# GOVERNOR'S INTERAGENCY COUNCIL ON HEALTH DISPARITIES

# STATE POLICY ACTION PLAN
## TO ELIMINATE HEALTH DISPARITIES

JANUARY 2024 UPDATE


**Governor's Interagency Council on Health Disparities**

PO Box 47990
Olympia, WA 98504-7990
Phone: 360-236-4110, TTY 711
Fax: 360-236-4088
E-mail: healthequity@sboh.wa.gov
Web: http://healthequity.wa.gov

# CONTENTS



# EXECUTIVE SUMMARY

The Governor's Interagency Council on Health Disparities (Council) was created by the state Legislature in 2006. Currently, our primary role is to identify priorities and create a state policy action plan to eliminate unjust health disparities (health inequities) by race/ethnicity and gender in Washington. Our work is authorized by chapters 43.20.270, 43.20.275, and 43.20.280 RCW.

Over the past 17 years, the Council has grown our understanding by hearing from community about health equity issues, convening subcommittees on priority topics, conducting special projects at the Legislature's direction, creating policy recommendations and reports, and promoting interagency collaboration.

## FOUNDATIONAL TRUTHS

The Council's redesign and this State Action Plan update are informed by our learnings and these foundational truths:

- Racism is a public health crisis.
- The COVID-19 pandemic has highlighted and magnified the human cost of health inequities.
- Climate change affects us all, exacerbates inequities, and must be addressed through a racial equity and intersectional lens.
- We are interconnected.
- There are many dimensions to health and well-being.
- Community holds inherent power.

Throughout this report, we use the term **"health inequities"** to describe differences in health outcomes that are unfair, unjust, and avoidable. Most differences in health are due to inequities, which refer to how the unequal and unfair distribution of resources in our society creates worse health outcomes for certain communities, including but not limited to communities who are Black, Indigenous, and People of Color (BIPOC), women, transgender, non-binary, experiencing poverty, living in rural areas, speakers of a language other than English, veterans, refugees, immigrants, living with disabilities, youth, LGBTQ+, and who have other marginalized identities.

Health inequities are neither coincidental nor random: they are an injustice that is perpetuated by our intentionally built systems and structures. Eliminating health inequities requires addressing inequities in our systems, structures, and culture, which are built on historical injustices stemming from slavery and genocide. This effort requires coordinated action to **address root causes**, such as classism, racism, anti-Indigeneity, sexism, geographic isolation, ableism, homophobia, transphobia, and discrimination based on immigration or documentation status.

**Racism is a public health crisis.** Racism harms us all by causing dire impacts on public, community, and individual health. As one example, the **ongoing COVID-19 pandemic** has highlighted and magnified the human cost of racism and health inequities, emphasizing how government is not currently structured in a way to respond to crises without leaving broad groups of people behind.

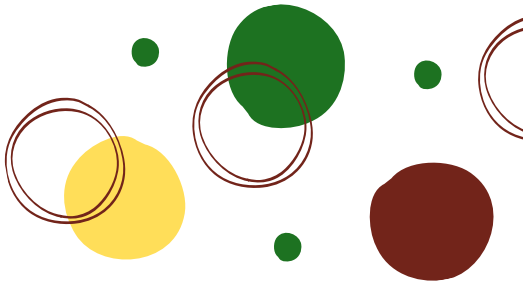
Inequities have been replicated and magnified in every disaster, placing a greater burden and irreplaceable losses on communities already experiencing marginalization. Washington must be prepared to handle multiple emergencies at once, such as environmental disasters, pandemics, and social disasters. Of particular significance is **climate change**, which threatens everyone's health and well-being, exacerbates inequities, and must be addressed through a racial equity and intersectional lens. Racism, the COVID-19 pandemic, and the climate crisis further demonstrate that we are interconnected with each other and with the natural environment.

For long-term prosperity and resilience, Washington must go beyond addressing gaps and reacting to crises. The Council believes that health is more than the absence of disease and consists of multiple, interdependent dimensions (mental, physical, social, environmental, etc.). Health is powerful and is at the foundation of all we do. We must work together, led by **communities' inherent power**, to reach toward the highest conceivable standards of health and well-being, so that all Washingtonians can attain **optimal health and well-being**.

## RECOMMENDATIONS

A resilient, thriving Washington state requires dedicated, sustained efforts to eliminate health inequities and advance health justice and equity. **Health equity** only exists when we all have the opportunity to reach our full potential. **Health justice** provides a framework to achieve lasting health equity goals and includes:

- Collaboration across areas of study and work
- Upstream interventions that address root causes of inequities
- Racial justice
- Adaptability
- Advocacy for systems change
- Community-based strategies



In this report, the Council recommends the following strategies to advance health justice and address health inequities in Washington.

**1. Pass legislation to update the Council's authorizing statute**

- Update the Council's name to "Governor's Council for Health Justice and Equity."
- Enable the Council to create a Health Justice vision and policy recommendations that guide state actions toward enduring health equity and optimal health for all.
- Align with initiatives that unify partners and reinforce accountability (e.g., state Pro-Equity and Anti-Racism – PEAR, environmental justice, and economic justice strategies).
- Center community voice and participatory processes.
- Update membership and structure to better reflect community experiences and allow the Council to address complex, evolving priorities.
- Grant the Council express authority to:
  - Use findings from Health Impact Reviews to inform strategies;
  - Take a position on policy; and
  - Independently endorse other groups' policy recommendations.
- Update Council reporting requirements.

**2. Increase funding for the Council through the state operating budget, so the Council can**:

- Hire and retain staff for research, analysis, policy development, communications, administration, Tribal relations, and community engagement.
- Fully operate and create meaningful, enduring relationships and strategies.
- Hold hybrid and accessible public meetings throughout the state so communities have a meaningful chance to participate.
- Use communication tools to share information, build connections across communities, and support collaboration.
- Provide language assistance services.
- Provide stipends and other supports to workgroup participants to remove barriers to participation.

Additional information on these recommendations begins on page 20.

