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INVESTIGATION INTO HEALTH CARE DISPARITIES OF U.S. PACIFIC ISLAND TERRITORIES

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS

OF THE

COMMITTEE ON GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTH CONGRESS

SECOND SESSION

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INVESTIGATION INTO HEALTH CARE DISPARITIES OF U.S. PACIFIC ISLAND TERRITORIES

WEDNESDAY, FEBRUARY 25, 2004

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HUMAN RIGHTS AND WELLNESS,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:05 p.m., in room 2154, Rayburn House Office Building, Hon. Dan Burton (chairman of the subcommittee) presiding.

Present: Representatives Burton, Watson, and Cummings, and Delegates Faleomavaega and Bordallo.

Staff present: Mark Walker, chief of staff; Mindi Walker and Brian Fauls, professional staff members; Nick Mutton, press secretary; Danielle Perraut, clerk; Richard Butcher, minority professional staff member; and Cecelia Morton, minority office manager.

Mr. BURTON. Good afternoon. A quorum being present, the Subcommittee on Human Rights and Wellness will come to order. I ask unanimous consent that all Members' and witnesses' written and opening statement be included in the record. Without objection, so ordered.

I ask unanimous consent that all articles, exhibits and extraneous or tabular material referred to be included in the record. Without objection, so ordered.

Today the subcommittee has the honor of being joined on the dais by my esteemed colleagues, the Honorable Madeleine Bordallo, the Delegate to Congress from Guam, whom I had not had an opportunity to talk to when I was over there, but I'm glad she's with us today. And the Honorable Eni Faleomavaega, who's the Delegate to Congress from American Samoa, and a good golfing buddy of mine when we have a chance to get out and play.

In the event of other Members of Congress joining us at today's hearing, I ask unanimous consent that they be permitted to serve as a member of the subcommittee for the day. Without objection, so ordered.

I'd also like to take this opportunity to recognize a good friend of mine, the Honorable Pete Tonorrio, Representative of the United States from the Commonwealth of the Northern Mariana Islands. He's doing a wonderful job for the people of the CNMI here in Washington, and I hope 1 day to welcome him as a friend and duly constituted colleague here in the Congress.

The subcommittee is convening today to examine disparities in the quality and access to health care experienced by the people of the U.S. Pacific Island Territories. We'll be discussing possible solutions that the Federal Government should seriously consider in order to alleviate these health burdens.

The medical system in the Continental United States prides itself on the quality of medical services supplied to the millions of Americans under its care. Unfortunately, there are populations of underserved American citizens and nationals who do not have the same access to adequate and proper medical care in other regions of the world.

These are the citizens of the U.S. Pacific Island Territories; namely the residents of Guam, American Samoa, the Commonwealth of the Northern Mariana Islands.

In a post-September 11th society, many foreign nationals have been hesitant to travel to the Pacific Islands, which regrettably has taken a great toll on the economies of Guam, CNMI and the American Samoas. As a result, this has drastically increased rates of unemployment on the islands, and consequently has left tens of thousands of men, women and children without proper health insurance or the means for medical care.

Due to these times of economic hardship, coupled with the caps placed on Federal Government services such as Medicaid, territorial governments are unable to afford the much needed equipment and qualified health professionals required to properly tend to the medical needs of their people. I had a chance to see that first hand during our visit over there. It's unconscionable that we don't do more to help those American citizens.

Late last year, I had the opportunity, as I said, to travel to both Guam and CNMI and witness first hand the deteriorating health care conditions on the islands. Needless to say, I was extremely surprised and disappointed by the lack of sufficient medical resources on the islands, and thus was moved to convene this important hearing today to better educate my colleagues and the American people as well as our health agencies on the ongoing plight of our fellow citizens and nationals.

One of the primary health care concerns encountered by these territories is the skyrocketing incidence of diabetes. That's something that should be researched, because there's no evident reason why that's happening, but it is happening. In recent years, the incidence of Type 2 diabetes, formerly known as adult onset diabetes, has reached epidemic proportions on these islands.

Hundreds of these patients require constant medical intervention to survive, mainly in the form of dialysis treatments. Unfortunately, the territories are ill-equipped to deal with the ever-increasing demand for dialysis machines and trained technicians to operate them. This has resulted in long waiting lists and late night appointments for people in desperate need of life saving medical attention.

These growing medical concerns place a tremendous budgetary strain on the already fragile economies of each territory.

To further exemplify the severity of these disparities in health care, Guam, the largest of the U.S. Pacific Island Territories, has only one fully functioning civilian hospital to serve its nearly

170,000 citizens. Currently only about 150 physicians reside on the island and must care not only for Guamanian patients but also thousands of patients who are transported to the territory every year from many of the smaller surrounding islands.

To add insult to injury, the Guam Memorial Hospital Authority recently declared bankruptcy and is currently $20 million in debt.

