Background and Purpose

The Governor's Interagency Council on Health Disparities is charged with creating a state policy action plan to eliminate health disparities by race/ethnicity and gender and to update the plan regularly. In June 2010, the Council submitted its action plan to the Governor and Legislature. The plan focused on five priorities: education, health insurance coverage, healthcare workforce diversity, obesity, and diabetes. The Council's update in 2012 will focus on a new set of priorities: environmental exposures and hazards, poverty, behavioral health, adverse childhood experiences, and the state system.

This policy paper provides context and supporting research on poverty and health disparities for the 2012 update. The Council convened a poverty and health disparities advisory committee to review, prioritize, and identify policy recommendations for its consideration. The specific charge of the committee was to identify actions to reduce poverty and the impacts of poverty on health disparities by race/ethnicity and gender.

Poverty and Health Disparities

Economic factors are an influential determinant of health—your income determines how healthy you are and how long you live (Adler et al 2008). Income has such an influence on health because it shapes where you live, where you work, your personal behaviors, and your access to healthcare and other resources (Adler et al 2008, World Health Organization 2008). In the *Health of Washington State*, the Washington State Department of Health (2007a,b,c; 2012) examines health disparities by income for a variety of health outcomes and behavioral risk factors. Following are just a few examples:

- Increasing levels of household income were strongly associated with decreases in prevalence of current cigarette smoking—32% of adults with annual household incomes less than $20,000 reported current smoking compared to 12% with incomes of $50,000 or more.
- Data from 2008–2010 showed that as income increased, the percentage of adults reporting current asthma decreased. People with incomes less than $25,000 per year were nearly twice as likely to report asthma as people with incomes of $75,000 per year or more. This association persisted after accounting for gender, education, race and Hispanic origin.
- The prevalence of diabetes was 11% among households with annual incomes less than $20,000 compared to 4% among households with incomes of $50,000 or more.
- There is a significant association between having a personal health care provider and income—65% of people with annual household incomes less than $20,000 reported having a health care provider compared to 85% of those with incomes greater than $50,000.

Economic factors are an influential determinant of health—your income determines how healthy you are and how long you live.

Strong evidence demonstrating the effect of poverty on health comes from intervention studies. An example is from Mexico's Oportunidades Program, which provided direct cash transfers to women, contingent upon their use of nutrition, education, and health resources designed to promote positive health behavior changes (Fernald 2008a). The program was credited with improving childhood nutrition and development, increasing contraceptive use, reducing teenage pregnancy rates, improving hypertension control, reducing obesity, increasing vaccination coverage, increasing antenatal care usage, improving school attendance and performance, and improving food security (Fernald 2008a, Fernald 2008b, Feldman 2009, Andalon 2001, Barham 2009, Barber 2009, Behrman 2009, Todd 2011).

Health disparities exist, not only by level of income, but also by race/ethnicity. Such racial/ethnic health disparities are due in part to the effects of racism including perceived discrimination (Williams and Mohammed 2009), but also to the economic disadvantage experienced by communities of color (Adler et al 2008, Braveman 2009). In recognizing this, the Council chose to focus on poverty as one of its priorities in addressing health disparities by race/ethnicity.

Poverty in Washington State

In Washington State, there are an estimated 888,718 individuals living in poverty[1]—this is 13.4% of the State's population (U.S. Census Bureau 2010). Table 1 shows the poverty rate for women is higher than for men and large disparities in poverty exist by race/ethnicity.

Table 1: People in Washington Living Below Poverty Level

	Number	Percent
Total Population	888,718	13.4%
Males	405,361	12.4%
Females	483,357	14.5%
Non-Hispanic White	490,095	10.2%
Hispanic/Latino	215,546	29.0%
American Indian and Alaska Native	26,213	27.2%
Black or African American	60,263	26.5%
Native Hawaiian and Other Pacific Islander	7,952	20.5%
Asian	52,113	10.9%
Multiracial	51,836	17.6%

Source: U.S. Census Bureau, 2010 American Community Survey

Over the past few years, the poverty rate in Washington rose from 11.3% in 2008 to 12.3% in 2009 to 13.4% in 2010.[2] Poverty is also more common in rural Washington—15% in rural communities compared to 11% in urban areas. Per-capita income (2007 dollars) was $29,632 in rural communities relative to $42,831 in urban communities (Washington State Department of Health 2010a).