# COUNCIL ACTIVITIES

The Council's authorizing statute (chapters 43.20.270, 43.20.275, and 43.20.280 RCW), the law that governs our work, directs the Council to address certain health topics on an incremental basis along with addressing the social determinants of health.

Since our creation in 2006, the Council has worked with partners to identify priorities, convene advisory committees, and create policy recommendations. The Council released the first State Action Plan in 2010 and has published periodic updates since. In addition to the list of health conditions and indicators mentioned in our statute, we have created recommendations on:

- Access to healthy food
- Health insurance coverage
- Healthcare services capacity in rural areas
- Healthcare workforce diversity
- Educational opportunity gaps
- Behavioral health
- Reproductive health access
- Environmental exposures and hazards
- Poverty reduction
- Disaggregated data
- Culturally and linguistically appropriate services
- Equity in state government
- Community engagement

The Council is also guided by our operating principles: embrace equity; focus on racism; prioritize social determinants of health; center community; commit to bold action; and be vigilant for unintended consequences (see Appendix A).

In all we do, the Council strives to center community voice and expertise.

"CENTER COMMUNITY: We recognize that we can only achieve health equity if communities impacted by health inequities are at the center of our work. We acknowledge that communities know best their assets, needs, and solutions. We strive to recognize and share power and structure our meetings to foster meaningful engagement. We will find opportunities as a Council, individual members, and staff to attend community meetings to listen, learn, and seek input to guide our work. We will strive to incorporate stories of lived experience into our reports and recommendations." (Excerpt from Council Operating Principles, adopted 2019)

## Council Activities between 2019 - 2023

- **July 2019 – October 2020:** At the direction of the Legislature, the Council convened and staffed the Office of Equity Task Force and the Environmental Justice Task Force.
- **January 2020:** The Council released a State Action Plan update with new recommendations.
- **January - March 2020:** State, national, and global health emergencies were declared concerning COVID-19.
- **March – September 2020:** Council staff was activated to support Washington state's response to the COVID-19 pandemic.
- **October 2020 – December 2022:** At the direction of the Legislature, the Council convened and staffed the Social Equity in Cannabis Task Force.
- **2020 – 2021:** The Council met less frequently due to reduced staff capacity.
- **January – March 2022:** Council Manager staff transition.
- **Spring – Fall 2022:** The Council resumed quarterly meetings and began the Redesign Process, including collaborative redesign workshops.
- **Summer 2023:** The Council organized a community engagement road trip to learn about partners' visions and priorities.
- **Fall 2023:** The Council submitted request legislation and a decision package (fiscal request) to the Governor's Office for consideration.

*The Council has one permanent staff position (1.0 FTE Council Manager), and staff capacity largely determines the Council's ability or inability to convene and to maintain momentum on shared priorities. It is significant to note how Council staff have been assigned to various projects over the past four years, including the COVID-19 pandemic response and legislatively mandated task forces. When convening a task force, Council staff have hired, onboarded, and supervised project staff; worked with the Governor's Office and Legislature on member appointments for the new workgroup; supported new staff and workgroup members in establishing workgroup governance and norms; assisted in facilitation, relationship building, research, and policy development; provided support and oversight for community and partner engagement and report writing; and more.*

# COUNCIL MEMBERSHIP

The Council currently has 17 members:
- A chair who is the Governor or the Governor's designee;
- Representatives of 14 state agencies, boards, and commissions; and
- Two members of the public who represent healthcare consumers.

A list of current Council members is provided below. The Council's interagency structure allows us to have a statewide and broad approach to addressing health inequities. The Council considers not only health and healthcare issues, but also the social factors that influence health and well-being, such as education, economic well-being, civic engagement, and the environment.

## Current Membership of the Governor's Interagency Council on Health Disparities

Governor's Representative and Council Chair: **Benjamin Danielson**

Consumer Representative and Council Vice Chair: **Victor Rodriguez**

Consumer Representative: **Leah Wainman**

American Indian Health Commission[1]: **Willie Frank**; *JanMarie Ward (alternate)*

Commission on African American Affairs: **Sara Franklin-Phillips**

Commission on Asian Pacific American Affairs: **Lydia Faitalia**

Commission on Hispanic Affairs: **Jessica Hernandez,** *María Á. Sigüenza (alternate)*

Department of Agriculture: **Nicole Johnson**; *Kelly McLain (alternate)*

Department of Commerce: **Diane Klontz**; *Kendrick Stewart (alternate)*

Department of Children, Youth, and Families: **Greg Williamson**; *Jennifer Helseth (alternate)*

Department of Ecology: **Millie Piazza**; *Courtney Cecale (alternate)*

Department of Health: **Elizabeth Perez**

Department of Social and Health Services: **Jessica Zinda**

Health Care Authority: **DoQuyen Huynh**; *Lena Nachand (alternate)*

Office of Superintendent of Public Instruction: Vacant

State Board of Health: **Stephen Kutz**; *Michelle Davis (alternate)*

Workforce Training and Education Coordinating Board: **Renee Fullerton**

[1] The Governor's Office of Indian Affairs delegated authority to the American Indian Health Commission to appoint a representative to the Council.

# REDESIGN PROCESS

# COUNCIL REDESIGN PROCESS

## PURPOSE

Several years ago, the Council began discussing the need to redesign our statute to incorporate our many years of work and learning. We have gathered these learnings through hearing about health equity issues from community, convening subcommittees on priority topics, conducting special projects at the Legislature's direction, creating policy recommendations and reports, and promoting interagency collaboration over the past 17 years. The redesign is meant to incorporate what we have learned alongside partners and create opportunity for greater collective impact.

**KEY LESSON:**
The Council heard from our advisory committees and members of the public, particularly communities most impacted by inequities, that Washington needs to address structural and institutional inequities in our state system as a key strategy to eliminating health inequities.

> *Resources are often designed to make us feel better without changing the systems that are making us sick.*
> ~ Community partner

**KEY LESSON:**
The compass should always be community. Partners shared that the Council needs to develop goals and do work that meets community expectations, and communities must be engaged in every step of the process.