Although the CNMI has a Commonwealth Health Center, the lack of proper equipment and health care staff forces thousands of patients to brave great distances overseas for care during medical emergency. Consequently, this is at the expense of the CNMI government. I think we had one case where the Speaker of the House had to be transported all the way to Hawaii for treatment because they didn't have any facilities to care for him on the islands.

American Samoa unfortunately also faces these same predicaments, having only one medical center, LBJ Tropical Memorial, to service the health-care needs of its entire population of 60,000, much like the CNMI.

Because the main area of concern deals with the shortage of qualified medical staff, the subcommittee will be receiving testimony from the Honorable Jefferson Benjamin, Secretary of Health for the Federated States of Micronesia, who will be speaking today on behalf of the Pacific Island Health Officers Association. Dr. Benjamin will discuss the ever-growing need for properly trained health care professionals on these islands. We'll also ask questions of other professionals from that area who will be part of the third panel.

To gain further insight into these most important issues, the subcommittee has the honor of hearing today from the Honorable Felix Camacho, Governor of Guam; the Honorable Togiola Tulafono, Governor of American Samoa; and the Honorable Juan Babauta, Governor of CNMI.

By the way, Governor Babauta, I would like to inform you that I did receive your letter regarding "the stateless children of the CNMI," which we talked about earlier today. We've already instructed our staffs to start researching the "stateless children" issue in order to explore how we can best address a case that at first glance looks to be a meritorious human rights concern. We thank you for bringing that to our attention.

In addition, the Honorable David Cohen, the Deputy Assistant Secretary of Insular Affairs at the U.S. Department of Interior will testify on his personal experiences observing health care disparities in the territories. I don't know of anybody that's better informed than David is. I had a chance to spend a lot of time with you over there, David, and we're really appreciative of you being here and hearing your testimony.

During my visit to Guam, I had the pleasure of meeting a very brave man, the Honorable Vincente Pangelinan, Speaker of the Guam Legislature. He was invited to testify today to share his own personal story of this recent cardiac medical scare that almost claimed his life, which may have been avoided if he had the proper access to immediate medical care. I think he went to Hawaii, as I said, to take care of that.

Unfortunately, due to continued health concerns the speaker was unable to come before the subcommittee today. So on behalf of the

members of the subcommittee, I'd like to wish him well and we hope that he has a speedy recovery.

The U.S. Department of Health and Human Services has offices and programs in place to identify and directly assist with underserved populations, such as the residents of the U.S. Pacific Island Territories. The Honorable Nathan Stinson, M.D., Deputy Assistant Secretary of the Office of Minority Affairs, is with us here today. He will discuss current HHS initiatives created to help alleviate some of the problems that we're talking about.

In closing, I'd like to add that the members of this subcommittee believe that it is one of our highest duties as Members of Congress to strive to find the best possible public policy solutions for ensuring that all Americans, any place in the world, have access to the highest quality health-care services.

It's my sincere hope that the information shared today will help to provide the necessary assistance for our fellow Americans across the Pacific Ocean and ultimately alleviate this health care crisis.

As I said to the Honorable Mr. Stinson, I hope that today the message will be carried back to our health agencies that additional resources need to be made available for these regions as quickly as possible, because are in dire need.

[The prepared statement of Hon. Dan Burton follows:]

Opening Statement
Chairman Dan Burton
Subcommittee on Human Rights & Wellness
Government Reform Committee
"Investigation into Health Care Disparities in United States Pacific Island Territories"
February 25, 2004

The Subcommittee is convening today to examine disparities in the quality and access to health care experienced by the people of United States Pacific Island territories. We will also be discussing possible solutions that the Federal government should seriously consider in order to alleviate these health burdens.

The medical system in the continental United States prides itself on the quality of medical services supplied to the millions of Americans under its care. Unfortunately, there are populations of underserved American citizens and nationals who do not have the same access to adequate and proper medical care.

These are the citizens of the United States Pacific Island Territories; namely the residents of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

In a post-September 11th society, many foreign nationals have been hesitant to travel to the Pacific Islands, which regrettably has taken a great toll on the economies of Guam, CNMI, and American Samoa. As a result, this has drastically increased rates of

unemployment on the islands, and consequently has left tens of thousands of men, women, and children without proper health insurance or the means for medical care.

Due to these times of economic hardship, coupled with caps placed on Federal government services such as Medicaid, territorial governments are unable to afford the much needed equipment and qualified health professionals required to properly tend to the medical needs of their people.

Late last year, I had the opportunity to travel to both Guam and the CNMI and witness first-hand the deteriorating health care conditions on those islands. Needless to say, I was extremely surprised and disappointed by the lack of sufficient medical resources on these islands, and thus was moved to convene this important hearing today to better educate my colleagues and the American people to the ongoing plight of our fellow citizens and nationals.

One of the primary health care concerns encountered by these territories is the skyrocketing incidence of diabetes. In recent years, the incidences of Type-2 Diabetes, formerly known as adult-onset Diabetes, have reached epidemic proportions on the Pacific islands.