Washington has a long history of supporting low-income individuals and families through a strong system of income, health care, and social service supports. In recent years, however, the State has had to cut funding for key public programs despite growing demand for them as a result of budget shortfalls. From 2009 to 2011, $2.7 billion was cut from K-12 education, $1.7 billion from healthcare, $1.3 billion from higher education, and more than $700 million from other human services (Economic Opportunity Institute 2012). Such cuts result in decreased access to needed health and social services among low-income individuals and families, which ultimately undermines health and exacerbates health disparities (Centers for Disease Control 2011).

[1] Poverty status is determined by comparing annual income to a set of dollar values called poverty thresholds that vary by family size, number of children, and age of householder. For more information see "How Poverty Is Calculated in the ACS" at www.census.gov/hhes/www/poverty/methods/definitions.html.

[2] American Fact Finder. Selected economic characteristics, Washington State, 2008, 2009, 2010. Accessed at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml.

Poverty and Health Disparities Advisory Committee Process

Poverty is a broad and complex issue, and therefore, the Council's poverty and health disparities advisory committee invested time to define its scope and select focus areas for its recommendations. The committee discussed poverty as a social determinant of health and health disparities. Committee members discussed the Council's guidance to consider the target population age group of preconception to 3 years. They discussed how poverty in early childhood could affect one's health throughout the lifespan and into future generations.

In addition, the committee discussed the moral and ethical dimensions to its work. The committee agreed that how healthy you are or how long you live should not be determined by your income and/or the color of your skin. Therefore, the committee agreed to keep the individuals and families affected by poverty and health inequities central in their discussions.

> How healthy you are or how long you live should not be determined by your income or the color of your skin.

Committee members decided to focus both on preventing poverty as well as preventing the adverse effects of poverty. Committee members brainstormed the following potential areas of focus as they relate to poverty and health: asset development, the tax and redistribution system, living wage, employment, early learning, K-12 education, secondary and post-secondary education, empowering communities to make healthy choices, access to services, housing, and healthcare.

Through their experiences serving diverse communities and providing a variety of services, the committee agreed there is a need to increase capacity for services in underserved communities, including racially/ethnically diverse, low-income, and rural communities. More specifically, they agreed to focus on capacity development in the following areas: early learning, access to healthcare services in rural communities, and access to healthy foods. Further, committee members recognized that a lack of adequate funding was an ongoing barrier to increasing such capacity.

Recommendations to the Council

Increasing Capacity for Culturally and Linguistically Competent Early Learning Services

Education, just like poverty, is an influential determinant of health. Greater educational attainment has been shown to result in more positive health behaviors, better self-reported health, improved health outcomes, and longer life expectancy (Robert Wood Johnson Foundation 2009a). Moreover, greater educational attainment among parents is linked to better health for their children, demonstrating the intergenerational effects of poverty. An important predictor of educational attainment is high quality early learning. There is strong evidence that comprehensive early childhood and development programs are effective in preventing cognitive developmental delay and increasing readiness to learn (Anderson 2003). High quality early childhood development programs have been associated with higher test scores, reductions in special education, reductions in grade retention, reductions in school dropout, increase in high school graduation rates and college enrollment rates, and short-term gains in child IQ scores (Burr and Grunewald 2006). Early childhood development programs are such an important determinant of health that the Commission to Build a Healthier America recently concluded that, "…investment in early childhood development is likely the most effective way to improve the health of the nation" (Robert Wood Johnson Foundation 2009b).

Washington State is becoming more racially/ethnically and linguistically diverse[3], so the early learning system will need to respond to this changing demographic in order to be effective. The Washington State Department of Early Learning, the Office of Superintendent of Public Instruction, and Thrive by Five Washington are working together on an Early Learning State and Local Coordination Project in order to better connect families to early learning services. Toward this effort, the agencies conducted individual and group interviews to learn about barriers to finding and accessing early learning services[4]. The process identified a number of capacity and coordination barriers including: (1) there are not enough people who meet professional standards in some parts of the state and in some communities of color, (2) too few early learning and K-12 teachers have the preparation and tools to support children's learning in developmentally and culturally competent ways, and (3) some communities, such as rural areas and refugee and immigrant communities, are isolated and have unique challenges.

Recommendation I—Increasing Capacity for Culturally and Linguistically Competent Early Learning Services: Create additional capacity for bilingual/bicultural early learning programs through both training of early learning professionals and support of bilingual/bicultural providers on the pathway to getting licensed. The Department of Early Learning can support this by promoting cultural competency training for early learning professionals on the diversity of racial/ethnic, linguistic and socio-economic backgrounds of children and families they work with.