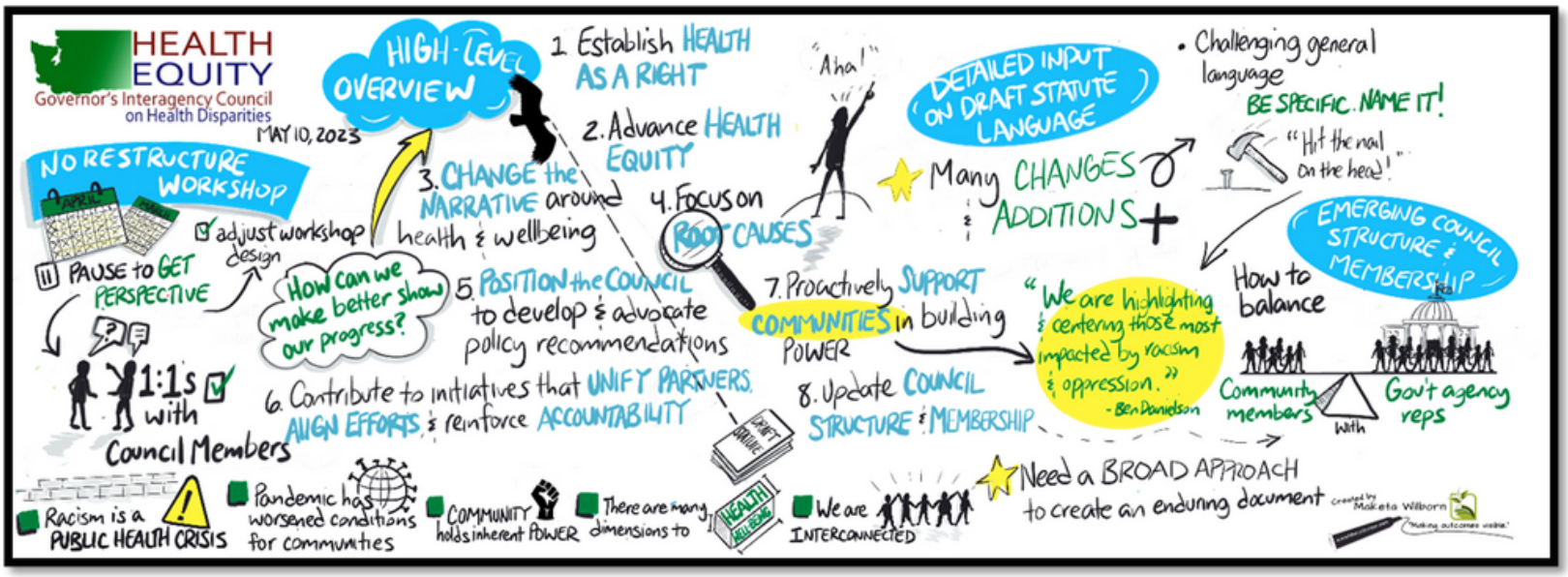
> *We already know what the problems are and have solutions - we just need people to listen to us.*
> ~ Community partner

## PROCESS

Since November 2022, the Council has been holding a series of public redesign workshops. We have also connected with key partners in community and government to learn how the Council can lead or support unified goals for health and well-being. Partners offered insight on how the Council could better engage communities as well as align with partners' visions and priorities to address health inequities and advance health justice and equity.

> *How [does the state] create policy for people [it doesn't] even know exist?*
> ~ Community Partner

## Visual Summary of the May 10, 2023 Redesign Workshop




### 2023 Community Engagement Road Trip

The Council organized 16 hybrid community outreach meetings during July and August 2023 to learn from organizations working in community to eliminate health disparities and promote health equity. We heard about community partners' visions and priorities, including strategies partners are centering as they serve communities and grow capacity.

The Council also heard recommendations from partners on how the Council could operate in the future to move toward meaningful, collective impact on health justice, equity, and well-being. Many of these recommendations are incorporated in our request legislation and decision package (see pages 20-24 for Council recommendations on statutory changes and fiscal investment).

## Learnings from 2023 Community Engagement Road Trip

**Community partners' visions and priorities:**

- Promote holistic health.
- Health looks like so many different things.
- Focus on the social determinants of health: food access, education, safety at work, air quality, quality housing, protection from pesticides, and so much more.
- Health and well-being can only happen with attention to relationships and culture.
- Move toward shared well-being and belonging.
- Healing is necessary for health and well-being.
- Health and well-being require systems change and a focus on addressing racism.
- Civic engagement is essential to systems change and health.
- Health should not be linked to work status, income, insurance coverage, or ability.
- Everyone should have quality healthcare services.
- People need access to culturally appropriate services (healthcare providers, navigators, follow-up, wraparound care, etc.).
- Language access is critical and remains a huge need.
- Address health workforce supply and service availability.
- While workforce diversity is important, it is not enough—health systems need to change to better serve people.
- Climate, energy transition, and utilities are all health equity issues.
- Organizations need stable and flexible funding so they can serve marginalized communities.

**Community partners' recommendations for Council operations:**

- Promote a flow of information, including information and data from community, information on policy status and implementation, and the Council's learnings and recommendations.
- Connect, convene, and help build relationships across partners. Build a statewide infrastructure that allows organizations to coordinate with the Council and with each other.
- Support transparency and systems navigation.
- Promote civic engagement and vitality. Create spaces for under-resourced community organizations. Create space for elder and youth voices.
- Co-design and co-create with community. Focus on community-led strategies instead of recycling research on disparities. Global, cross-system goals should be developed by the most impacted groups.
- Work on big issues together: health equity, systemic racism, incarceration, racial wealth gap, language justice, etc.
- Incorporate equitable and liberating principles within the Council. We cannot have equitable outcomes without equitable processes.
- Enact a cohesive community engagement strategy and communications strategy. "Set the table" in government and make it ready for community voice. True access includes considerations of language, internet access, ability to read/write, etc.
- Learn about communities across the state (they are not all the same) and maintain reciprocal relationships.
- Integrate the Council's work in all state agencies.
- People need to see that government is taking action in meaningful ways.
- Fully staff and resource the Council to do this work.