Hundreds of these patients require constant medical intervention to survive, mainly in the form of dialysis treatments. Unfortunately, the territories are ill-equipped to deal with the ever-increasing demand for dialysis machines and trained technicians to

operate them. This has resulted in long waiting lists and late night appointments for people in desperate need of life-saving medical attention.

These growing medical concerns place a tremendous budgetary strain on the already fragile economies of each territory.

To further exemplify the severity of these disparities in health care, Guam, the largest of the U.S. Pacific Island territories, has only one fully functioning civilian hospital to service its nearly 170,000 citizens. Currently, only about 150 physicians reside on the island - and must care not only for Guamanian patients, but also thousands of patients who are transported to the territory every year from many of the smaller surrounding islands.

To add insult to injury, the Guam Memorial Hospital Authority recently declared bankruptcy, and is currently $20 Million in debt.

Although the CNMI has a Commonwealth Health Center, the lack of proper equipment and healthcare staff forces thousands of patients to brave great distances overseas for care during medical emergencies. Consequently, this is at the expense of the CNMI government.

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Because a main area of concern deals with the shortage of qualified medical staff, the Subcommittee will be receiving testimony from the Honorable Jefferson Benjamin, Secretary of Health for the Federated States of Micronesia, who will be speaking today on behalf of the Pacific Island Health Officers Association. Dr. Benjamin will discuss the ever-growing need for properly trained health care professionals on the Pacific Islands.

To gain further insight into these most important issues, the Subcommittee has the honor of hearing today from the Honorable Felix Camacho, Governor of Guam; the Honorable Togiola Tulafono, Governor of American Samoa; and the Honorable Juan Babauta, Governor of CNMI.

By the way, Governor Babauta, I would like to inform you that I did receive your letter regarding the "stateless children of the CNMI". I have already instructed my staff to start researching the "stateless children" issue in order to explore how we can best address a case that at first glance looks to be a meritorious human rights concern. Thank you for bringing it to my attention.

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During my visit to Guam, I had the pleasure of meeting a very brave man, the Honorable Vicente Pangelinan, Speaker of the Guam Legislature. Mr. Pangelinan was invited to testify today to share his own personal story of a recent cardiac medical scare that almost claimed his life, which may have been avoided if he had the proper access to immediate medical care. Unfortunately, due to continued health concerns, Speaker Pangelinan is unable to come before the Subcommittee today. On behalf of the Members of the Subcommittee, I would like to wish Speaker Pangelinan well, and we hope that he has a speedy recovery.

The United States Department of Health and Human Services has offices and programs in place to identify and directly assist with underserved populations, such as the residents of the U.S. Pacific Island territories. The Honorable Nathan Stinson, M.D., Deputy Assistant Secretary, Office of Minority Affairs, is with us here today and will discuss current HHS initiatives created to help alleviate some of the added health burdens that Pacific Island territories face.

In closing, I would like to add that this Subcommittee believes it is one of our highest duties as Members of Congress to strive to find the best possible public policy

solutions for ensuring all Americans access to the highest quality healthcare services in the world.

It is my sincere hope that the information shared today will help to provide the necessary assistance for our fellow Americans across the Pacific Ocean and ultimately help alleviate this health care crisis.

Mr. BURTON. With that, Mr. Faleomavaega, would you have an opening statement you'd like to make?

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman, for your leadership and your sensitivity in calling this hearing this afternoon, as it pertains to the health care needs of the insular areas. And not only as the chairman of the full Committee on Government Reform but also a senior member of the House International Relations Committee that you and I have served on together, I cannot thank you enough, Mr. Chairman, for your initiative in calling this hearing to bring to the attention of the Members of the Congress the problems that we have and health care needs, not only of the CNMI and Guam, but also American Samoa, although you did not have the opportunity of visiting my district or territory.

In the interest of time, Mr. Chairman, I would like to submit my statement to be made part of the record, as I'm quite certain that our Governor, who will be testifying later, will provide the members of the committee with a very comprehensive overview of the health care needs of the territory.

I also would like to offer my personal welcome to Deputy Assistant Secretary David Cohen, representing the Department of Interior, and Dr. Stinson, representing the Department of HHS. And my personal welcome to the Governors of the insular areas, Governor Babauta, my dear friend, who previously served as the representative of the CNMI to Congress, and is currently the Governor of CNMI. And also Governor Tulafono, my good friend here, I certainly would like to welcome him.

Mr. Chairman, as I said earlier, I will introduce later my Governor when he has the opportunity to testify before our committee. Again, I want to give you my highest commendation. One of the very few occasions that committees in the Congress have given specific direction to look into or to focus into this very important area that is most needful for the insular areas, and I want to thank you for your initiative in calling this hearing this afternoon. Thank you, Mr. Chairman.

Mr. BURTON. And I want to thank you for pointing out that sometimes it's difficult to say these various names like Faleomavaega. [Laughter.]

You've been kidding me for years about that, and it's nice to know you stumble just a little bit once in a while. [Laughter.]