Increasing Capacity for Healthcare Services in Rural Communities

The *2012 Rural Health Care Strategic Plan for Washington State* (Washington Rural Health Connection 2012) documents a changing state population—one in which communities of color and communities in poverty are growing at faster rates in rural areas than in urban areas. The plan also documents a complex set of health issues faced by rural communities, including higher rates of obesity and smoking and lower rates of health insurance and access to a personal health care provider. Similarly, the Washington State Department of Health (2010a) reports that rural residents are more likely to be hospitalized; more likely to delay a medical visit due to cost; less likely to have an annual dental visit; and less likely to be screened for cervical, breast, and colorectal cancers. Moreover, as health reform provisions are implemented, more Washingtonians will have health insurance, posing a challenge to accessing healthcare services in rural communities (Washington Rural Health Connection 2012).

To address these issues, the rural health care strategic plan outlines a series of local and statewide strategies to maintain essential services as well as to transform the system in order to ensure and promote the health of rural Washington into the future. Included are strategies related to local public health, emergency medical services, primary care, community leadership and civic engagement, financing, ensuring an adequate supply of providers, health information technology, and quality improvement. The plan was developed with broad consensus from key stakeholders representing federal, state, and local public health; hospitals; community health centers; providers, and others.

Recommendation II—Increasing Capacity for Healthcare Services in Rural Communities: In an effort to sustain and improve the health of rural communities and to reduce health disparities for low-income and communities of color, the Legislature should support the strategies in the *2012 Rural Health Care Strategic Plan for Washington State*.

[3] Washington's population grew by 14.2% from 2000-2010 (Office of Financial Management, 2010). During this time, each of the communities of color grew at considerably faster rates (e.g., the Hispanic population grew by 54.9%). Communities of color make up more than a quarter (25.2%) of the state's total population. Washington is among the top ten states with the largest limited English proficient (LEP) population and the highest growth in LEP population (Migration Policy Institute 2011).

[4] Improving State and Local Coordination of Early Learning in Washington: Summary of Community Research. Available here: http://www.del.wa.gov/partnerships/elac/state-local.aspx.

Increasing Capacity to Access Healthy Food in Diverse Communities

The *Dietary Guidelines for Americans* (U.S. Department of Agriculture 2005) recommend eating a variety of fruits and vegetables, low fat dairy and meats, whole grains, and healthy fats within caloric needs while limiting intake of unhealthy fats, added sugars, sodium and alcohol. A nutritious diet can reduce the risk of obesity, high blood pressure, high cholesterol and chronic diseases like diabetes and cardiovascular disease (U.S. Department of Agriculture 2005, Washington State Department of Health 2007d). In Washington State, 26% of adults reported eating fruits and vegetables five or more times a day (Washington State Department of Health 2007d). The rate for Blacks and people of Hispanic origin was slightly lower (21% for each), though differences were not significant after adjusting for age, gender, income, and education. The percentage of adults reporting eating five or more servings of fruits and vegetables a day varied by income—20% among adults with annual household incomes less than $20,000 versus 27% in households with incomes greater than $50,000. Adults in rural areas are also less likely than those in urban areas to eat fruits and vegetables five or more times per day (Washington State Department of Health 2010b). In addition, food insecurity and hunger is more common among African Americans, Hispanics, and those in poverty (Children's Alliance 2011).

In 2010, Governor Gregoire issued Executive Order 10-02, which directed representatives from the Departments of Agriculture, Health, and Social and Health Services, along with the Office of Superintendent of Public Instruction and the Washington State Conservation Commission, to offer recommendations for improving the state's food system. In January 2012, an interagency workgroup consisting of state agencies and partners submitted a final report (Washington State 2012), which recommended the formation of a Food System Roundtable to provide a forum for discussion, information sharing, and to assist in coordinating efforts to improve the food system. The Food System Roundtable's primary aim would be to develop a 25 year vision for the food system in Washington State.

Recommendation III—Increasing Capacity to Access Healthy Food in Diverse Communities: The Department of Social and Health Services and the Department of Health should convene the Food System Roundtable, as recommended in the Report on Washington's Food System—Response to Executive Order 10-02. The Food System Roundtable should consider and include in its 25 year vision the needs of diverse communities in accessing healthy foods, including communities of color, immigrant, refugee, low-income, and rural communities. The interagency workgroup's agencies and partners should engage diverse communities to serve on the Food System Roundtable as well as to provide input into the 25 year vision.

