¹¹

References:

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Disparities In Housing Occupancy Exist Across Race/Ethnic Groups In California.

Figure 15. Percentage of Adults Who Own or Rent Their Home by Race/Ethnicity, California, 2011-2012



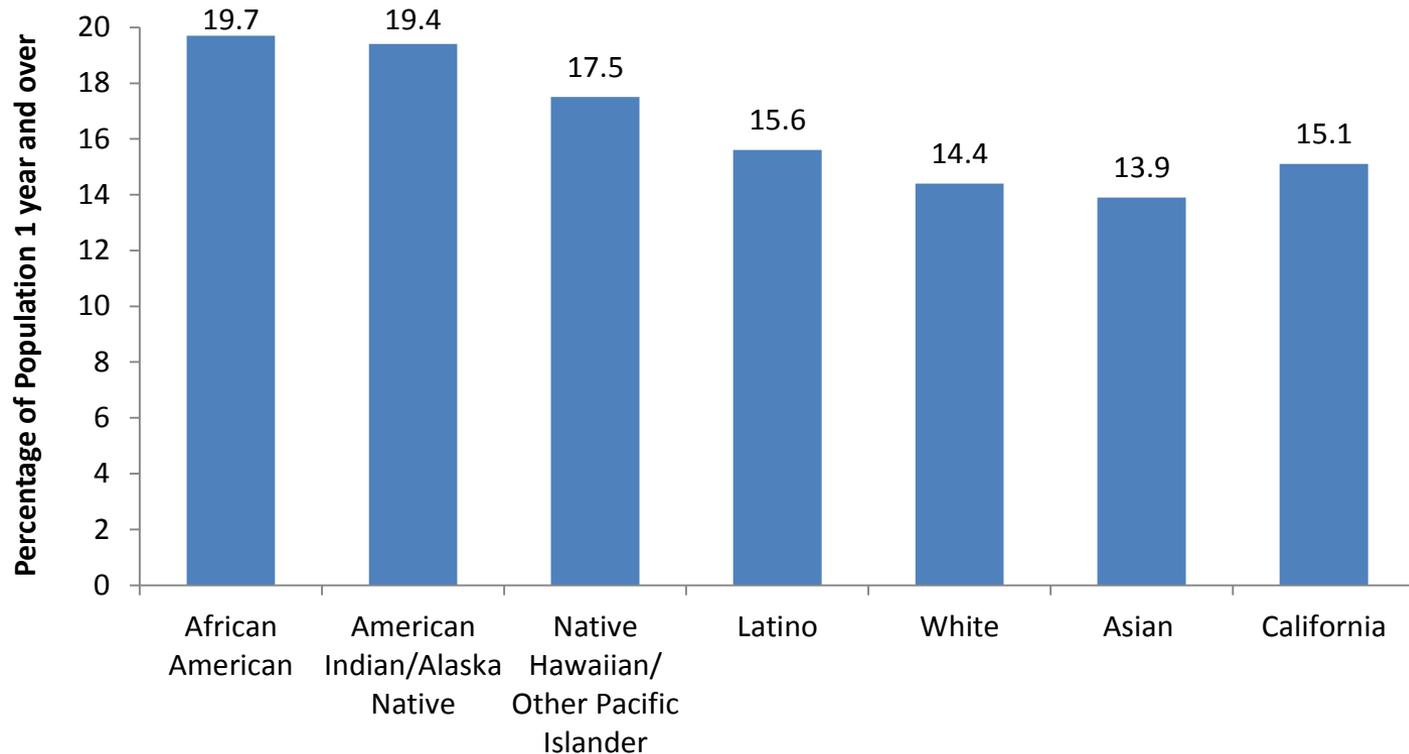
Source: UCLA, California Health Interview Survey, 2011 – 2012.

Data methodology and limitations are available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

Note: Each race and ethnic group excludes percentages of “Have other arrangement” and may not add to 100%.

African American Families Are More Likely To Experience Disruption Of A Residential Move Than Other Families.

Figure 16. Percentage of People who Changed Their Residence from Last Year to Current Year by Race/Ethnicity- 2006-2010

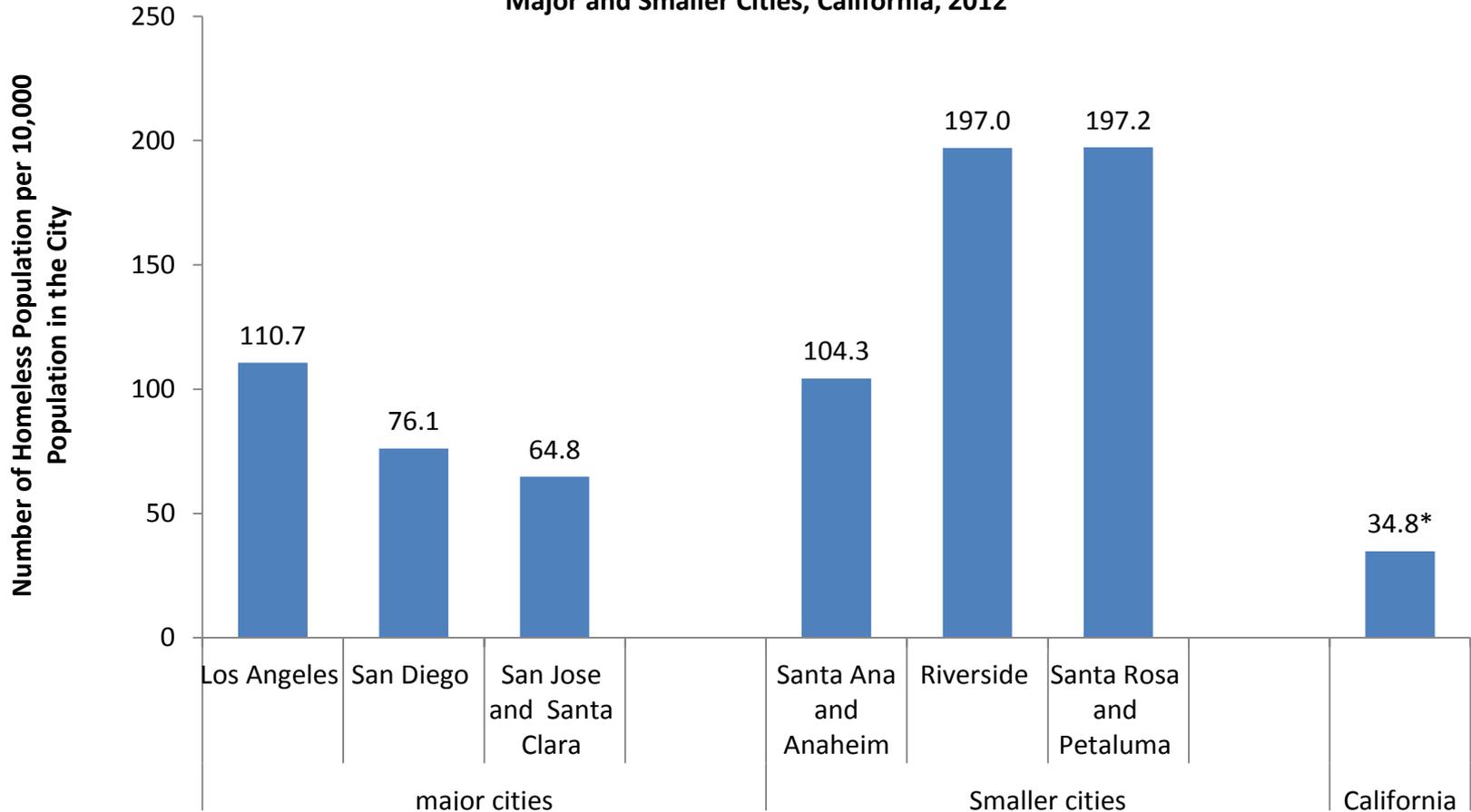


Source: American Community Survey, 2006-2010 – 5 year estimates.

Data methodology and limitation are available at: https://www.census.gov/acs/www/methodology/methodology_main/

More Homeless People Were Counted In Smaller Cities Than Major Cities In California.

Figure 17. Homeless People Per 10,000 Population by Major and Smaller Cities, California, 2012



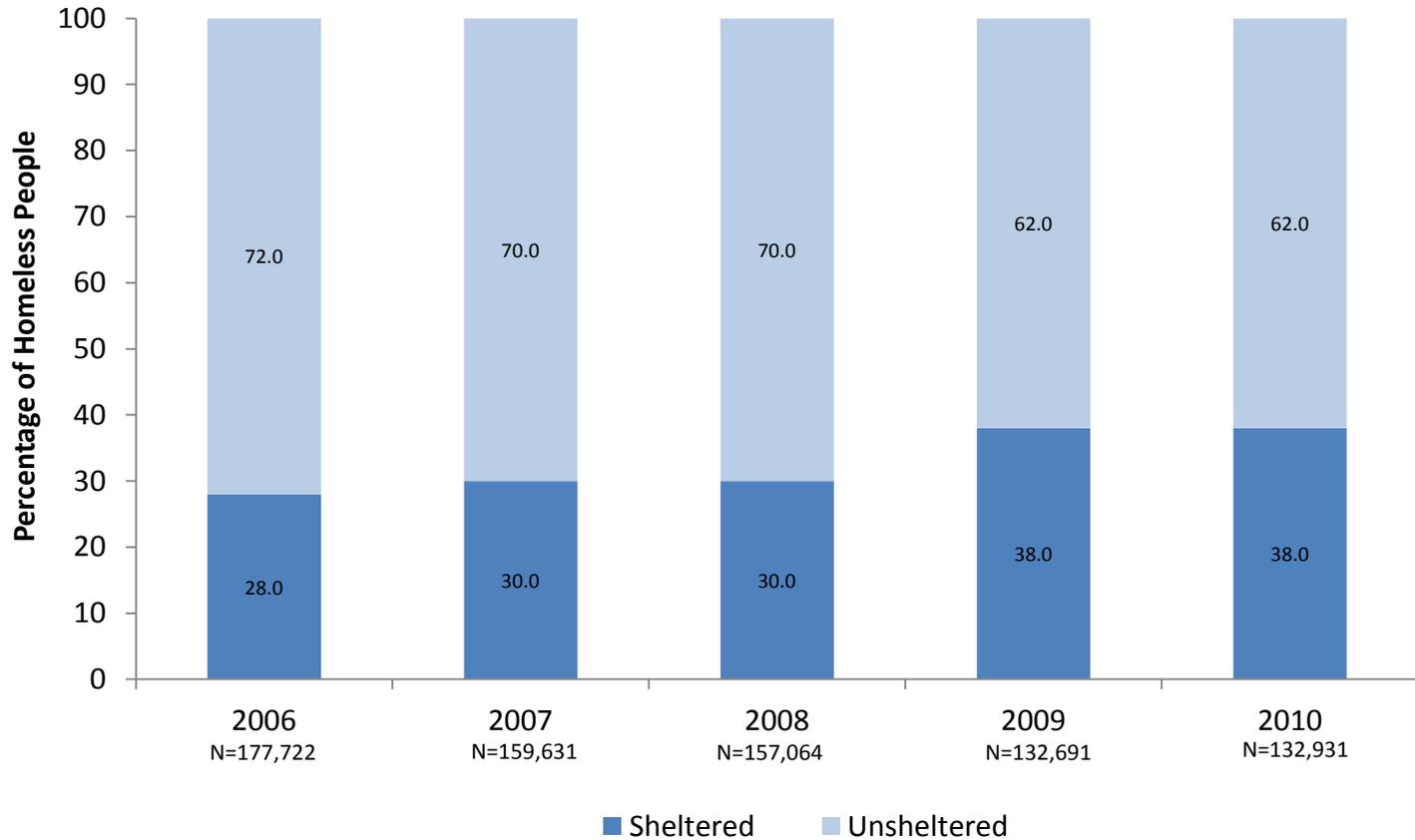
Source: The 2012 Point-in-Time Estimates of Homelessness , Volume I of the 2012 Annual Homeless Assessment Report, The U.S. Department of Housing and Urban Development

Note: The total homeless population in 2012 – 131193.