Mr. FALEOMAVAEGA. I must say, Mr. Chairman, we ran a full schedule today——

Mr. BURTON. Don't give me any excuses. [Laughter.]

We had a hearing this morning, and hopefully our good friend Mr. Tonorrio or whoever is going to be elected by the good people of the Northern Marianas to give full congressional authority to have a representation by the CNMI.

Also, we had the hearing for which I wasn't able to make it to the delegate voting procedure, or hearing that we had in the resources committee. I had to help with Chairman Pombo's bill to recognize the 50 years of the Bravo shot, or the unique strategic relationship that we've had with the Republic of the Marshall Islands, which again thank you for your support, and for which Chairman Hyde and our ranking senior member, Mr. Lantos, and

the members of our International Relations Committee approved the bill and the resolution.

Hopefully it will be considered by the full House before March 1st, because that is the day we're looking at as the basis of which the resolution was introduced. We ought to recognize the tremendous contributions that the people of the Marshall Islands have given to our country in the last 50 years. Many of the Americans don't even know that one of the best missile testing operations going on in the Pacific lies in the Marshall Islands. And the fact that the Marshal Islands also was the home port where we tested some 67 nuclear devices, which kind of kept us on the go in our competition with the Soviet Union and defeating communism. I would be remiss if I did not mention the fact that the people of the Marshall Islands have made a tremendous contribution, and hopefully, we will have a chance to go and visit those islands again.

Thank you, Mr. Chairman, again, and you can call me John Wayne any time you want, Mr. Chairman, if Faleomavaega sounds too complicated. [Laughter.]

Mr. BURTON. You know, that very nice comment that you made about the Marshall Islands, I thought for a moment you were going to run for delegate from there.

Ms. Bordallo.

Ms. BORDALLO. Thank you very much, Mr. Chairman.

I want to say this before I begin my very short testimony here, that the territories have been very fortunate in the past month or so. We are getting visits from a number of Members of Congress and most recently the Secretary of Interior. I think that once you visit Guam, as you have, Chairman Burton, that you will be friend of the territories forever. Once you get out and visit the Pacific areas, meet our people, learn about our customs and our traditions, you will fall in love with the islands.

So the more that we can invite Members of Congress to come and visit us, I think they will understand more about us and the difficulty we have on many issues.

I want to thank you, Chairman Burton, for holding this hearing today on health care disparities in the U.S. Pacific Territories. And I want to especially welcome the Governor of Guam, the Governor of CNMI and the Governor of American Samoa, Presidents of the Senate are here, other distinguished visitors from several of our territories are in the audience today. I want to thank you very much. And of course, our Secretary David Cohen, who's been on the witness stand most of the day today, in different public hearings and all the others who are here.

Mr. Chairman, as you said earlier, you have visited Guam and the Northern Marianas, and you have seen first hand the challenges that we face in providing quality health care for our communities. I'm particularly pleased that you had an opportunity to visit the Guam Memorial Hospital and that you were well briefed by Hospital Administrator Bill McMillan and the Director of Public Health on Guam, and the Director of Public Health on Guam, Mr. Peter John Camacho.

The issue of disparities manifests itself in higher occurrence of serious and chronic diseases and in mortality rates that exceed national averages. The question here is whether these health dispari-

ties are further enhanced by the lack of adequate Federal funding. As you are aware, the territories have a Medicaid cap that limits the amount of Federal Medicaid funding to about 20 percent of actual costs for indigent medical care.

The recent Medicare prescription drug benefit contains a new cap for the territories, which is a great concern to our constituents. While Medicare subscribers on Guam pay into the system, their prescription drug benefit would not be the same as a Medicare subscriber in one of the United States.

We now have a new disparity, Mr. Chairman, in another Federal health care program. By every health indicator, the territories lag behind the States, and are now near Third World levels. Perhaps our distances and our remote locations contribute to this situation. However, the disparities may in fact be caused by the disparities in Federal programs, especially where these Federal programs directly impact the indigent population.

The greatest irony is that these are the very same programs that are meant to extend the benefits of quality health care to the most vulnerable population throughout the United States. It is not just unfortunate that Medicaid and SCHIP and Medicare have caps, but it is tragic for those who depend on those programs for their basic health care needs.

Mr. Chairman, I want to thank you for your commendable interest in these issues, and I hope the information we learn today from the territorial representatives will help us to formulate a strategy to address the caps in Federal health programs, and to put the Federal resources where they are needed the most.

Mr. Chairman, I would like to enter into the record my full statement, along with a statement from Speaker Ben Pangelinan and Senator Luli Angararo.

[The information referred to follows:]

Office of

The People

Mina'Bente Siete Na Liheslaturan Guåhan

vicente (ben) c. pangelinan
Speaker

Committee on Utilities and land
Chairman

FEB 25 2004

The Honorable Dan Burton
Chairman, Human Rights and Wellness Subcommittee
House Committee on Government Reform
U.S. House of Representatives
B371CRHOB
Washington, DC 201515

Dear Chairman Burton:

Ya hu na bai u chuele este na oputunidad pare bai u nahi un dangkulu na Si yu'os ma'ase' hagu yan todos I membrus sihi gi este na kumitea. Dangkulu na ayudu en nanahi hami kumu yi nahi hami ni tiempon miyu para en ekunug hami.