# FOUNDATIONAL TRUTHS

These foundational truths provide shared purpose and meaning for this redesign:

- Racism is a public health crisis.
- The COVID-19 pandemic has highlighted and magnified the human cost of health inequities.
- Climate change affects us all, exacerbates inequities, and must be addressed through a racial equity and intersectional lens.
- We are interconnected.
- There are many dimensions to health and well-being.
- Community holds inherent power.

Research shows that clinical care has a smaller impact on our health than the resources we have access to and the conditions where we live, learn, work, and age (social determinants of health). [2],[3] Instead of using the term "health disparities," which hides the unfair, unjust, and avoidable nature of most differences in health, the Council uses the more accurate term **"health inequities"** to refer to how the unequal and unfair distribution of resources in our society impacts health and well-being, leading to poorer health outcomes and shorter life expectancies experienced by communities of color and additional marginalized communities. In short, health inequities are neither coincidental nor random: they are an injustice that is perpetuated by our intentionally built systems and structures.

Communities who are Black, Indigenous, and People of Color (BIPOC), women, transgender, non-binary, experiencing poverty, living in rural areas, speakers of a language other than English, veterans, refugees, immigrants, living with disabilities, youth, LGBTQ+, and who have other marginalized identities experience poor health outcomes that are unfair, unjust, and avoidable.

**State policy and law are determinants of health** and play an important role in where environmental harm is concentrated in our state, who gets or is denied access to quality and affordable healthcare services, equity or inequity in labor, meaningful opportunity for or denial of educational attainment, and more. Our state and country have a painful history of harmful policies, including but not limited to colonization of Tribal lands and the Hawaiian and Pacific Islands, nuclear testing and decimation in the Compact of Free Association Islands, Chinese exclusion, Japanese American incarceration, redlining, segregation, and laws banning interracial marriage.

**Eliminating health inequities requires addressing inequities in our systems, structures, and culture, which are built on historical injustices with roots in slavery and genocide**. Centuries of colonial and imperial practices aimed at destruction of communities and culture have resulted in historical trauma and intergenerational trauma that continue to negatively impact the health and well-being of people who live in Washington. Acknowledging and addressing historical trauma are first steps to repairing harm, and we must rebuild our state government system to avoid causing harm in the first place.

[2] https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/
[3] https://pubmed.ncbi.nlm.nih.gov/26526164/

**Historical trauma:** "[S]ituations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent."

- Indian Health Improvement Act, Chapter 43.71B RCW

Through research and the expertise of our community partners, we know that addressing health inequities requires coordinated action to **address root causes** that are "diverse, complex, evolving, and interdependent in nature."[4] Root causes include but are not limited to classism, racism, anti-Indigeneity, sexism, geographic isolation, ableism, homophobia, transphobia, and discrimination based on immigration or documentation status.

[4] https://www.ncbi.nlm.nih.gov/books/NBK425845/

## Racism is a Public Health Crisis

The Centers for Disease Control and Prevention (CDC) states, "A growing body of research shows that centuries of racism in this country has had a profound and negative impact on communities of color. The impact is pervasive and deeply embedded in our society—affecting where one lives, learns, works, worships and plays and creating inequities in access to a range of social and economic benefits—such as housing, education, wealth, and employment."[5] Across a variety of measures of health outcomes, healthcare, and social determinants of health (e.g., food security, quality housing, interaction with the police), people of color and American Indian/Alaska Native people have worse experiences and outcomes than white people.[6],[7]

> *"Racism IS a public health crisis.*
> *~Community Partner*

Racism harms us all by causing dire impacts on public, community, and individual health. There have been at least 250 statements across the nation declaring Racism as a Public Health Crisis, adopted by cities/towns, counties, state governors, school boards, health associations, and public health departments.[8]

According to the Network for Public Health Law, "[t]reating racism as a public health crisis means recognizing that it affects entire groups of people, not just individuals, and that proposed solutions must be focused on policy and systems change rather than individual behaviors."[9] The American Public Health Association finds "[t]hese declarations are an important first step to advancing racial equity and justice and must be followed by allocation of resources and strategic action."[10]

Although the WA State Board of Health, the WA State Public Health Association, and some local and public health jurisdictions in Washington have declared Racism Is A Public Health Crisis, Washington state as a whole has not yet made such a declaration.

[5] https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/
[6] https://www.cdc.gov/minorityhealth/racism-disparities/index.html
[7] https://www.kff.org/racial-equity-and-health-policy/report/key-data-on-health-and-health-care-by-race-and-ethnicity/
[8] https://www.apha.org/-/media/Files/PDF/topics/racism/Racism_Declarations_Analysis.ashx
[9] https://www.networkforphl.org/resources/topics/racism-as-a-public-health-crisis/
[10] https://www.apha.org/Topics-and-Issues/Racial-Equity/Racism-Declarations

**Health inequities, due to racism and other systems of oppression, cost us all and have a large, avoidable financial toll on our state and country.** Nationally, health inequities lead to "delayed care, access barriers, missed diagnoses and limited access to preventive services and scientific advances" that result in roughly $42 billion in lost productivity each year.[11] According to the 2022 Black Well-Being Report, "[r]esearch shows that 30% of medical costs for Black, Hispanic, and Asian Americans are excess costs related to health inequities."[12] Additionally, the overall economic burden of health inequities on minoritized racial/ethnic populations has been estimated at $421-$451 billion and the economic burden on adults without a 4-year college degree has been estimated at $940-$978 billion. These costs come in the forms of "excess medical care expenditures, lost labor market productivity, and the value of excess premature death."[13]

Disparate impacts of the COVID-19 pandemic and response are directly linked to racism's harmful effects on our health and well-being. **The COVID-19 pandemic has highlighted and magnified the human cost of health inequities, emphasizing how government is not currently structured in a way to respond to crises without leaving broad groups of people behind.**

Negative social, economic, and health impacts from the COVID-19 pandemic will continue to reverberate throughout the state and future generations. Generational impacts include the exponential effect of missed educational attainment, "profound effects on the Washington labor market,"[14] and the most significant decline in life expectancy in the U.S. in the past century. "[O]verall U.S. life expectancy declined by 2.7 years between 2019 and 2021, American Indian and Alaskan Native (AIAN) people experienced a decline of 6.6 years, Hispanic people and Black people dropped 4.2 and 4 years, respectively, compared to a decline of 2.4 years for [w]hite people and 2.1 years for Asian people."[15] When data are disaggregated, we see that Native Hawaiian and Pacific Islander people in Washington continue to experience much higher rates of COVID-19 contraction, hospitalization, and death compared to white people[16] due to deeply entrenched health inequities caused by structural racism and other forms of oppression.