* As a percentage of total California population per 10,000 in 2012.

In California, The Gap Between Sheltered And Unsheltered Homeless Is Narrowing.

Figure 18. California Sheltered and Unsheltered Homeless Population, 2006 -2010



Source: Department of Housing and Community Development, Analysis of Impediments to Fair Housing, September 2012.

ENVIRONMENTAL QUALITY

Exposure to toxins and harmful contaminants in the air, water, and soil can have serious health consequences. Strong evidence shows that environmental health risks disproportionately affect children.¹ Children are generally more susceptible to various pollutants than adults because their nervous, immune, digestive, and other bodily systems are still developing, and because children eat more food, drink more fluids, and breathe more air in relation to their body weights.^{1,7} It is also well established that poorer people, some racial and ethnic groups, and those who are in lower socioeconomic positions experience higher exposure and health risks from pollution.⁷ Despite decades of progress, 131.8 million Americans (42% of the population) still live in areas where pollution levels are too often dangerous to breathe.⁷ California has some of the most polluted air in the nation with nearly 90% of residents living in counties with unhealthy air.⁷ Exposure to high levels of air pollutants such as ozone and fine particulate matter increases the risk of premature death, infant mortality, respiratory infections, pulmonary inflammation, heart diseases, and other illnesses. Such exposure also has been associated with the exacerbation of asthma, bronchitis, and respiratory effects serious enough to require emergency room visits and hospital admissions.¹⁰ Children are sensitive to lead, and exposure to lead which is often found in water and soil can affect brain development, resulting in neurobehavioral effects such as lowered IQ.¹⁰

Indoor air has become an important public health and safety concern. Poor indoor air can cause or contribute to the development of infections, lung cancer, and chronic lung diseases such as asthma.⁴ Secondhand smoke is a major toxic indoor air pollutant that can be very harmful to health regardless of the duration of the exposure.^{6,8} It has a number of serious impacts on infants' and children's health including sudden infant death syndrome, exacerbation of asthma, increased respiratory tract infections, and causes developmental toxicity resulting in low birth weight and impaired lung function growth.⁸

The work environment is as important as the external environment in terms of its impacts on health and well-being. Occupations may include risk factors for poor health. Strong evidence links the environmental risks such as exposure to chemical or adverse climatic conditions, ergonomic and physical demands, stress level, low skill discretion, and lower level of decision authority with adverse health outcomes including physical and mental health, coronary heart disease, long-term disabilities and chronic conditions.^{5,9} In 2011, about 4,700 U.S. workers were killed on the job and approximately 50,000 died from occupational diseases.² Work place deaths are estimated to cost the U.S. economy about \$6 billion annually.³ More than 4 million work-related injuries and illnesses were reported, but the true toll of job injuries is two or three times greater – about 7.6 million to 11.4 million each year. The cost of these injuries and illnesses is estimated at \$250 billion to \$300 billion a year.²

Although all workers are afforded equal protection under the Occupational Safety and Health Act, a greater proportion of Hispanic, foreign-born workers, and those with lower levels of educational attainment are employed in high-risk occupations and experience higher risks of occupational injuries and illness or other work-related health outcomes.³

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High Concentration Of Non-white Or Hispanic Population In Areas With High Burden Of Pollution.

Figure 19a. Non-White or Hispanic/Latino Population, 2010

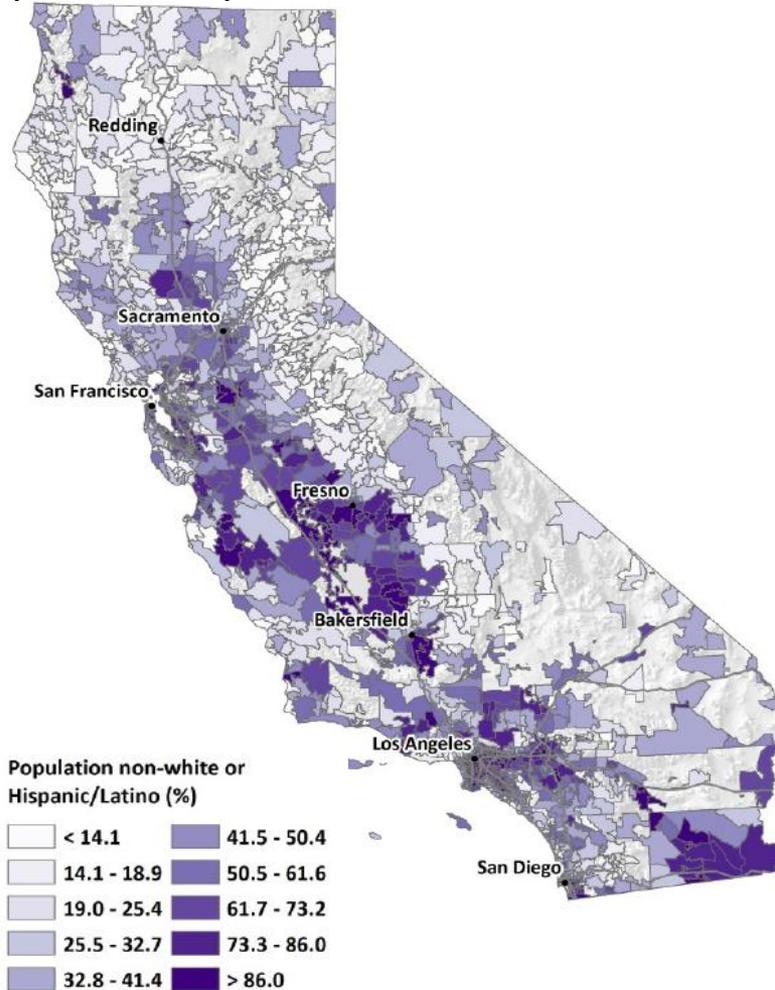
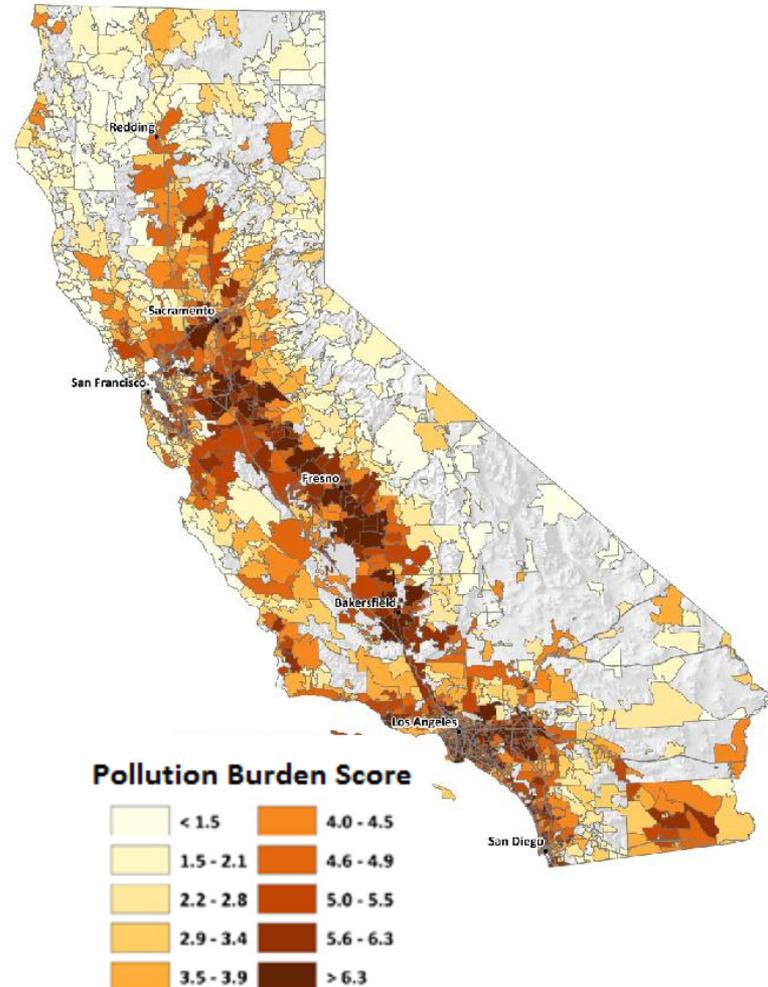


Figure 19b. Pollution Burden of California



Source: California Communities Environmental Health Screening Tool, Version 1.1, 2013

Pollution Burden scores for each ZIP code are derived from the average percentiles of the six Exposures indicators (ozone and PM2.5 concentrations, diesel PM emissions, pesticide use, toxic releases from facilities, and traffic density) and the five Environmental Effects indicators (cleanup sites, impaired water bodies, groundwater threats, hazardous waste facilities and generators, and solid waste sites and facilities). Indicators from the Environmental Effects component were given half the weight of the indicators from the Exposures component. The calculated average percentile (up to 100th percentile) was divided by 10 and rounded to one decimal place for a Pollution Burden score ranging from 0.1 -10, where 10 is the highest burden.

Data methodology and limitation are available at: <http://www.oehha.ca.gov/ej/ces11.html>

Work-related Fatal Injuries Are More Likely Among Workers In The Farming, Fishing And Forestry Industries.

Figure 20a. Work-related Fatal Injury Rates by Occupation and Race/Ethnicity, California, 2006-2010

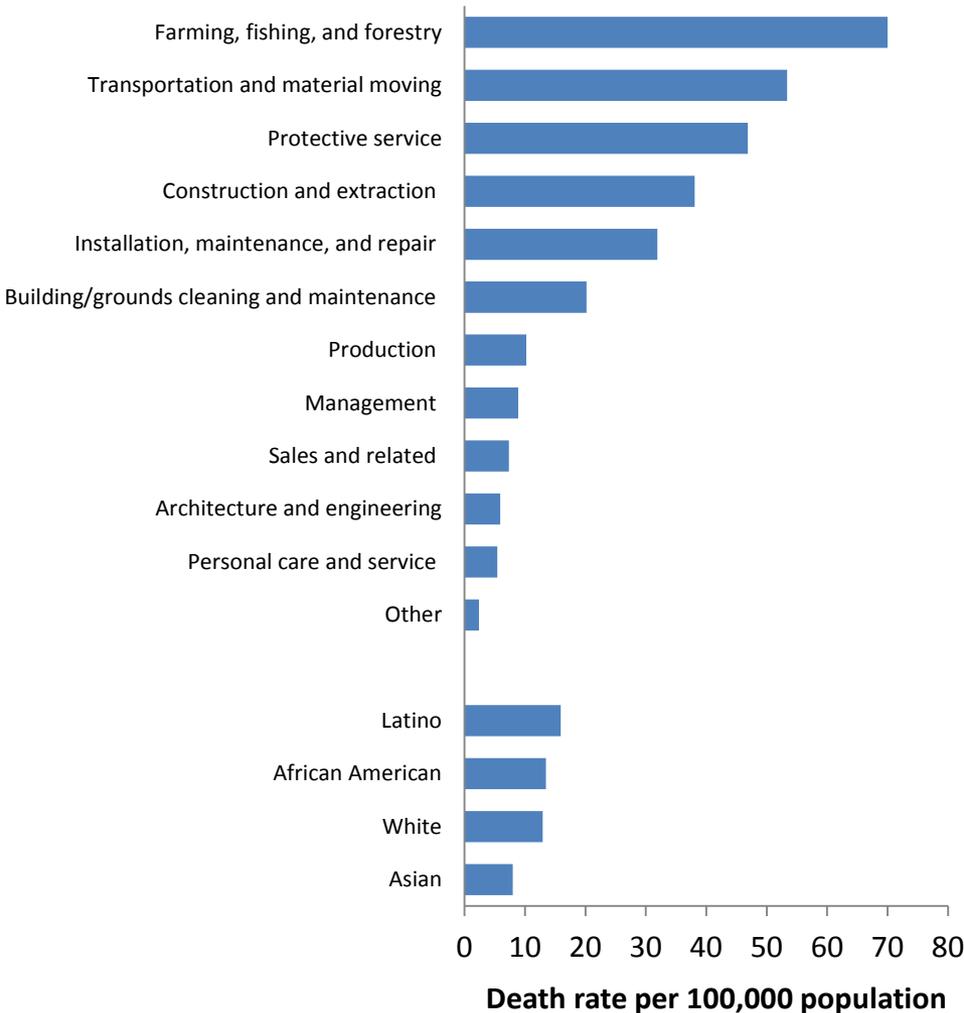


Figure 20b. Race/ethnicities of the Population* Employed in Farming, Fishing, and Forestry, 2006-2010