I would like to take this opportunity to extend sincere appreciation to you and the members of this committee. You have given us much help by taking your time to listen to us.

The people of Guam embrace this day to share our thoughts and concerns on the health care disparities that exist between Americans on the continent and those of us living in the U.S. Pacific Island territories.

In my written testimony, I will point out the disparities between the health care system in the U.S. and in Guam. I will outline our concerns including additional funding for vulnerable members of our community.

Hopefully, specific initiatives will be the outcomes of these fact-finding hearings of Congress which will bridge the divide in the quality and availability of health care that separates us.

We met during you most recent visit to our island in December of 2003. Thank you for following through on your word to help the people of Guam. You indicated your support for Guam's efforts to receive more federal government support to help our island cope with regional immigration, especially in the realm of health care. You also indicated your support for Guam's efforts to receive restitution for war claims. Prior to our visit Mr. Chairman, the War Claims Commission was on island to hear oral testimony about atrocities experienced during World War II. A report will be presented to Congress very shortly for consideration. I beseech your continued support.

155 Hesler St., Hagåtña, GU 96910
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Mr. Chairman, you acknowledged health care was the most urgent problem facing Guam and pledged to do something to help. The people of Guam recognize your efforts to date.

After your visit to our only public hospital, you said, "The hospital here has some real needs that have not been adequately addressed out here, not because they have not been trying, but they don't have the resources."

While the people of Guam respect the intent of this hearing, our leaders move forward to help ourselves narrow these disparities. The 27th Guam Legislature implemented a one thousand percent increase in some cases on the excise taxes on alcohol and tobacco products to fund health care prevention programs and community public health centers. We continue to work on crafting sound public policy using Compact Impact funding to expand emergency care and cancer treatment facilities to meet our people's unmet needs. I am sad to say that despite these drastic increases we still need your help.

Chamorros and Health Care Today:

Health care services on Guam are affected by several factors not commonly found in U.S. mainland communities of comparable size. The fact that we are isolated from the U.S. mainland, are an unincorporated territory of the U.S., and are vulnerable to communicable diseases from other Pacific areas, greatly effects our health care services today.

Isolation: Guam's relative isolation from the U.S. mainland—its main source of medical supplies and equipment—poses problems such as high transportation costs, shipping delays, and large fluctuations in inventory levels. Isolation also limits the availability of on-island continuing education programs necessary for the health care profession. The island has a local source of trained health personnel: the nursing program at the University of Guam and the nursing assistant program at the Guam Community College. Guam has a small population base and is financially unable to support highly specialized health care services, so isolation limits the population's access to these services which are available in distant major population centers such as Hawaii, the Philippines, and the mainland U.S.

Political Status: Guam is an unincorporated territory of the United States and although Chamorros are U.S. citizens, they do not receive all the rights of citizenship granted to citizens in the 50 states, although Guam does participate in the material benefits from the federal government.

The territory's political status prevents the island from participating fully in some health-related federal programs like the Supplemental Security Income (SSI) program, and the unique, fixed ceiling on the federal share of Medicaid.

Rapid Changes in the Structure of the Health Care Delivery System:

The government has limited financial resources to meet the even increasing health care costs, yet dominates the island's health system through its control of Guam's only civilian hospital, its operation of district public health centers, its participation in the federal Medicaid and Medicare programs, and in the provision of health insurance for its 12,000 employees. Our local health care system has seen increases in demand and the technology and specialization to address these demands, yet the lack of government finances and human resources are barriers to meet these challenges.

Vulnerability to Communicable Diseases:

Guam has become a center for commerce, education, and tourism in the Pacific. A large number of tourists, H-2 workers, and temporary residents stay or pass through Guam from the Neighboring Pacific Islands, Japan, the Philippines, and other Asian countries. Most of these people are permitted to use the health care system; therefore, Guam's system needs to be large enough to accommodate these potential patients. This large influx of people makes Guam vulnerable to tuberculosis, sexually transmitted diseases, cholera, measles, etc., and puts an additional strain on Guam's Communicable Disease Control and health service resources.

In 1994 I researched and wrote the Guam Section of the Pacific American Foundation's Joint Health Project commissioned by the Queen's Health Systems of Hawaii. We discovered, "Pacific Islanders do not start from an even playing field, and current federal assistance is predicated on two premises: 1) the profound lack of health resources in many Pacific American communities; and 2) poor access to health care even when health resources are potentially available to Pacific Americans."

This report urgently recommended current federal support for enabling services and for the resource development and maintenance for Pacific Americans continue and be expanded as much as possible.