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APPENDIX:
Increasing Capacity to Provide Social and Health Services through Revenue Generation

The poverty and health disparities advisory committee discussed the topic of increasing capacity to provide social and health services through revenue generation but could not come to consensus. Therefore, the committee agreed not to forward a recommendation to the Council for its consideration. This appendix and the following recommendation are provided by the following members of the poverty and health disparities advisory committee for informational purposes only: Nathan Furukawa (primary author), Jacqueline Jones-Walsh, Faaluaina (Lua) Pritchard, Marcia Meyers, Flor Alarcon Avendana, and Tutrecia Giles.

Taxation and Revenue in Washington State

For the fiscal year 2013, Washington State is projected to have a budget shortfall of $3.1 billion, representing an estimated 19.6% of the 2013 budget for the state (Oliff 2012). While the economy has slowly improved in recent years, the recovery of revenue in Washington State is slow. As a result Washington State has had to cut funding for key public programs despite growing demand for them. From 2009 to 2011, $2.7 billion was cut from K-12 education, $1.7 billion from healthcare, $1.3 billion from higher education, and more than $700 million from other human services (Economic Opportunity Institute 2012). Despite these cuts, Washington still has the 4th highest budget shortfall as a percent of the 2013 budget (Oliff 2012).

The primary reason for the budget shortfall is weak tax collections. The average combined local and state tax burden on Washingtonians is $93.24 per every $1,000 of income (Office of Financial Management 2011). This is below the national average of $102.10 per $1,000, despite Washington having the 13th highest per capita income. This places Washington as 35th lowest in the nation and 9th lowest among the 13 western states. Moreover, the current tax burden represents the lowest tax rate in Washington in the past 50 years (Office of Financial Management 2011).

The reason behind Washington's low taxes relative to income lies in its overreliance on consumption taxes to generate revenue. Among all states, the top three sources of revenue come from individual income tax (34.2%), general sales and gross receipt taxes (31.0%), and selective sales taxes (17.4%) (U.S. Census Bureau 2011). By contrast, top revenue generators for Washington were the retail sales tax (44.9%), B&O tax (18.8%), and selective sales tax (13.4%) (Office of Financial Management 2011).

Due to the absence of a state income tax, Washington relies largely upon general and selective sales tax revenues to fund its operational budget. Accordingly, Washington has the 4th highest state and local average combined sales tax rate in the country at 8.79% (Drenark 2011). As sales taxes generate revenue from consumption, they do not increase robustly during periods of economic gain (Economic Opportunity Institute 2011). As personal income grew from $50 billion in Washington in 1979 to about $320 billion in 2012, the taxable retail sales grew from $25 billion to $100 billion over the same period. Revenue has grown much slower relative to the economy (Office of Financial Management 2011).

Disproportionate Taxation of Low-Income Earners

Washington State's overreliance on consumption taxes places a disproportionate tax burden on the poorest Washingtonians. A report by the Institute for Taxation and Economic Policy found that Washington had the most unequal tax system in the nation, defined by the ratio of the percentage of income paid to state and local taxes of the poorest 20% compared to the percentage of income paid to state and local taxes by the top 1% (Davis 2009). In Washington, the poorest 20% paid 17.3% of their

income to state and local taxes compared to the top 1% paying 2.6%; equating to a ratio of 6.7. By comparison, the most equal states, New York, South Carolina, and Vermont, had ratios of 1.3, 1.3, and 1.1, respectively. The report concluded that Washington's lack of a progressive income tax to offset regressive sales and excises taxes were responsible for its ranking as the state with the most regressive tax system.

Poverty and Health Disparities

The burden of poverty on health is complex and related to individual behaviors; social and community networks; working and living conditions; and socioeconomic, cultural, and environmental circumstances (WHO 2008). At an individual level, decreased income due to a high burden of taxation decreases an individual's disposable income which limits access to health promoting activities, such as healthy eating, stable housing, and utilization of health services. At a more distal level, the disproportionate taxation of the poor undermines the effect of taxes and transfers in reducing poverty (UNICEF 2012). As less revenue is generated, programs that alleviate poverty in both the long and short term are cut or eliminated, hindering economic mobility.