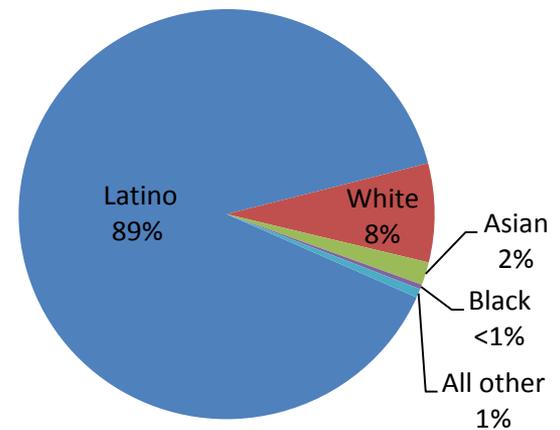
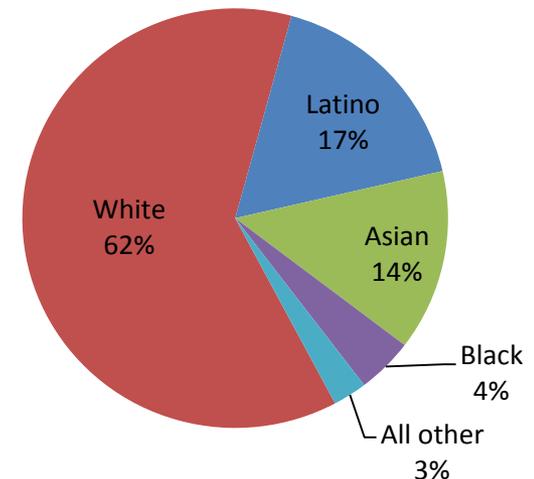


Figure 20c. Race/ethnicities of the Population* Employed in Management, 2006-2010

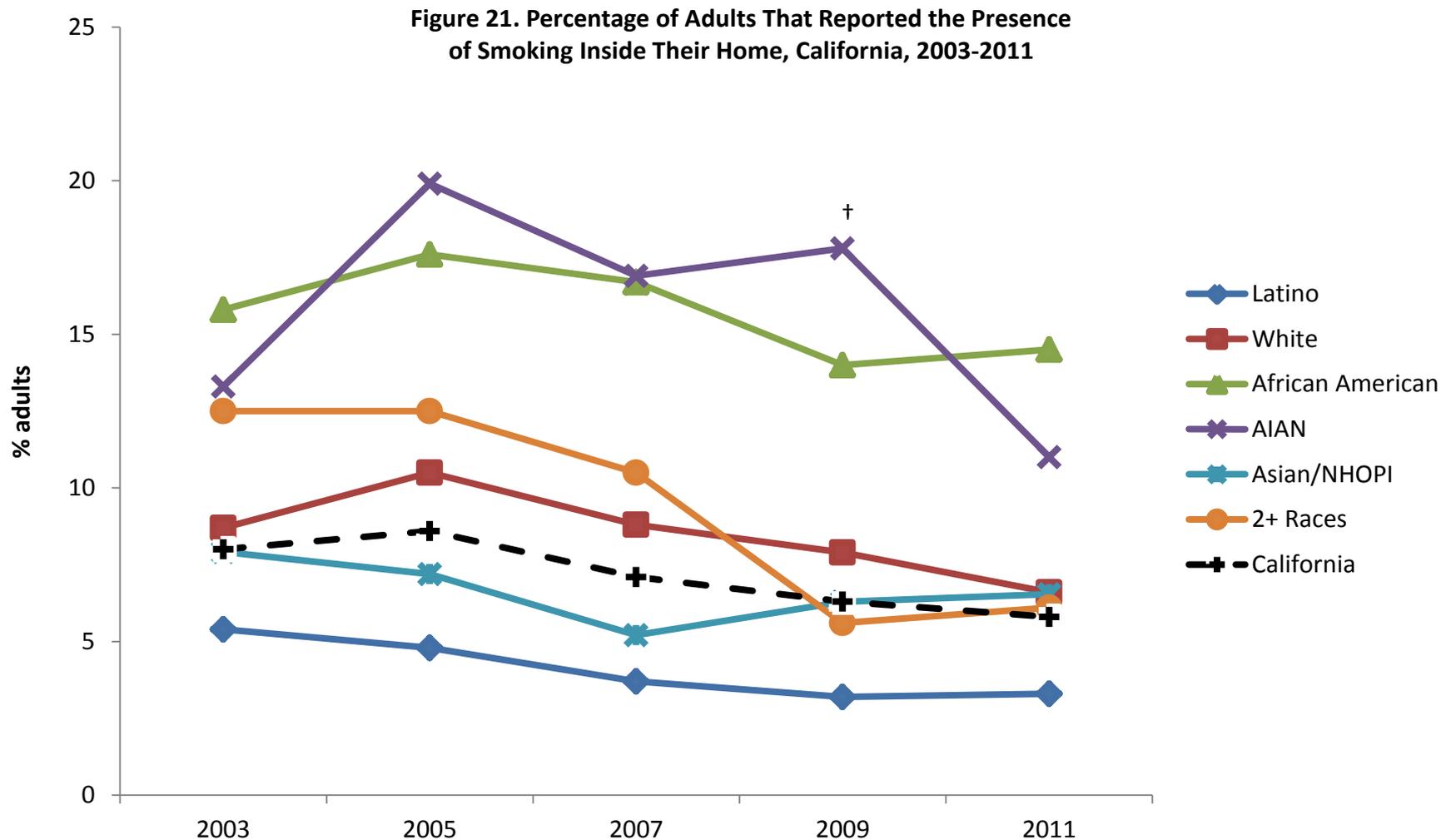


Source: California Department of Industrial Relations. American Community Survey, 5-year estimate.

Data methodology and limitation are available at: <http://www.dir.ca.gov/dosh/cfoi/cfoi.htm>, https://www.census.gov/acs/www/methodology/methodology_main/

*Civilian population 16 years and over.

African Americans Are More Likely To Be Exposed To Secondhand Smoke.



Source: UCLA, California Health Interview Survey, 2011-2012

Data methodology and limitation area available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

†Statistically unstable

ACCESSIBLE BUILT ENVIRONMENTS

Built environment refers to human-modified surroundings including homes, schools, workplaces, park/recreational areas, business areas, roads, highways, and transportation systems.^{8,10} Growing evidence suggests links between the built environment and physical and mental health problems such as anxiety, depression, attention deficit disorder, substance abuse, aggressive behavior, asthma, heart disease, obesity, diabetes, and injury.^{6,10} The burden of illness is greater among minorities and low-income communities.¹⁰ Lower-economic communities are often over-saturated with alcohol outlets and advertisements, have limited access to park or other recreational facilities, lack of grocery stores, adequate transportation and proper sidewalks, and have dangerously high traffic speeds.^{1,5,10} These characteristics of built environment are often associated with eating and physical activity behaviors, which in turn impact health outcomes.⁸

Physical activity is a critical mechanism by which built environment can affect health.⁹ The built environment can be structured in ways that give people more or fewer opportunities and choices to be physically active.⁴ In the last decade, rapidly increasing rates of overweight and obesity have become a major public health concern, and it is estimated to cost the United States \$100 billion each year in related health care.^{6,7} People are less active because they walk less, vehicle exhaust degrades air quality, motor vehicle use increases with increased distances traveled, as well as vehicle related injury.⁶ One of the most common opportunities for incidental physical activity among children is getting to and from school; however, the percentage of children walking or bicycling to school has dropped from approximately 50% in 1969 to just 13% or as few as 5% in some areas in 2009.³

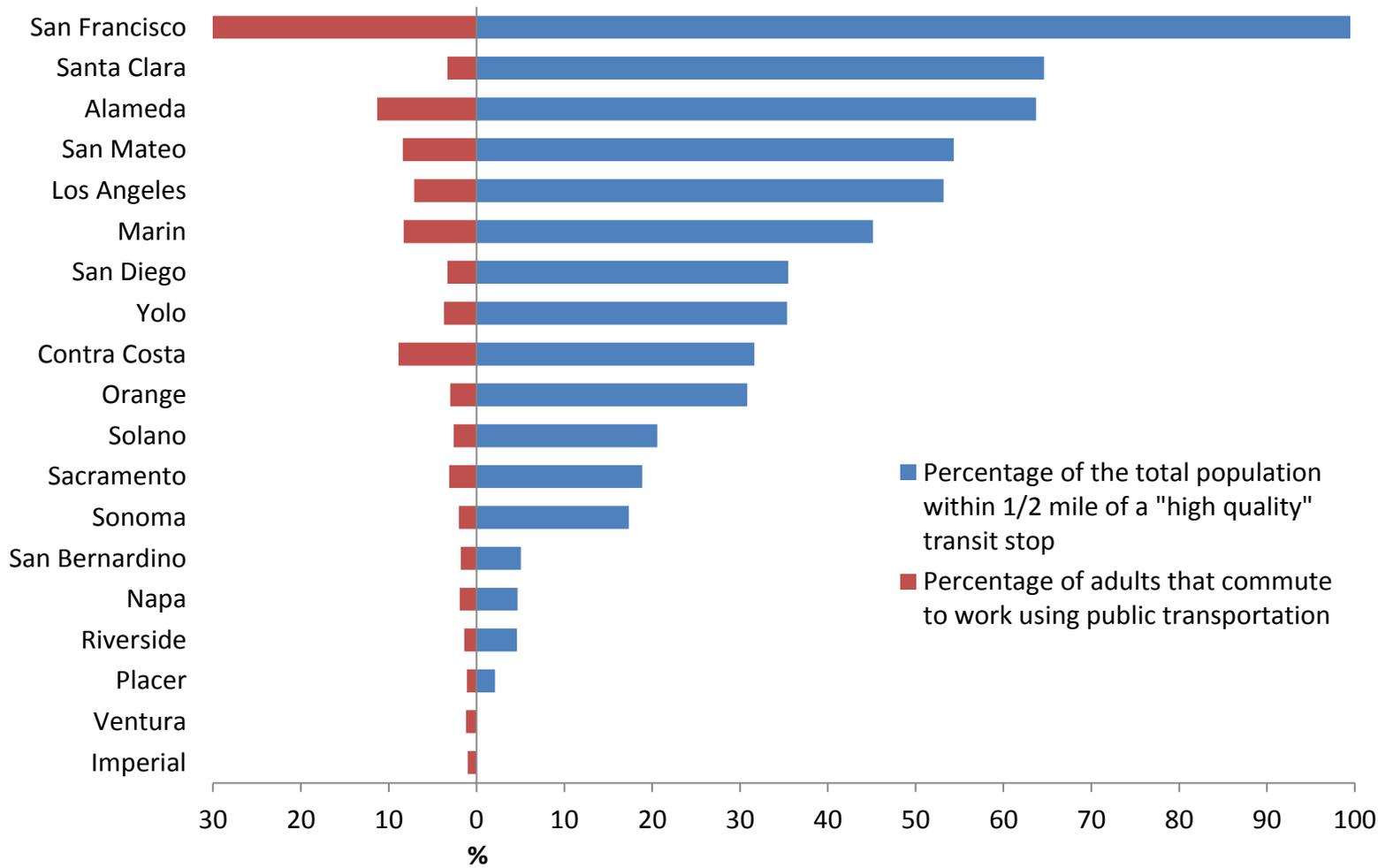
Changes to the built environment can have a positive impact on many health-related issues from diabetes and asthma to traffic safety.¹ People living in highly walkable, mixed-use communities have higher levels of transport-related walking, overall physical activity and a lower body mass index (BMI) than those in less walkable communities.¹¹ However, planning for increased pedestrian and bicycle use will require structural designs for safety that increase the visibility of pedestrians and bicyclists and increase the physical separation between them and moving cars. Access to a variety of safe transportation options can also potentially save lives by preventing chronic diseases, reducing and preventing motor-vehicle-related injury and deaths and improve environmental health.² Public transportation systems minimize the number of vehicles travelled by a single-occupant, reduce the production of automobile emissions, increase incidental physical activity, and particularly minimize pedestrian and bicycle injuries.²