**The COVID-19 pandemic is not over—people continue to die.** As of November 18, 2023, there have been 16,589 recorded deaths in Washington associated with COVID-19. At the time of writing, there have been 262 COVID-19 associated deaths since the start of the current respiratory season (beginning October 2023).[17] Communities will struggle for many years to survive and recover.

[11] https://www.ama-assn.org/delivering-care/health-equity/inequity-damages-health-and-drains-economy
[12] https://www.blackfuturewa.org/blackwell-being
[13] https://jamanetwork.com/journals/jama/fullarticle/2804818
[14] https://esd.wa.gov/labormarketinfo/covid-19-economic-data
[15] https://www.kff.org/racial-equity-and-health-policy/press-release/recent-widening-of-racial-disparities-in-u-s-life-expectancy-was-largely-driven-by-covid-19-mortality/
[16] https://doh.wa.gov/sites/default/files/2022-02/COVID-19MorbidityMortalityRaceEthnicityLanguageWAState.pdf
[17] *According to the Washington State Department of Health, "COVID-19 death data may be underrepresented due to various factors that currently and historically impact reporting. Only death data reported officially to Washington State through death certificates and positive reported labs into WDRS reporting system are used in the counts in the dashboard. COVID-19 deaths early in the pandemic may not have been captured and reported due to the lack of available testing. Currently, deaths of persons who only tested with a home testing kit, may not have had COVID-19 listed as a cause of death, and are not counted."* (https://doh.wa.gov/data-and-statistical-reports/diseases-and-chronic-conditions/communicable-disease-surveillance-data/respiratory-illness-data-dashboard)

> *I have hope for more change. We saw our Latino communities left behind during the pandemic.*
> ~ Community Partner

**Washington must be prepared to handle coinciding emergencies, such as environmental disasters, pandemics, and social disasters, without leaving broad groups of people behind.** Inequities have been replicated and magnified in every disaster, placing disparate burden and irreplaceable losses on communities already experiencing marginalization. A University of Washington assessment conducted during the COVID-19 pandemic shows that "[f]armers, ranchers and growers in eastern Washington, and BIPOC and military veteran farmers, tended to experience a greater financial impact compared to other food producers in the state" while "[f]armers were already facing other challenges, from worker shortages to wildfires and heat waves related to climate change."[18]

**Climate change affects us all, exacerbates inequities, and must be addressed through a racial equity and intersectional lens.** The Washington State Department of Health (Department) examined excess deaths in Washington between 2020 – 2021 when our state was experiencing both the COVID-19 pandemic and a heat dome. The Department found that "there were 7,367 (12 percent) more deaths than expected" and "the true burden of the heat dome and COVID-19 is higher than the number of deaths directly attributed to either event."[19] Furthermore, "[i]n the two-year period, excess death rates were highest for American Indian/Alaska Native (AI/AN), Native Hawaiian and Other Pacific Islander (NHOPI), and Black persons."[20] The Department found, "[t]he six weeks of the heat dome were among the deadliest weeks of 2020 and 2021. Heat waves and heat domes have become more common, and it is likely that this trend will continue."[21]

**These crises demonstrate that we are interconnected with each other and with the natural environment.** Promoting individual and human health requires care and respect for the health of all beings, as our health and well-being cannot be disentangled from each other. Our health is more than our individual choices. We can only be healthy if plants, water, salmon, and land are healthy.[22]

**Health is powerful and it is at the foundation of all we do.** Attaining one's full health potential requires having power, access, opportunity, knowledge, and resources. Our state government must go beyond addressing gaps and work toward the highest conceivable standards, so that all Washingtonians can attain **optimal health and well-being**.

[18] https://sph.washington.edu/news-events/sph-blog/farm-to-table-covid19
[19] https://doh.wa.gov/sites/default/files/2023-09/422243-ExcessDeathsCOVID19HeatDome.pdf
[20] https://doh.wa.gov/sites/default/files/2023-09/422243-ExcessDeathsCOVID19HeatDome.pdf
[21] https://doh.wa.gov/sites/default/files/2023-09/422243-ExcessDeathsCOVID19HeatDome.pdf
[22] *In 2009, the CDC established the One Health Office to promote collaboration across disciplines and to improve the health of humans, animals, plants, and our shared environment. The Washington State Department of Health convenes One Health meetings with other state agencies and partners. In 2019, the Governor issued a proclamation to promote One Health efforts in Washington State. The proclamation declared that "the state of Washington seeks to protect and improve the health of all Washingtonians, which is inextricably linked to the health of Washington's domestic animals, wildlife, and environment […]"* (https://doh.wa.gov/sites/default/files/legacy/Documents/5640/OneHealthGovernorProclamation.pdf?uid=644b076060055)

> *Health disparities are real. The evidence base is large and irrefutable. As such, the time is now to shift the research emphasis away from solely documenting the pervasiveness of the health disparities problem and begin focusing on health equity, the highest level of health possible…*
>
> ~ Shobha Srinivasan, PhD and Shanita D. Williams, PhD, MPH, APRN - [Public Health Reports]

**Health consists of multiple, interdependent dimensions:** mental, physical, occupational, social, emotional, spiritual, intellectual, environmental, financial, and more. Health is more than the absence of disease and can look different for each individual, community, and state. As community has spotlighted over the years, there remains a critical and growing need to support cultural and linguistic diversity, including providing culturally and linguistically appropriate services in all settings where people seek care, belonging, health, and well-being.