Consideration of Alternatives

Washington State has the opportunity to enact a more equitable tax system that has the ability to reduce health disparities and find additional revenue to close its budget deficit and continue to provide social and health services. This is timely given the Washington State Supreme Court's ruling that the State was not meeting its constitutional duty to provide education for its children and its demand that the legislature finds additional revenue for education (McCleary v. State 2012).

Several options have been considered, including the increase in sales tax, the introduction of an individual income tax, and a tax on capital gains. One consideration to raise revenue is to increase the sales tax rate from its current rate of 6.5% to 7.0% until July 1st, 2015, which would raise an estimated $494 million per year for the state in FY2013 (Office of the Governor 2011). While this may generate funds for the immediate future, the increasing reliance on regressive consumption taxes further exacerbate the burden of taxation on the poor, thereby exacerbating health disparities.

In 2010, WA State considered adding an income tax on top earners through Initiative 1098 (I-1098). The initiative would have added an income tax to Washingtonians making more than $200,000 or jointly more than $400,000 and would have amounted to approximately 4% tax on the top 1% of earners (Watkins 2010). It was estimated to generate $11.2 billion over five years and have an estimated cost of $39.3 million (0.4%) for state implementation over that same period (Office of Financial Management 2010). The initiative was ultimately voted down 36% to 64%.

The benefits of an income tax are that it is progressive; robustly grows with the economy; can allow for the taxation of intangible wealth from stocks, bonds, and capital gains; can be administered in tandem with the federal income tax system; and can allow for tax breaks to specific sectors, industries, or individuals (Watkins 2008). The amount of revenue generated depends on the tax schedule. For instance, an income tax on incomes over $100,000 (single; $200,000 joint) is estimated to generate $2.06 billion biennially at a top marginal rate of 3% and $3.43 billion biennially at a top marginal rate of 5%. The detriment of such a tax is that it is subject to declines during recessions and decreased earnings (St Louis Federal Reserve 2010).

Finally, a tax on unearned income including income from interest, dividends, and capital gains has previously been considered. A capital gains tax of 5% would generate an estimated $727.5 million per year with a $5,000 exemption (single; $10,000 joint) or $698 million with a $10,000 exemption (single; $20,000 joint) (Office of the Governor 2011). Washington remains one of six states in the nation that do

not tax unearned income and it represents an opportunity to generate additional revenue without exacerbating the burden on the poorest households (Watkins 2008).

In examining revenue options, longer-term considerations for the stability of tax revenue should be addressed. Data demonstrate that states with overreliance on a single source of revenue are more subject to budget fluctuations and shortfalls (St Louis Federal Reserve 2010). According to the Herfindahl-Hirschman Index which is a measure of the diversity of state revenue sources, Washington ranks 5th least diverse. Washington's reliance on sales taxes to generate 58.3% of its budget contrasts to New Hampshire, the state with the most diverse revenue sources, which generates its revenue equally from sales, individual income, property, corporate, and other sources. As such, New Hampshire has more consistent revenue that is subject to fewer fluctuations and crises. The National Conference of State Legislatures (2007) recommends a balanced range of revenue sources as a key principle of high-quality state revenue systems.

In addition, there is growing evidence that increases in taxes on high-income households from their current rate would not harm the economy, but may in fact strengthen it through public investment (Huang 2012). Despite claims otherwise, upper income taxpayers do not change their economic behavior in response to changing tax rates (Saez 2010). Further, the labor and work force at high incomes are shown to be insensitive to changes in income tax rates (Huang 2012). While some argue that capital gains taxes reduce private savings, the Congressional Research Service (CRS) concludes that "capital gains tax rate increases appear to increase public saving and have little to no impact on private savings" (Hungerford 2011). Further, the CRS finds that higher tax rates are more likely to encourage entrepreneurship (Gravelle 2011). Finally, the Congressional Budget Office has concluded that in the context of the federal income tax, which parallels what a state income tax would resemble, its increase would strengthen long-term economic growth because the negative impact of economic growth from increased taxes would be offset by the reduction in budget deficits, gains from public investments, and growth in public education, basic research, and infrastructure (Elmendorf 2010). Raising taxes to generate more revenue for public services is, therefore, a sound option to confront the challenges presented by the existing budget deficit.

Recommendation

In order to reduce health disparities, Washington State must decrease the burden of taxation it imposes on lower income households and ensure the stability of institutions and programs that facilitate economic mobility. Washington State should do this be ensuring diversification of revenue sources that rely more heavily on progressive taxes and less heavily on regressive taxes.

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