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The Percentage Of The Population With Access To Public Transit And That Uses Public Transit By County Is Low Overall In Comparison To San Francisco County.

Figure 22. Public Transportation Use and Access in California by Counties of the Metropolitan Planning Organizations: SANDAG, SCAG, MTC, and SACOG

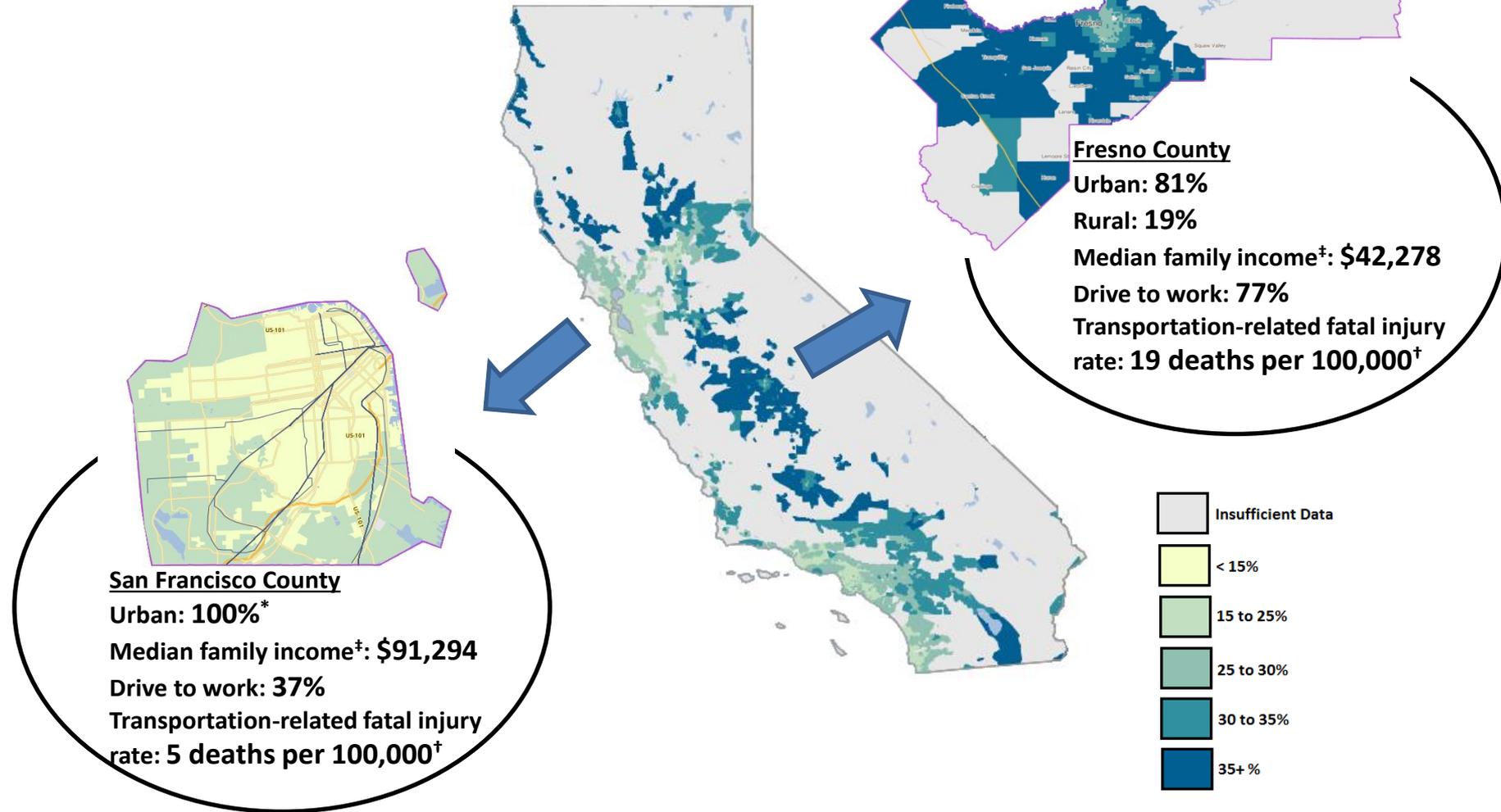


Sources: American Community Survey, 2006-2010, Southern California Association of Governments (SCAG), 2012, San Diego Association of Governments (SANDAG), 2012, Metropolitan Transportation Commission (MTC), 2012, and Sacramento Area Council of Governments (SACOG), 2008. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

Data methodology and limitation are available at: http://www.cdph.ca.gov/programs/Documents/HCI_RailFerryBus_51_Narrative_and_examples_11-26-13SoCal_MTC_Sac.pdf 34

The Burden Of Transportation Cost Relative To Income Is Higher In The Rural Regions And Counties Of California.

Figure 23. Transportation Costs as a Percentage of Income, California, 2009.



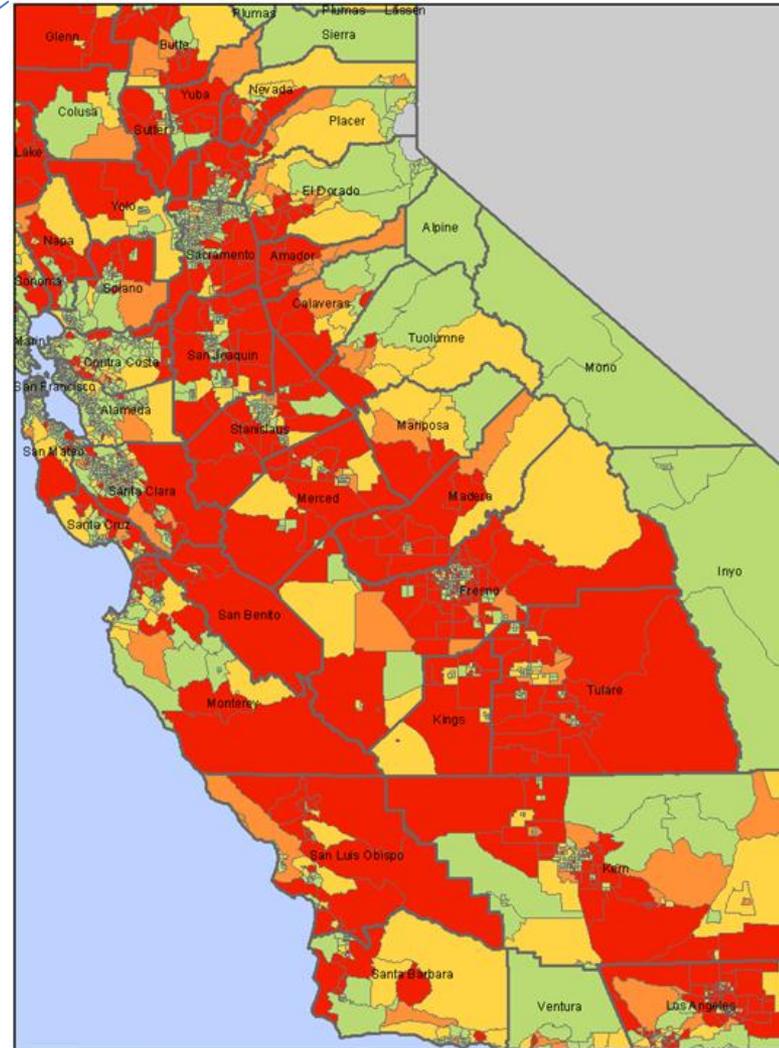
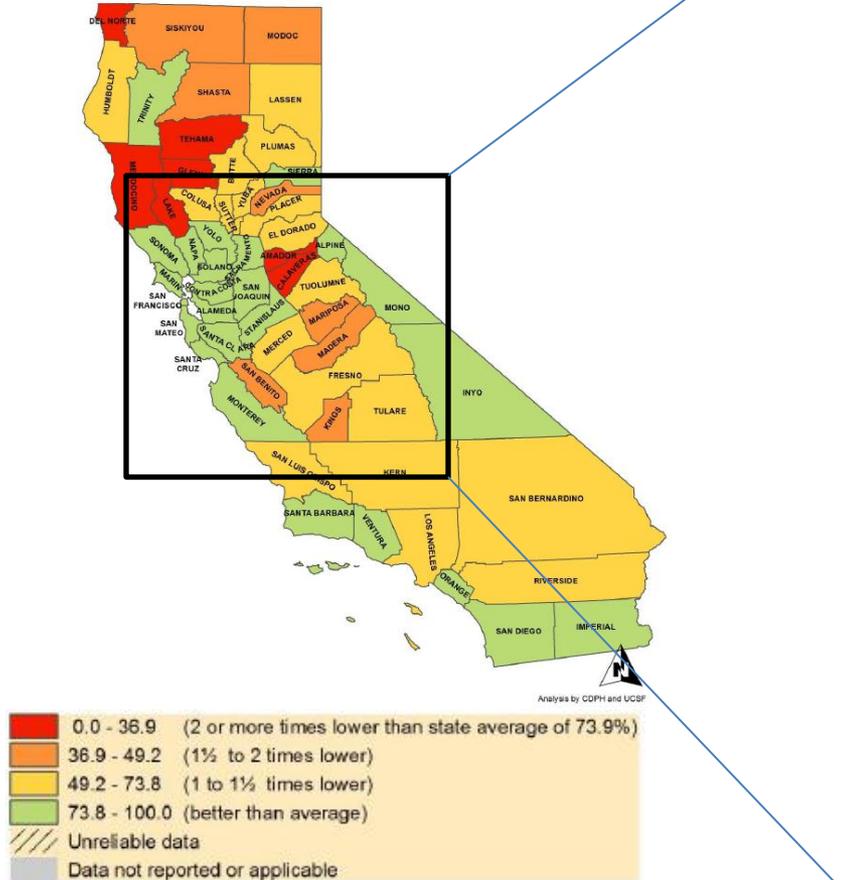
Sources: H+T Affordability Index (2009), American Community Survey, 5-year estimate (2008-2012), CDC WISQARS (2004-2010), California Health Interview Survey (2011-2012).
 Data methodology and limitation are available at: <http://htaindex.cnt.org/about.php>, https://www.census.gov/acs/www/methodology/methodology_main/,
<http://www.cdc.gov/ncipc/wisqars/fatal/help/datasources.htm>, <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

†Age-adjusted death rate, *Statistically unstable

‡Median family income with own children under 18 years.