> *There would be so much potential if healthcare were accessible, affordable, appropriate, affirming, and available to everyone. There would be so much health potential and power of prevention if people did not have to delay or forgo healthcare services. There would be integration of care to address physical, mental, emotional, and spiritual health, well-being, and quality of life. All of this could help people achieve their highest potential, and certain powers could come into being in the world as a result.*
>
> ~ Public meeting participant

**Community holds inherent power.** The Council and the state must structure ourselves to be led by that power. We have learned from community partners that health and well-being can only happen with attention to relationships and culture. They remind us that definitions and conditions for well-being and liberation must be determined by communities, and the Council should develop goals and do work that meets community expectations.

## Exploration: Health as a Right

> *We all have the right to treatment for health issues just because we are a person.*
> *~ Community Member*

During the redesign, the Council explored the foundational question: Is health a need, an opportunity, or something else? How we see health determines the way we demand it, protect it, and promote it.

The Council acknowledges that writing and using policies/law to uphold ideas around the right to health are relatively new concepts within the context of time immemorial. Indigenous ways of knowing and being include a holistic approach, where there is inherent understanding that people are connected to each other, to land, and to other animals.[23]

Written and legal declarations related to Health as a Right occurred after World War II. The World Health Organization (WHO) preamble was the first written document to outline Health as a Right, defining health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[24] This document also states, "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."[25] Since then, there have been additional documents outlining the right to health on an international level.[26]

The U.S. has signed the following frameworks that name Health as a Right:

- World Health Organization Constitution
- International Convention on the Elimination of All Forms of Racial Discrimination
- International Covenant on Economic, Social, and Cultural Rights (signed, but not ratified)
- Convention on the Rights of the Child (signed, but not ratified)
- Universal Declaration of Human Rights
- World Health Assembly Resolution 58.33

Naming health as a right on the state level can be one tool to initiate a change in the cultural attitudes around health and caring for each other. There are also opportunities to center Indigenous People-led initiatives, advocate for things like standardized living wages, universal healthcare, access to clean water, improved birth outcomes, increasing culturally-appropriate services, reductions in carbon emissions, recognition of traditional medicines, and more.[27] There may also be legal or financial responsibilities associated with declaring Health As A Right. The WHO stated that "[a]cknowledging health as a human right recognizes a legal obligation on [countries] to ensure access to timely, acceptable, and affordable healthcare."[28]

[23] https://opentextbc.ca/indigenizationfrontlineworkers/chapter/indigenous-ways-of-knowing-and-being/
[24] https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf#page=6
[25] https://apps.who.int/gb/bd/pdf_files/BD_49th-en.pdf#page=6
[26] https://www.ohchr.org/sites/default/files/Documents/Publications/Factsheet31.pdf
[27] https://www.thelancet.com/article/S0140-6736(15)60901-1/fulltext
[28] https://www.who.int/news-room/fact-sheets/detail/human-rights-and-health

The Health Disparities Council reflected on the concept of Health is a Right at our May 10, 2023, public meeting.

Participants responded to the question:
**How would our world be different if we had access to quality healthcare**—if it was a right and you did not have to worry about how your identity is received or the availability of culturally and linguistically appropriate care?

**Some responses from Council members and public participants:**

> *"Proper healthcare for all means less stress for people, better quality of life, and a healthier society overall."*

> *"[Our children] would not have to worry about making decisions between rent, food, and healthcare."*

> *"We could relax into the knowledge that our families are cared for. The calculus of always having to scrap things together is exhausting."*

> *"Mental health, behavioral health, and substance use treatment are destigmatized further and readily available. We would live in a world where the demonstrated dignity of all allows us a big sigh of relief that we all matter."*

> *"The world would be different because poverty would not be a forgone conclusion, and we would have the chance to materialize the things we can only dream of right now."*

> *"We could take a collective exhale... People would feel they are heard, seen, and cared for. We would breathe clean air, live in safe homes, next to family and neighbors who care for us."*

# RECOMMENDATIONS

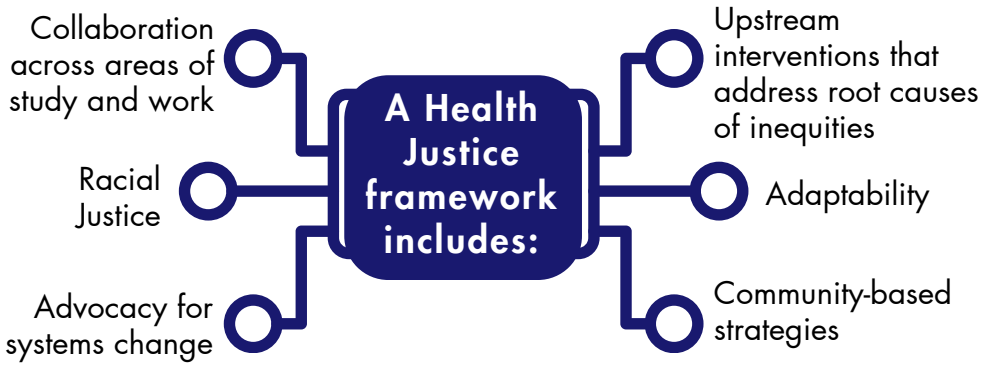
# COUNCIL REDESIGN: STATUTORY UPDATES

The Council recommends updates to our authorizing statute (chapters 43.20.270, 43.20.275, and 43.20.280 RCW) to align Council efforts with community visions, statewide priorities, current structures, and multisectoral approaches to advance health justice and equity. The Council urges the Legislature and the Governor to adopt Council request legislation, House Bill 2346 (updating the Governor's Interagency Coordinating Council on Health Disparities) in the 2024 legislative session.