Congress needs to address the basic needs of the diverse cultures and ethnic groups that make up the national populace. Gather information from various sectors of the community that is critical to the formation of national policy, information that reflects the unique needs of the Pacific American communities, especially those living on Guam.

The impetus for Guam to team up with our sister territories and nearest state neighbor, both geographically and culturally, should be embraced by our national representatives. Such teamwork is necessary, if we are to succeed in crafting a national health policy that answers the question...where do Pacific Americans fit in?

Recommendation 1: We ask Chamorros be specifically included with programs and federal subsidies such as those given to American Indians and Alaskan Natives on the bases of their indigenous status. We face some of the same barriers and limited resources, and require the same special consideration and support by the federal government. This support is vitally needed for our people who live on Guam as well as for those who reside within the continental United States.

Recommendation 2: Guarantee that costs shifting of federal programs will not create greater costs than those Guam is currently absorbing. The question of who pays for Medicare costs concerns us. Guam currently pays more than the amount required under the costs sharing formula. We need the federal government to fund its entire share of the program.

Recommendation 3: Increase the number of Chamorros being placed in health care organizations that serve Chamorros. Efforts should be made to address the lack of Chamorros in the health care professions. Chamorros are normally constrained from accessing such training because of distance and/or inadequate finances. On the mainland, use of Chamorros as providers, especially in community-based health care organizations, would help reduce the language and cultural-insensitivity problems that are barriers to health care utilization.

Recommendation 4: Increase funding for research on the health and well being of Chamorros. Their unique health problems and the rising rates of disease within their growing populations necessitate increased funding to support medical and other health-related research on Chamorros. Such research should also encompass health-related social issues (parenting, education, etc.) and the role cultural differences play in those issues. Further it is vitally important that Chamorros be actively involved in all aspects and at all levels of this research.

Chamorro Health:

Early detection and treatment of heart disease, diabetes and other diseases will contribute greatly to the reduction of health care costs in the long run.

Education and outreach programs that proactively inform our young population of the positive effects of diet and lifestyle changes in the treatment of these diseases must be incorporated as benefits covered in any health care program. The cost-saving potential of such programs will be of tremendous benefit to the territory.

The analysis required to formulate the polices that will ensure the resources are made available to meet the needs of Chamorros and other Pacific Americans cannot occur without the collection of data made possible by the identification of Chamorros and other Pacific Americans as a specific ethnic group.

While some factors such as age and sex cannot be changed by policy, other factors such as educational levels, employment, awareness, etc. can be influenced and changed to make accessing health care easier. These and other standard statistics, combined with specific ethnicity information, can be used to develop outreach programs to bring health care to those who need it. Once this database is established, we can track specific health problems and further refine and enhance health care and the appropriateness of that care. Education and prevention programs can then be used to change the quality of life of our people away from home.

The Territorial Government's Health Care System and Its Cost:

The hospital is not able to provide some specialty services and patients requiring these services are usually referred to off-island facilities. Cardiovascular, neurological, and other health problems are referred for treatment off-island.

Because Guam Memorial Hospital is the region's only public inpatient facility with any substantial specialty services capability, a large portion of the Micronesian population avail themselves of these services. We find that a significant financial burden is placed on the facility, due to the non-payment of services rendered to them.

Medicaid is the state-federal program that pays for health care for the poor, regardless of their age. According to the Guam Health Plan 1985-1990, funding for Guam's Medicaid program had been established at a 50% federal/local match rate, with a fixed ceiling on the federal share. The ceiling on the federal share was originally set at $900,000, which was increased to $2 million in 1984 and $6.2 million in 2004. This amount represents less than thirty percent of the cost of the program.

Due to financial constraints in the local government, Guam has been unable to match the federal share. The present funding base, in terms of the statutorily defined allotment ceiling and the matching ratio between federal and local shares, places Guam in a significantly disadvantaged position. The reason for Guam's overmatch is a result of the coupling of the income/resource criteria and the categorical criteria. Clients may be eligible through the "means test" but yet still be ineligible because of failure to make it through the federally mandated categorical criteria. If Guam's share were based on the statutory formula, the Territory would surely be eligible for a higher federal match than 50 percent.

Private Health Care Providers and Insurance, the costs:

This geographic isolation and relatively small population base hinders the development of specialty services such as cardiology, neurosurgery, and other so-called super specialties. Even though the island remains served by the largest number of doctors within the region, the US Department of Public Health still

classifies some areas of Guam as medically under-served. Despite the classification, medical care on Guam is accessible.

The most obvious problem with implementing elements of health reform is the current status of Guam's health care system that has only one hospital and a very limited number of physicians. Off-island referrals have become common practice whenever local facilities and specialists are needed but are not readily available.

Recommendation 5: Universal Coverage--maximizing our public health care dollars is critical for Guam because public revenues are largely derived from a service-wage economy that rises and falls with the number of tourists that visit our island. Universal coverage will help improve collection at Guam Memorial Hospital (GMH) and reduce the current level of public subsidies.