Access To Parks Within Walking Distance Varies By Community, But It Is Lower In Non Urban Areas.

Figure 24. Percent of Population within ½ Mile of Park, Beach, Open Space, or Coastline, by California County, 2010.

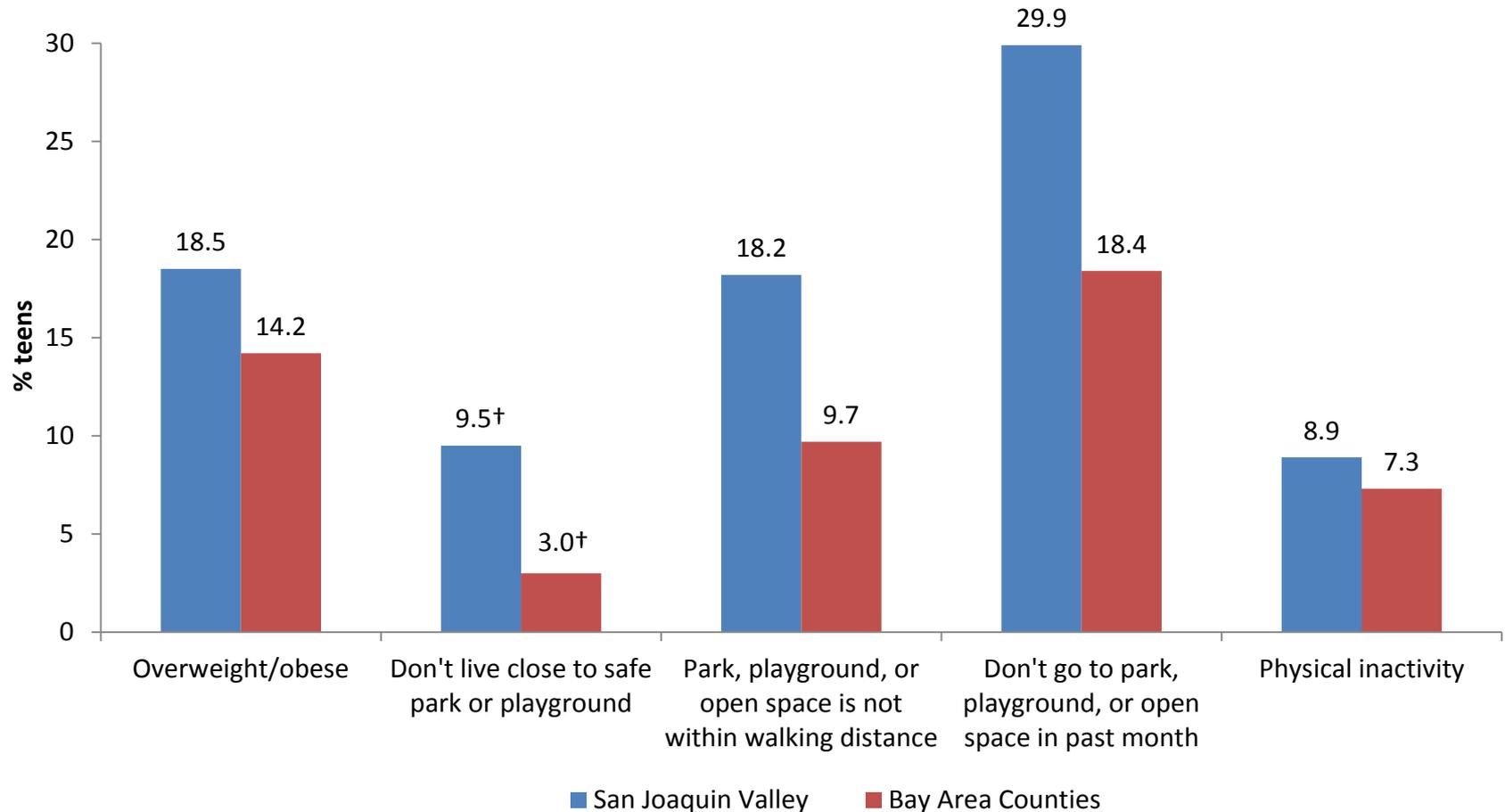


Source: CALANDS (2012), U.S. Census (2010). Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicator Projects.

Data methodology and limitation are available at: http://www.cdph.ca.gov/programs/Documents/ParkBeachOpen_Narrative_Examples4-12-13.pdf

Physical Activity In Teenagers Is Associated With Place And Access To Parks.

Figure 25. Teenagers from the Bay Areas Have Higher Access to Safe Parks and Are More Likely to be Active Than Teenagers From San Joaquin Valley.



Source: UCLA, California Health Interview Survey, 2011-2012

Data methodology and limitation area available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

† Statistically unstable

PREVENTIVE EFFORTS

Improving health care services includes increasing access to and use of preventive services.^{1,2} Preventive services are services that: 1) Prevent illness by detecting early warning signs or symptoms before they develop into a disease (primary prevention). 2) Detect a disease at an earlier, and often more treatable, stage (secondary prevention).³ Clinical Preventive Services include disease screening, immunizations, and counseling by healthcare professionals.² Also educating people about health and promoting healthy behaviors through community level can help postpone or prevent illness and disease. In addition, detecting health problems at an early stage increases the chances of effectively treating them, often reducing suffering and costs.²

There is significant underutilization of effective preventive care in the United States, resulting in lost lives, unnecessary poor health, and inefficient use of health care dollars.¹ In several important areas, use of preventive care among people who have systematically experienced greater obstacles to health on the basis of their racial or ethnic group, socioeconomic status, gender, age, mental health, cognitive, sensory or physical disability, sexual orientation or gender identity, geographic location, or other characteristics historically linked to discrimination or exclusion lags behind that of advantaged population groups.⁴ It is well established that preventive care reduces the prevalence of disease and helps people live longer, healthier lives⁵ and people with a usual source of care to get preventive services have better health outcomes and fewer disparities and costs.^{6,7,8} Also greater use of clinical preventive services in the United States could avert the loss of more than two million life-years annually.⁹

Breastfeeding reduces the likelihood and severity of many common infections in babies and breastfeeding is associated with a reduced risk of atopic dermatitis (eczema).¹⁰ It is estimated that 27% of hospitalizations for lower respiratory tract infections could be prevented each month by exclusive breastfeeding. Similarly 53% of diarrhea hospitalizations could be prevented each month if babies were exclusively breastfed.¹¹ Breastfed babies have a reduced risk of infections of the middle ear¹ and urinary tract.¹² Breastfeeding also protects babies' future health. Babies who are exclusively breastfed for the first three months of life are less likely to develop coeliac disease in the first 7 years.¹³ Exclusive breastfeeding is causally associated with reduced blood pressure in children⁵. It is associated with a reduced risk of being overweight or obesity or developing insulin dependent (type I) diabetes mellitus.¹⁴ Breast milk has a particularly significant impact for babies born pre-term. It contains specific factors that are needed for brain and eyesight development in the early days.¹⁵ Premature babies who received only breast milk were 6–10 times less likely to develop necrotizing enterocolitis (a life threatening bowel disorder) than babies fed formula milk.¹⁶ There are long term health benefits for women as well.¹¹ The risk of breast cancer, some forms of ovarian cancer, type II diabetes¹ and post-menopausal osteoporosis leading to hip fracture is lower in women who have breastfed.¹⁴

Getting a high-quality screening mammogram and having a clinical breast exam (an exam done by a health care provider) on a regular basis are the most effective ways to detect breast cancer early. Early detection of breast cancer with screening mammography means that treatment can be started earlier in the course of the disease, possibly before it has spread. Results from randomized clinical trials and other studies show that screening mammography can help reduce the number of deaths from breast cancer among women ages 40 to 70, especially for those over age 50. Black women have the highest breast cancer death rates of all racial and ethnic groups and are 40% more likely to die of breast cancer than white women.¹⁷ According to Centers for Disease Control and Prevention (CDC), cervical cancer is the easiest female cancer to prevent, with regular screening tests and follow-up.

Vaccines are among the most cost-effective clinical preventive services and are a core component of any preventive services package. Childhood immunization programs provide a very high return on investment. For example, for each birth cohort vaccinated with the routine immunization schedule (this includes DTaP, Td, Hib, Polio, MMR, Hep B, and varicella vaccines), society: saves 33,000 lives, prevents 14 million cases of disease, reduces direct health care costs by \$9.9 billion, and saves \$33.4 billion in indirect costs. Despite progress, approximately 42,000 adults and 300 children in the United States die each year from vaccine-preventable diseases.¹⁸

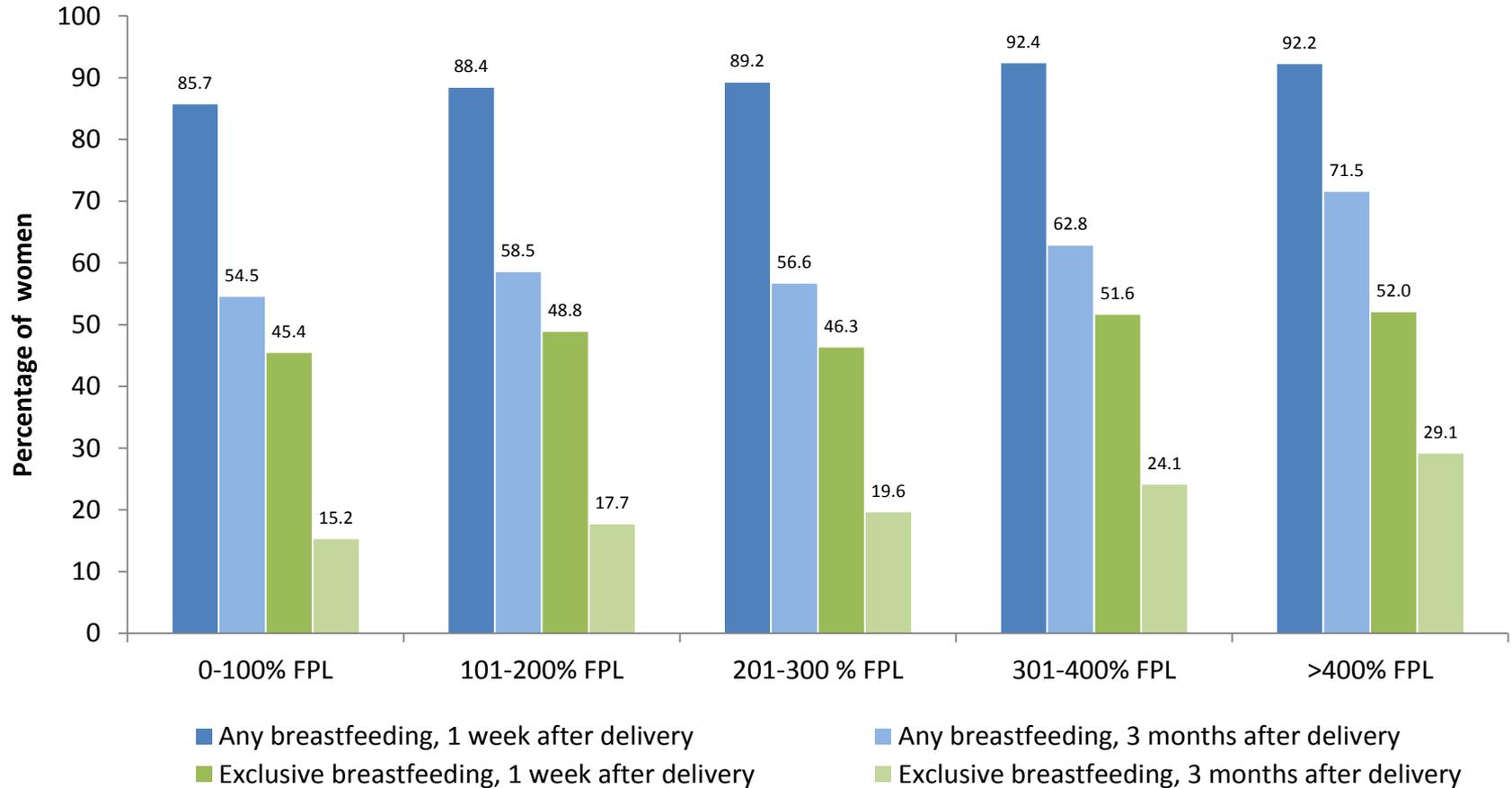
Among children and adolescents, physical activity can: improve bone health, improve cardiorespiratory and muscular fitness, decrease levels of body fat, and reduce symptoms of depression. More than 80 percent of adolescents do not do enough aerobic physical activity to meet the guidelines for youth.¹⁸