Statutory updates, along with increased fiscal investment, would allow the Council to provide policy coordination and leadership to help Washington respond to statewide health crises with strategies that are equal in scope and timeliness. Beyond survival and closing gaps, statutory updates would allow the Council to help move our governmental systems toward promoting optimal health and well-being for all Washingtonians.


## HEALTH JUSTICE FRAMEWORK

A resilient, thriving Washington state requires dedicated, sustained efforts to eliminate unjust health disparities and advance health justice and equity.




Health justice "requires addressing the structural determinants of health that are the root cause of health inequities, such as the social and economic policies that create unequal conditions in health care, employment, housing, and education."[29]

In practice, health justice approaches have been applied to multiple policy topics, including the COVID-19 response,[30] school discipline,[31],[32] childcare,[33] and environmental health.[34] The United Nations and U.S. CDC have referenced the health justice framework to discuss inequities exacerbated by the COVID-19 pandemic.[35],[36]

[29] https://www.researchgate.net/publication/369103245_INTRODUCTION_What_is_Health_Justice
[30] https://blog.petrieflom.law.harvard.edu/2021/10/13/community-based-organizations-health-justice/
[31] https://blog.petrieflom.law.harvard.edu/?s=Addressing+school+discipline+disparities+through+the+health+justice+framework&submit=Search
[32] https://aulawreview.org/blog/a-health-justice-response-to-school-discipline-and-policing/
[33] Libman, K., Adler, S., Musburger, P. (2022). Cooperative ownership as a health justice intervention: A promising strategy to advance health equity through the U.S. childcare system. Journal of Law, Medicine & Ethics, 50, 738-744.
[34] Miao, G., Michel, K.H., Yuen, T. (2023). A health justice agenda for local governments to address environmental health inequities. Journal of Law, Medicine & Ethics, 50, 758-768.
[35] Venkatapuram, S. (2022). "Global health justice: Now is the time." United Nations, UN Chronicle. Available at: https://www.un.org/en/un-chronicle/global-health-justice-now-time.
[36] Ward, M.C. (2023). "Health justice as a tool to fight existing and future pandemics." U.S. Centers for Disease Control and Prevention (CDC), Conversations in Equity. Available at: https://blogs.cdc.gov/healthequity/2023/05/31/health-justice-as-a-tool-to-fight-existing-and-future-pandemics/.

## REDESIGN CORE CONCEPTS

The Council's recommendations for statutory updates are grounded in the following core concepts.

1. Consider health as a right
2. Advance health justice and equity
3. Focus on root causes
4. Change the narrative around health and well-being
5. Position the Council to develop and advocate policy recommendations
6. Contribute to initiatives that unify partners, align efforts, and reinforce accountability
7. Proactively support communities in building power
8. Update Council structure and membership

## RECOMMENDED STATUTORY UPDATES

- **Update the Council's name to "Governor's Council for Health Justice and Equity."** Enable the Council to focus on health inequities (instead of only disparities), root causes, and social determinants of health, which are the primary drivers of health and well-being. Expand our focus to include additional systems of oppression that intersect with and compound race- and gender-based discrimination.
- **Enable the Council to create a Health Justice framework and policy recommendations that guide state actions toward enduring health equity and optimal health for all.** The vision, goals, and policy recommendations should recognize racism as a public health crisis and climate change's role in worsening inequities. They should focus on the social and structural determinants of health as well as the diversity of communities across the state. This change would support community visions and priorities, state government efforts, and multisectoral strategies to address inequities.
- **Promote collaboration that benefits all Washingtonians.** Align with initiatives that unify partners and reinforce accountability (e.g., state Pro-Equity and Anti-Racism – PEAR, environmental justice, and economic justice strategies). This change would provide coordinated direction and avoid redundancy by clarifying the Council's responsibilities in relation to key entities created after 2006, such as the WA State LGBTQ Commission, WA State Office of Equity, and Environmental Justice Council.
- **Center community voice and participatory processes**, so that communities who are most impacted by inequities have meaningful opportunities to shape narratives, priorities, and policy recommendations. The Council should have the ability to implement participatory models, such as collaboratives or community assemblies, to support our work.

- **Update membership and structure to better reflect community experiences and allow the Council to address complex, evolving priorities.** Add the WA State LGBTQ Commission, additional community member seats (including 2 seats reserved for youth), and flexible seats to Council membership. Require Council members to be individuals who are committed to and well-informed regarding principles of health justice and equity. Require each member state agency to appoint an executive staff person or their designee to serve on the Council in order to promote agency commitment and coordination.
- **Support evidence-based policy and coordination by expressly allowing the Council to:**
  - Use topics and findings from Health Impact Reviews (RCW 43.20.285) to inform our priorities, strategies, and recommendations.
  - Develop positions on policy.
  - Independently endorse or comment on policy recommendations/positions of other groups (e.g., state and governmental entities, community-based and non-governmental entities) to promote coordination and development of promising practices.
- **Update Council reporting requirements**, with a spotlight on policy adoption and accountability among state agencies and decision-makers.

Updating and clarifying the Council's name, membership, authority, and responsibilities would allow the Council to support state government more effectively in addressing health inequities and promoting optimal health and well-being, thereby benefiting all Washingtonians.

**RECOMMENDATION 1:** The Council recommends the passage of legislation to update the Council's name, membership, authority, and responsibilities in statute.

***Responsible Party:*** Legislature and Governor
***Measure:*** Passage and adoption of legislation
***Timeline:*** 2024

# COUNCIL REDESIGN: FISCAL INVESTMENTS

The Council recommends increased investment in Council operations to support effective, enduring strategies for addressing health inequities and advancing optimal health and well-being in Washington. The Council submitted a decision package (fiscal request) to the Governor's Office for consideration for the 2024 legislative session. The decision package requested roughly **$1.9 million per year** in base operating funds.

The Council's budget has not been adjusted since our creation in 2006, preventing the Council from fully meeting our statutory intent and requirements. For 17 years, the Council has primarily relied on 1.0 FTE assigned staff position (Council Manager) to organize public meetings; conduct studies, research, and other forms of information gathering; facilitate communication and collaboration between agencies, private and public sectors, and communities of color; and support Council members in developing policy recommendations and reports for state decision makers, among other required efforts.