We articulate the following statements that any health care reform must include as being essential for the development of accessible and quality health care for our people. Health care reform must...

Provide the resources necessary for our isolated communities to develop and train our doctors, nurses and other health care professionals willing to serve our islands.

Modify eligibility requirements for minority education and training programs so they will include and recruit people who live in our own communities.

Recognize that our population is at risk for certain diseases and expand funding for health promotion/disease prevention programs to help conquer these diseases.

Provide financial incentive for institutions to reach out to our brothers and sisters living in communities outside our islands.

Prioritize and recognize our Pacific American heritage in institutions that serve us.

Glancing over this testimony, one might assume that Guam is within the mainstream of health care and that we have no specific problems implementing health care reform.

The People of Guam have unique disparities:

The high cost of doing business in the Pacific with minimum profit margin. A population estimated at 150,000 has difficulty sustaining operations and personnel costs to privately run health clinics. The medical care community has experienced rising costs of health care. Government employees carry the burden of additional medical insurance costs with reduced benefits to provide a sufficient

level of profit margin to private health care providers. Once our largest medical insurance provider, PacifiCare recently renegotiated the company's way out of providing service to 16,000 government employees, retirees, and family members.

In previous years our people had the option of off island health care in the Philippines, Hawaii, or California. Citizens of our small community, with limited resources, now only have two choices for off island treatment—hospitals in the Philippines or California. Hawaii will not receive our patients due to high levels of nonpayment from Guam patients.

This disparity is a historical one--the injustices our peopled suffered during WWII in Forced Labor Camps, by the hand of Imperial Japanese Soldiers left mental, physical, and emotional wounds that equate to higher health care bills today for our elderly and their families.

Today I testify for justice from a body having the control of our government, like no other state in the union, this disparity--this inequality deserves your attention far beyond Compact Impact Funds.

Today's hearing reminds me of a quote from our Pacific American Foundation Report, "while the sun rises on the continental United States, Pacific Americans are still asleep in the darkness. As the nation moves toward health care reform, help us to enjoy the early sunrise with the rest of the nation.

Thank you, maraming salamat po, yan Si Yu'os ma'ase.

Mr. BURTON. Thank you, yes, we will put your whole statement into the record, without objection.

Ms. BORDALLO. Thank you.

Mr. BURTON. We will now swear in our witnesses. Will you both rise, so I can get you sworn? Raise your right hands, please.

[Witnesses sworn.]

Mr. BURTON. Since you're a friend of mine after our trip over there, David, I think we'll start with you, the Honorable Mr. Cohen.

STATEMENT OF DAVID COHEN, DEPUTY ASSISTANT SECRETARY, OFFICE OF INSULAR AFFAIRS, U.S. DEPARTMENT OF INTERIOR; AND NATHAN STINSON, JR., DEPUTY ASSISTANT SECRETARY, OFFICE OF MINORITY HEALTH, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. COHEN. Thank you very much, Mr. Chairman. Thank you, members of the subcommittee and guest members for today.

I'm pleased to appear before you today to discuss health care in Guam, American Samoa and the CNMI. I would summarize our assessment of health care issues in the Pacific Territories with the following observations. No. 1, we don't know enough. No. 2, what we do know causes us concern. Health care in the Pacific Territories faces many daunting challenges.

One of the greatest challenges is that the last comprehensive study on health was published in the mid-1990's by the Institute of Medicine. The comprehensive health care data we use today are dated and inadequate. Existing evidence suggests that our own communities face the likelihood of poor health. Factors that contribute to this prospect are economic hardship, poverty, joblessness and under-employment, limited primary and specialty care, and the under-utilization of services.

Health problems are exacerbated by a number of systemic problems. The tradition of heavily subsidized health care in the Pacific Territories can sometimes impede investment in health care. Health care management systems have not efficiently allocated the limited health care resources that are currently available. A perennial lack of funds is a problem for improving facilities, buying up to date equipment, purchasing sufficient supplies and drugs and paying for off-island medical referrals, which are very important in the islands.

Unlike the States, Medicaid reimbursements to the territories, as the Congresswoman has noted, are subject to caps. They are also subject to a reimbursement formula that is much less favorable than what States are eligible for.

Like the general U.S. population, island communities suffer diseases related to the cardio and cerebral vascular system, cancer, and of course injuries. Nutritional diseases such as diabetes and obesity are also leading causes of death. Of the serious diseases faced by the resident of the territories, many are chronic diseases precipitated by lifestyle choices.

Over the last 50 years, island populations have increasingly adopted our mainland diet, with its emphasis on processed foods that are high in fat, high in carbohydrates and low in fiber. Island

residents have also moved toward more sedentary work. Smoking is another major risk factor.

The good news is that lifestyle choices can eliminate many of the diseases discussed above. Educational efforts therefore could produce positive health results.