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Three Months After Delivery, Poor Mothers Are More Likely to Drop Breastfeeding.

Figure 26. Percentage of California Women Who Ever Breastfed or Fed Breast Milk by Federal Poverty Level (FPL), 2012



Source: California Department of Public Health, Center for Family Health, Maternal, Child and Adolescent Health Program - Maternal and Infant Health Assessment (MIHA), 2012.

Note: Indicators for breastfeeding at 3 months postpartum limited to women whose infant was at least 3 months old at the time of survey completion.

Poor Women Are More Likely Not To Have A Mammogram Or A Pap Test In California.

Figure 27. Percentage of California Women Who Have Not Had a Mammogram or a Pap Test by Annual Income Level, 2012

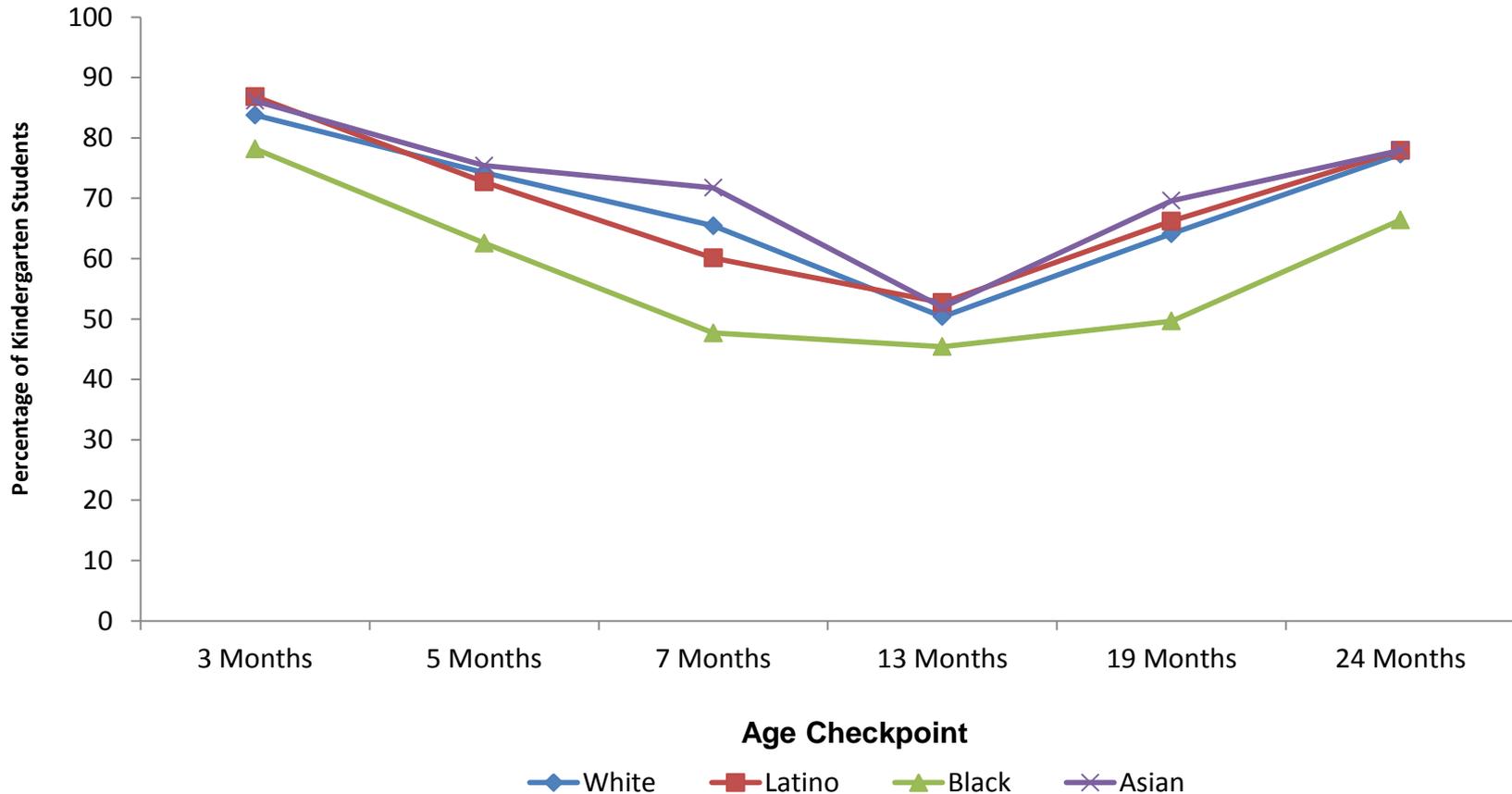


Source: Behavioral Risk Factor Surveillance System, 2012

Definitions: Mammogram - Women aged 40+ who have not had a mammogram within the past two years . Pap test - Women aged 18+ who have not had a pap test within the past three years.

In Every Age Checkpoint, African American Kindergarteners Were Reported The Lowest Immunization Rate.

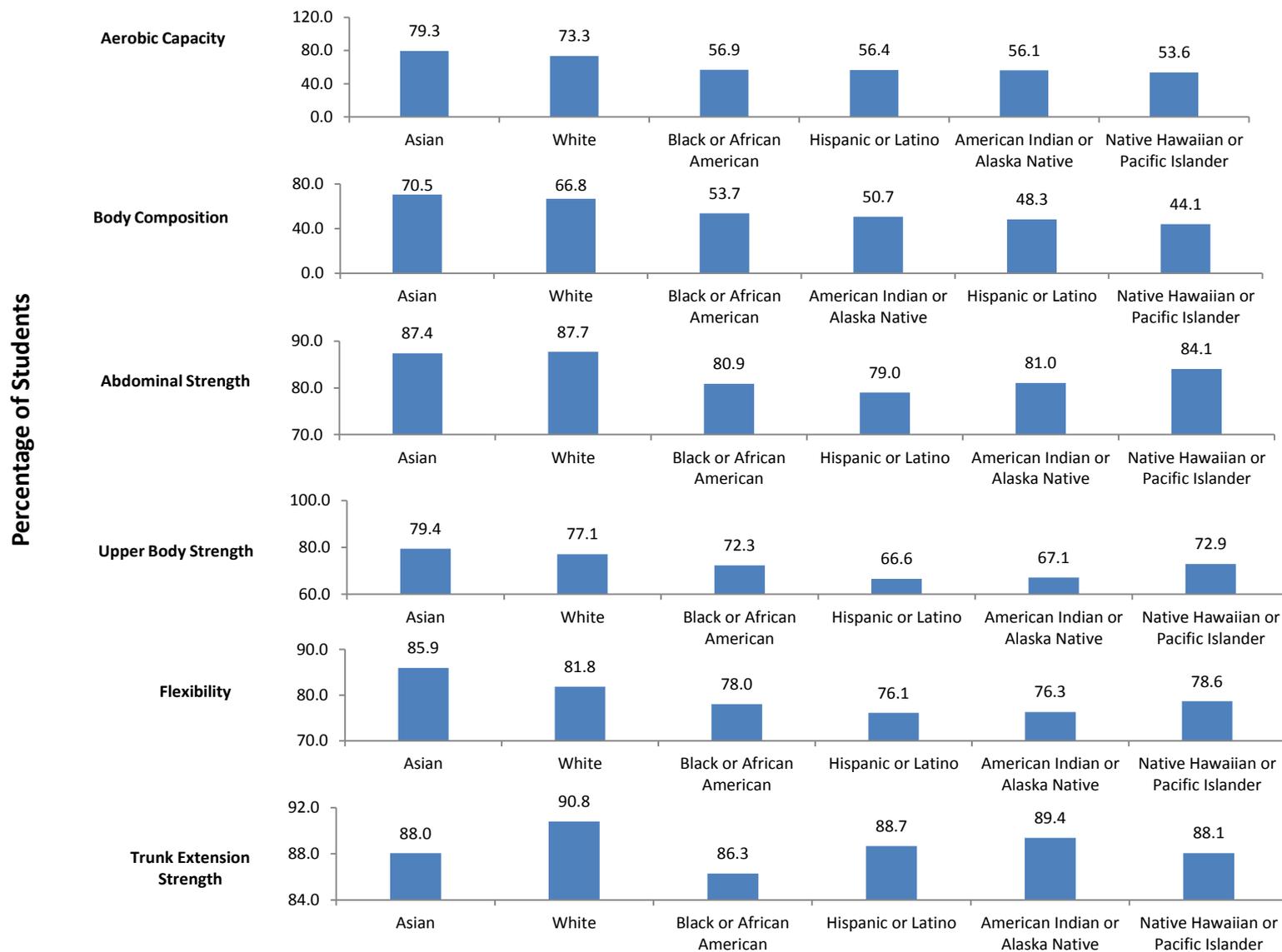
Figure 28. Immunization Coverage among Kindergarten Students by Age Checkpoint and Race/Ethnicity - 2010-2011



Source: 2010-2011 Kindergarten Retrospective Survey Results, Immunization Branch, California Department Of Public Health.

Notes: 1. Age checkpoints are defined according to whether or not children are up-to-date for age appropriate doses of DTaP, polio, and MMR at 3, 5, 7, 13, 19 and 24 months. 2. As recorded on student immunization record (blue card). Individual racial groups do not include Hispanic children. Children of Hispanic ethnicity may be of any race.

Figure 29. Total Percentage Of Grades 5, 7, And 9 “Physically Fit”* Children In California By Race/Ethnicity, California, 2012-2013



Source: California Department of Education, 2012-2013 California Physical Fitness Report.