> *"I'm always alarmed when there are groups with as much knowledge that you have and that don't have resources… We need to get you funded, so the work actually takes hold.*
> ~ Community Partner

The Washington State Board of Health (Board) was directed in statute to staff and convene the Council (RCW 43.20.275). While the Council and Board operate in a resourceful and efficient manner, this long-term underinvestment has created severe limitations on the Council's work. In particular, current funding does not provide for community engagement or Tribal relations staff. The Council needs the ability to hire and retain additional staff if we are to build collaborative relationships of trust with Tribal, community, and additional partners. Additionally, community partners have said that compensation, language assistance services, and hybrid meetings (i.e., meetings that offer both in-person and remote participation), among other supports, are essential for public participation.

> *"Invest in knowing your partners.* ~ Community Partner

**Adequate, sustainable funding would allow the Council to:**

- Hire and retain staff for research, analysis, policy development, communications, administration, Tribal relations, and community engagement.
- Fully operate and create meaningful, enduring relationships and strategies.
- Hold hybrid and accessible public meetings throughout the state so communities have a meaningful chance to participate.
- Use communication tools to share information, build connections across communities, and support collaboration.
- Provide language assistance services.
- Provide stipends and other supports to workgroup participants to remove barriers to participation.

> *You can have the best intention or the best idea, but that's not enough. Staff, offices, programs need resources. If you don't give significant resources to the people who can make the change, then it's just talk and games.*
> ~ Community Partner

**RECOMMENDATION 2:** The Council recommends dedicating additional funding ($1.9 million per year) through the State Operating Budget (General Funds-State) to support the Council's operation.

***Responsible Party:*** Legislature and Governor
***Measure:*** Passage and adoption of legislation (State Operating Budget)
***Timeline:*** 2024

# APPENDICES

# APPENDIX A.

Health Disparities Council's Vision and Operating Principles

## VISION

Adopted May 2, 2019

Guided by our North Star that is Equity, we honor the broad differences and bonding similarities that make up this state.

The power entrusted to us by the people inspires us to be channels for change. We shift power by sharing priorities, being transparent and reflective and disrupting oppressive practices so everyone has the opportunity to thrive.

We intentionally act to heal wounds and cultivate trust; instilling equity into every level of government and beyond, assuring true democracy's light shines on all communities.

## OPERATING PRINCIPLES

Adopted December 6, 2018

**EMBRACE EQUITY**

Equity is a journey toward well-being, where everyone has the opportunity to reach their full potential, as defined by those impacted by inequity. Equity is not equality—equity acknowledges that everyone is not starting from the same place. Equity is achievable and requires unwavering commitment to prioritizing resources and supports toward communities of color and other marginalized communities. Achieving equity requires us to identify, name, and dismantle institutional racism and oppression.

**FOCUS ON RACISM**

We are committed to promoting equity for all historically marginalized communities. However, we recognize that racism is ingrained in our history and deeply embedded in our institutions today, leading to the inequities we see across all sectors. Therefore, while we seek to challenge and undo all forms of oppression, we are committed to centering racism as our primary focus.

# OPERATING PRINCIPLES continued

Adopted December 6, 2018

**PRIORITIZE SOCIAL DETERMINANTS OF HEALTH**

We acknowledge that health is much more than access to healthcare services or absence of injury and illness. Health starts where we live, learn, work, and play and is shaped by our exposures and experiences across the lifespan. We recognize that achieving health equity requires equitable opportunity across all sectors. Therefore, we embrace our interagency structure and ability to work across government sectors to promote equitable opportunity for all.

**CENTER COMMUNITY**

We recognize that we can only achieve health equity if communities impacted by health inequities are at the center of our work. We acknowledge that communities know best their assets, needs, and solutions. We strive to recognize and share power and structure our meetings to foster meaningful engagement. We will find opportunities as a Council, individual members, and staff to attend community meetings to listen, learn, and seek input to guide our work. We will strive to incorporate stories of lived experience into our reports and recommendations.

**COMMIT TO BOLD ACTION**

Health inequities exist because of racism and oppression that hinder opportunities for communities to thrive. Eliminating racism and oppression requires revolutionary change. We commit to using the authority we have and our collective influence to push for revolutionary change. We will use our time in Council meetings to engage in action-oriented discussions and we will commit as individual Council members to be bold and serve as champions for equity in our respective agencies.

**BE VIGILANT FOR UNINTENDED CONSEQUENCES**

Policy, program, and budget decisions can have adverse unintended consequences if equity is not intentionally and systematically considered. We commit to using an equity lens in the development of recommendations as a Council and in our decisions as individual Council members in our respective agencies. We honor the **Seven Generation Principle**[37] as standing in the present, while looking back three generations to the wisdom and experience of our ancestors, thinking about issues in the current context, and planning forward for three generations for the protection of our children and the generations to come.

---

[37] We acknowledge the Tribal and Urban Indian Pulling Together for Wellness Leadership Advisory Council, American Indian Health Commission for Washington State for sharing this articulation of the Seven Generation Principle.

# APPENDIX B.

## Equity Language Guides

The following resources are intended to assist the reader as well as create shared understanding of various equity-related terms used throughout the report.

**Health Disparities Council's Equity Language Guide** (2018):
https://healthequity.wa.gov/sites/default/files/2022-01/EquityLanguageGuide_Final.pdf

**Washington State DEI Council's Glossary of Equity-Related Terms** (2023):
https://ofm.wa.gov/state-human-resources/workforce-diversity-equity-and-inclusion/diversity-equity-and-inclusion-resources/dei-committee-documents

**Governor's Interagency Council**
**on Health Disparities**
PO Box 47990
Olympia, WA 98504-7990
Phone: 360-236-4110, TTY 711
Fax: 360-236-4088
E-mail: healthequity@sboh.wa.gov
Web: http://healthequity.wa.gov