* Children who are in Healthy Fitness Zone (HFZ) required California school fitness-gram test. Available at: <http://www.cde.ca.gov/ta/tg/pf/healthfitzones.asp>

DISCRIMINATION

The impact of discrimination on health has been described in the public health literature since the 18th century¹ and the growing body of research on discrimination and health indicates a deleterious effect of discrimination on various health outcomes.² Research indicates that discrimination is associated with poor health status, and the association is strongest in the case of mental health. Higher levels of discrimination were associated with higher levels of illness and health risk.³ The relationships between multiple forms of perceived and self-reported discrimination and both mental (including physiological stress) and physical health outcomes are also associated.⁴

Health disparities have existed between Whites and minority populations (i.e., African Americans, Hispanics, etc.) for many years. Racism is associated with these health disparities, like increased ambulatory blood pressure in African Americans⁵, chronic health conditions in Asian Americans⁶, systolic blood pressure for African American women⁷, carotid artery disease in African American women⁸, and the health status of Chinese Americans⁹.

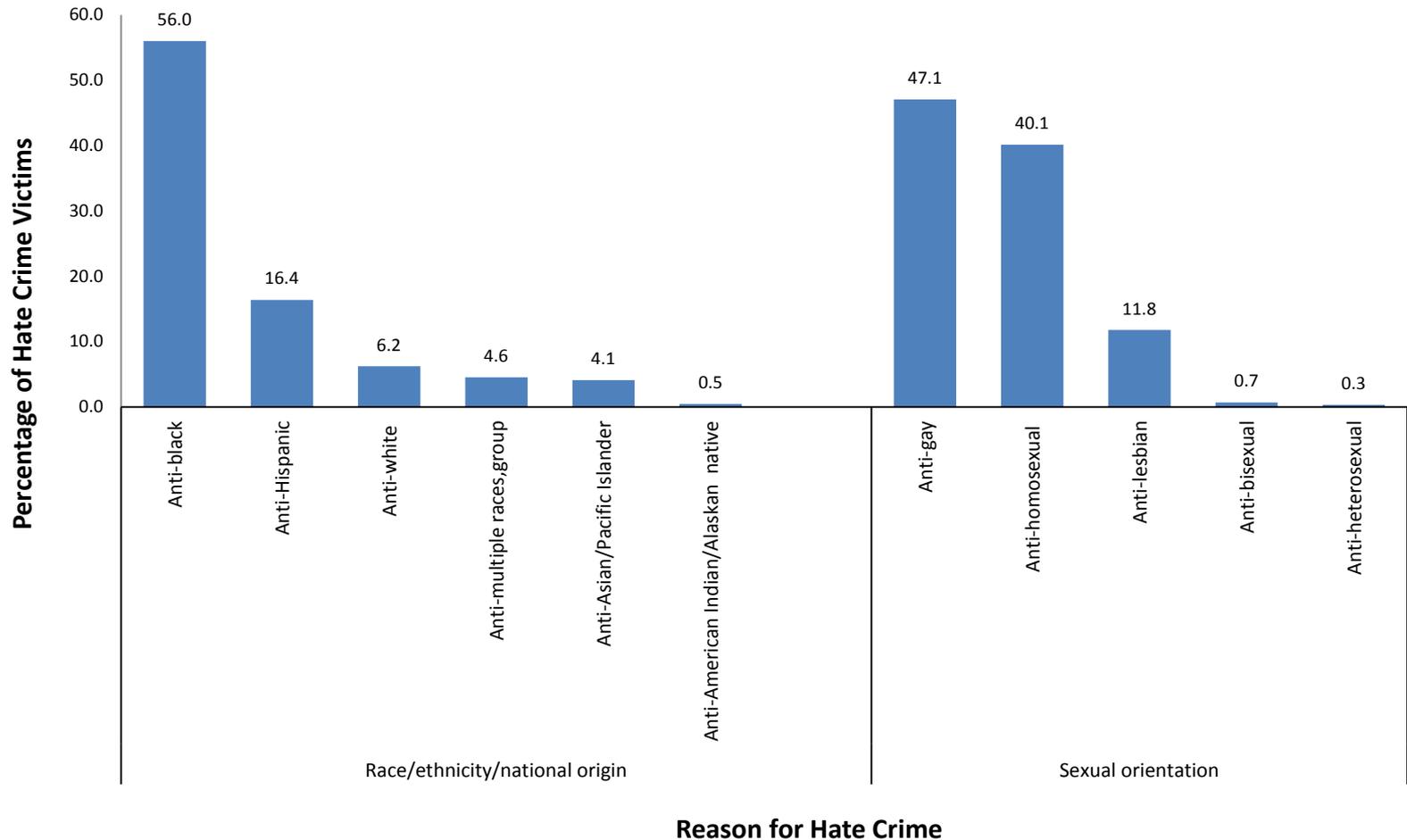
Most sexual orientation hate crimes were perpetrated in public settings by one or more strangers, but victimization also occurred in other locales, and perpetrators included neighbors, coworkers, and relatives.¹⁰ In California, hate crimes with a race/ethnicity/national origin bias are consistently the most common type of hate crime in the last ten years, accounting for 56.8 percent of all hate crime events in 2012. Within this category, hate crimes with an anti-black bias motivation continue to be the most common hate crime, accounting for approximately one-third of all hate crime events since 2003. Hate crimes with a sexual orientation bias were the second most common type of hate crime in California, comprising 25.3 percent of hate crimes reported in 2012. Within this category, hate crimes with an anti-homosexual motivation have increased 23.9 percent since 2003.¹¹

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Anti-Black Bias Motivation And Anti-Gay Motivation Are The Most Common Hate Crimes In California.

Figure 30. Percentage of Hate Crime Victims by Race/Ethnicity/National Origin and Sexual orientation, California, 2012



Source: Hate Crime in California, 2012, Table 4, California Department of Justice

Note: Victim Type by Bias Motivation. Anti-multiple races and groups are not included in the graph.

NEIGHBORHOOD SAFETY AND COLLECTIVE EFFICACY

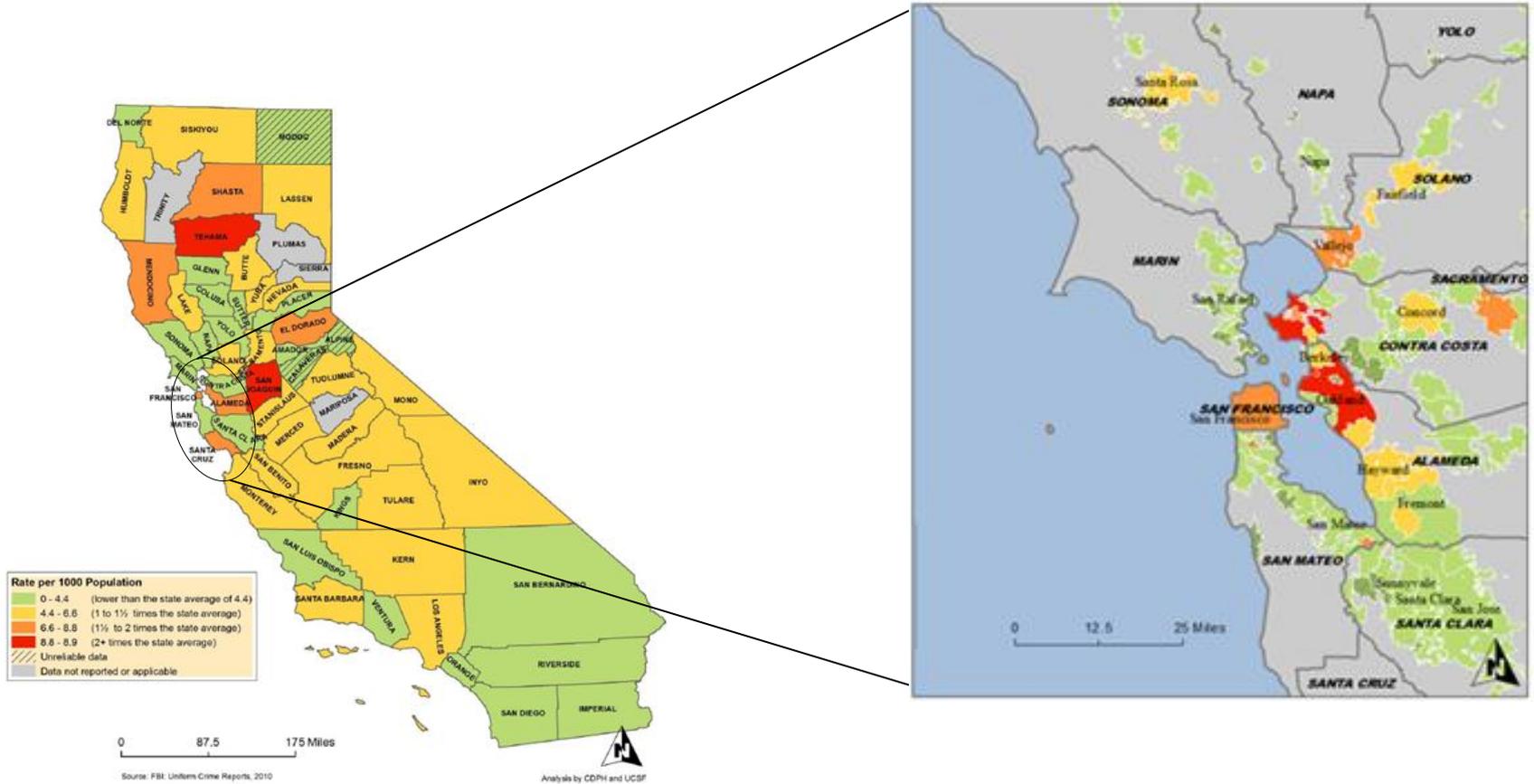
Communities and neighborhoods that ensure access to basic goods, that are socially cohesive, that are designed to promote good physical and psychological well-being, and that are protective of the natural environment are essential for health equity.⁴ Many American neighborhoods, however, are becoming poorer and more segregated.⁵ In these neighborhoods, there are an abundance of poor performing schools with high dropout rates, and limited access to transportation, quality affordable housing, adequate parks and recreation, and grocery stores⁵. Such low-income and minority neighborhoods are also more likely to have higher concentrations of stores selling tobacco, fast food and alcohol.³ Research suggests that the risk factors for chronic disease, mortality, coronary heart disease, and low birth weight tend to be higher in those types of neighborhood.⁵

Studies have consistently shown an association between a deteriorated physical environment and higher rates of crimes, making neighborhoods less safe for any physical activity (i.e. walking, biking), and in some cases resulting in social isolation.⁸ Unsafe neighborhoods increase the risk of obesity among younger children by limiting their outdoor play and increasing indoor activities such as TV watching.² Youth growing up in unsafe neighborhoods are more likely than other youth to become victims or perpetrators of violent crime⁵. In addition, witnessing violence and crime is related to higher levels of aggression, stress, withdrawal, and lower levels of school achievement.⁶ Violence contributes to negative perceptions of neighborhoods and impacts real estate, housing, and economic development.⁷ For instance, financing for businesses (i.e. supermarkets) in crime-ridden areas are difficult because the insurance, security, and other operating costs are higher, and people who live in these areas earn lower incomes and tend to spend less.¹

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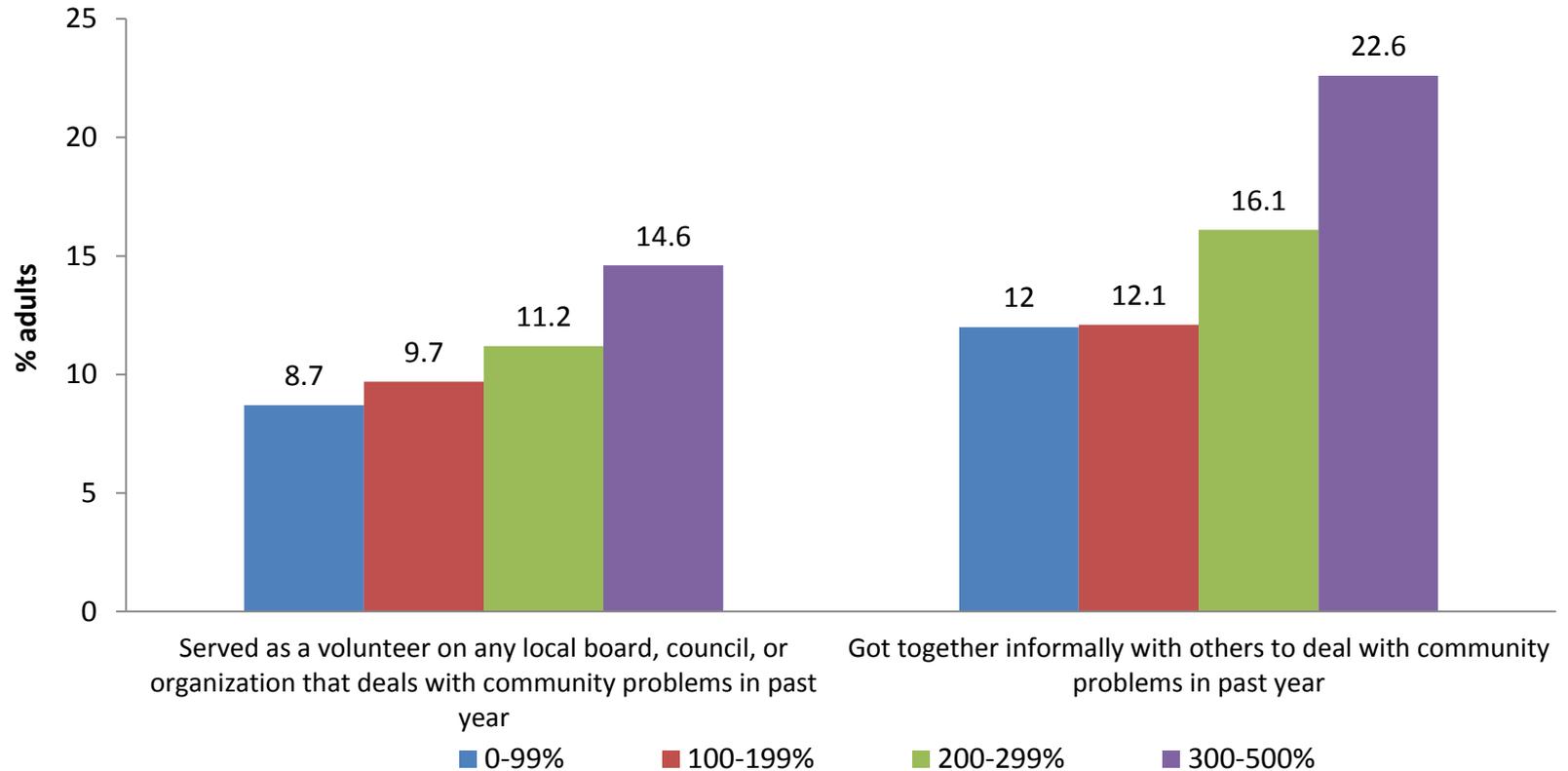
Figure 31. Number Of Violent Crimes Per 1,000 Population By County, California, 2010



Source: Federal Bureau of Investigation: Uniform Crime Reports, 2010. Analysis by CDPH-Office of Health Equity and UCSF, Healthy Community Indicators Project.

Lower-Income Adults Are Less Likely To Engage In Volunteer Work Or Get Together With Others To Deal With Community Problems.

Figure 32. Percentage of Adults Participated in Community Services by Federal Poverty Level, California, 2011-2012.



Source: UCLA, California Health Interview Survey, 2011-2012

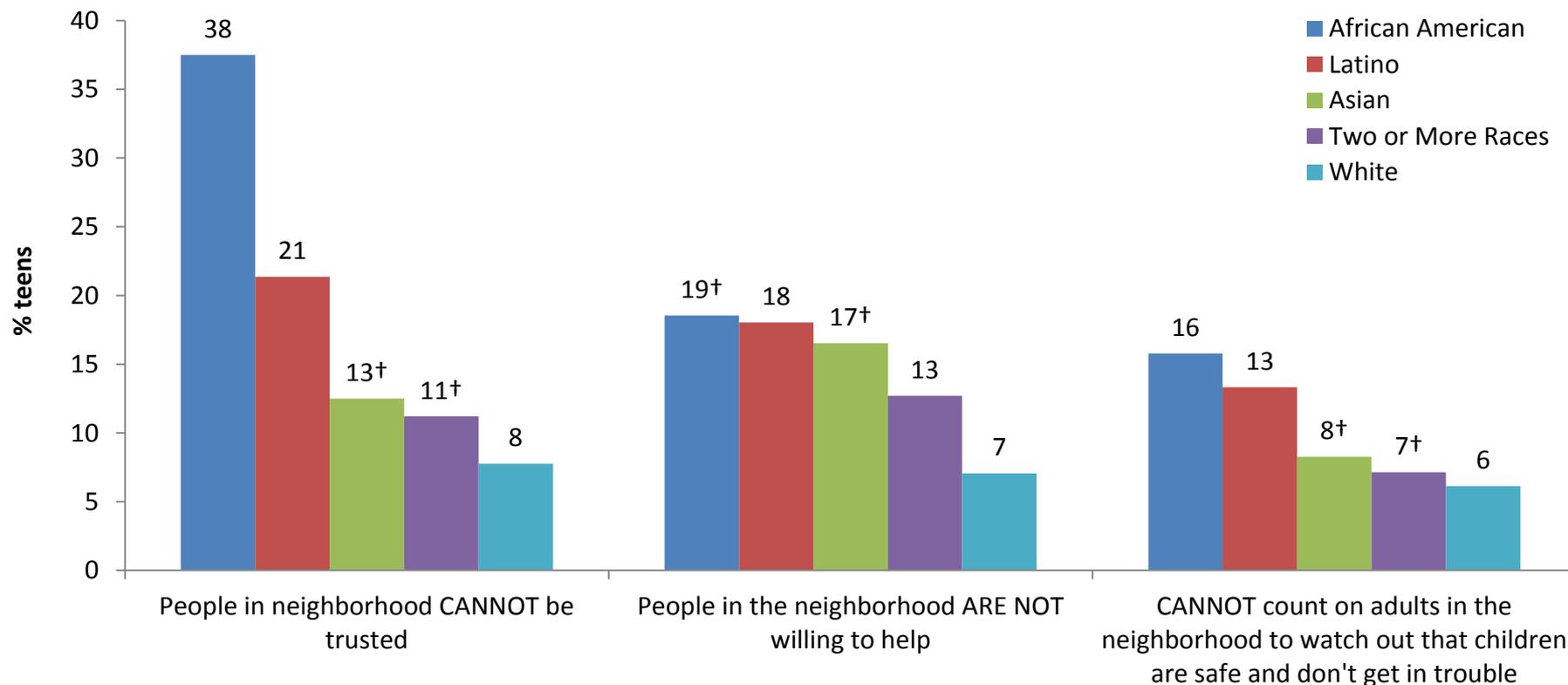
Data methodology and limitation are available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

† Statistically unstable

Low-income, according to UCLA Health Policy Brief, is defined as income less than 200% of the federal poverty level (FPL)

African American Teens Have Lower Perception Of Their Neighborhood Cohesion Compared To Teens Of Other Race/Ethnic Groups.

Figure 33. Perception of Neighborhood Cohesion Among Teenagers, Ages 12-17, by Race/Ethnicity, California, 2011-2012.



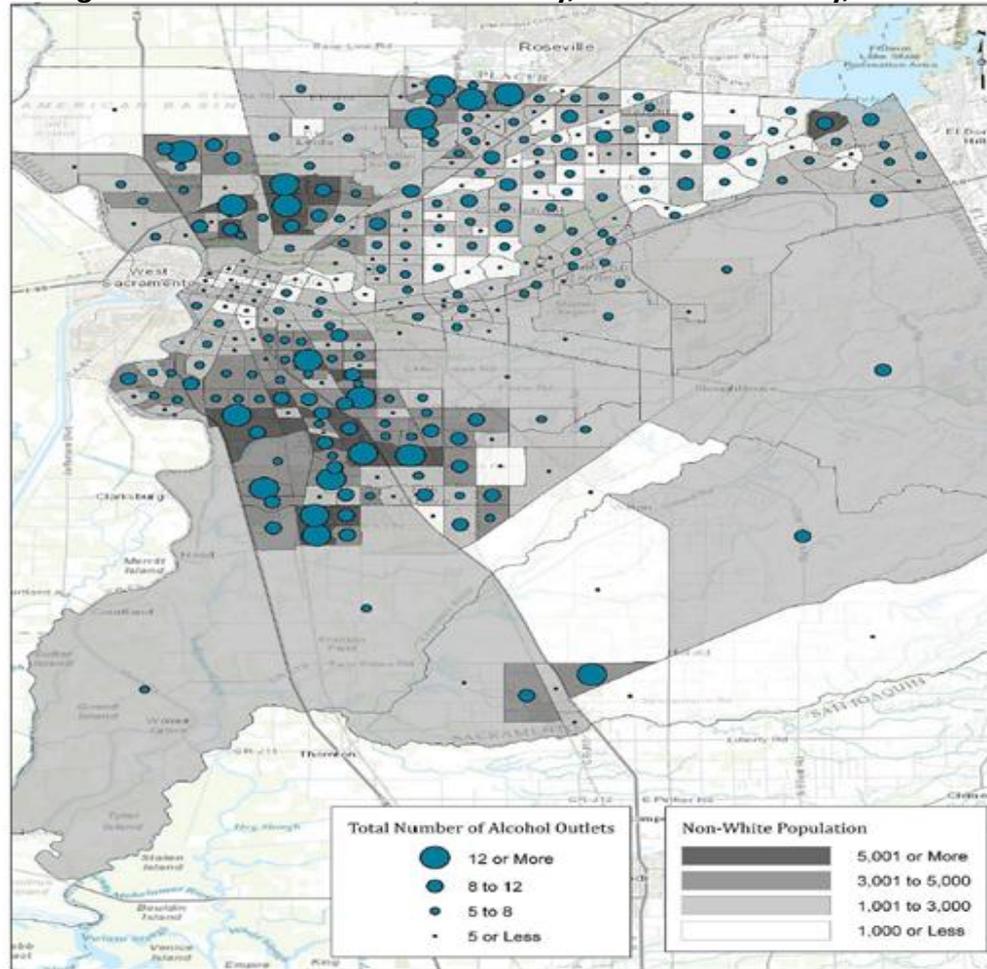
Source: UCLA, California Health Interview Survey, 2011-2012

Data methodology and limitation are available at: <http://healthpolicy.ucla.edu/chis/Pages/default.aspx>

† Statistically unstable

High Density Of Alcohol Sale Outlets In Non-White Neighborhoods.

Figure 34. Alcohol Sales Outlet Density, Sacramento County, 2010.



Source: Alcohol Beverage Control (ABC) Retail Authorization for both On-Sale and Off-Sale outlets. U.S. Census Bureau. Racial/ethnic disparities – A data informed perspective, a 2013 report from California Department of Alcohol and Drug Programs.