The lack of funds dedicated to health care is an overarching problem. Isolation and distance from metropolitan centers contributes significantly to this deficit in resources. Shipping costs are vastly increased for all things needed by island health care systems. It's difficult to attract off-island doctors, nurses and other personnel to the respective islands on a long term basis. Off-island medical referrals for specialized treatment consume large portions of each territory's health care budget. The acquisition of technical assistance for solving health care problems usually involves inordinate delays and complications.

In addition, air travel makes the territories vulnerable to infections from the outside. Diseases such as tuberculosis and measles, which are less controlled in Third World countries than in the United States, make appearances from time to time in the territories. They must be dealt with on an emergency basis.

Under the compacts of free association, approximately 6,900 Freely Associated State's citizens are now in Guam and 2,100 in the CNMI. Respiratory disease seems to be more prevalent in the FAS than in the U.S. Territories. Marshallese women have five times the breast cancer rate of Caucasian women in the United States, and 75 times the rate of cervical cancer. With FAS migration, the health problems of the FAS become the health problems of Guam and the CNMI.

Over the next 20 years, the Office of Insular Affairs will provide approximately $76 million in assistance to the Federated States of Micronesia and approximately $33 million in sector grants to the Republic of the Marshall Islands, under the revised compacts of free association. This assistance will include as a top priority funds targeted at improving health of the citizens of the FSM and RMI in their home countries.

Assuming improved health, education and economic opportunity, there will be two benefits, we hope. One, fewer FAS citizens may find it necessary to migrate to Guam and the CNMI, and two, those FAS citizens who do migrate will likely be healthier.

We also provide now compact impact funds under the compact to compensate not only for the health effects of migration and the strain of local health care budgets, but also education and other types of services as well, $14.2 million this year for Guam and $5.1 million for the CNMI.

The Office of Insular Affairs provides a variety of types of technical assistance funds for a variety of health care needs. These are summarized in my written statement. Our technical assistance program is well received in the territories and our assistance, along with HHS grants, can only constitute a small part of each individual territory's health care financing.

Mr. Chairman, we welcome the subcommittee's interest in the territory's health care challenges, and look forward to working with you on these important issues. Thank you.

[The prepared statement of Mr. Cohen follows:]

Statement

Of

David B. Cohen

Deputy Assistant Secretary of the Interior
for Insular Affairs

Before the

House Subcommittee on Human Rights and
Wellness

Regarding

Health Care in the U.S. Pacific Territories

February 25, 2004

Mr. Chairman and members of the Subcommittee on Human Rights and Wellness, I am pleased to appear before you today to discuss health care in the U.S. Pacific island territories of Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands (CNMI).

I would summarize our assessment of health care issues in the Pacific territories with the following observations:

- We don't know enough.
- What we do know causes us concern.
- We see alarmingly high rates of diabetes, hypertension, obesity, and many types of cancer and other diseases.
- Lifestyle choices cause many of the diseases that afflict territorial residents.
- Problems are exacerbated by isolation and distance.
- Problems are exacerbated by migration.

We Don't Know Enough

It is no secret that health care in the Pacific territories of Guam, American Samoa and the CNMI faces many daunting challenges. One of the greatest challenges is the fact that the last comprehensive study on health systems and services in the United States territories and freely associated states (FAS) was published in the mid-1990s at the urging of the Congress by the Institute of Medicine. The comprehensive health care data we use today are dated and inadequate.

The Office of Management and Budget recently revised its Statistical Policy Directive No. 15 to require Federal agencies to disaggregate data on Pacific Islanders from data on Asian Americans. This new policy will not, in and of itself, ameliorate the paucity of good data on the Pacific territories. Since such a large proportion of residents of the Pacific territories are Pacific Islanders, however, disaggregation of data should certainly be helpful. The positive effects of the revision to Statistical Policy Directive No. 15 will hopefully become apparent as more and more agencies implement it.

What We Do Know Causes Us Concern

Existing evidence suggests that, contrasted with the general United States population, island communities face the likelihood of poor health. Other factors that contribute to

this prospect are economic hardship, poverty, joblessness and underemployment; limited access to primary care and specialty medical care; and underutilization of services.

Existing evidence also suggests that a number of dangerous diseases are more prevalent in the territories than in the fifty states, as I will discuss later. These health problems are exacerbated by a number of systemic problems that the island health care systems face.

- Geographic isolation is a major problem, which I will discuss more fully later.
- A perennial lack of funds is a problem for improving facilities, buying up-to-date equipment, purchasing sufficient supplies and drugs, and paying for off-island medical referrals.
- The retention of well-educated health care professionals is a problem due to low pay vis-à-vis the fifty states.
- An economic downturn like that experienced by Guam and the CNMI as a result of the mid-1990s Asian economic crisis means that local government funds are less available for all government activity, including health care.
- Poor persons often have unattended health problems. The territories' large populations of poor persons have increased in recent years due to the economic downturn in Guam and the CNMI.
- The tradition of virtually free health care in American Samoa and sizeable subsidies in Guam and the CNMI impedes investment in health care in the territories.
- Inadequate health care bill collection efforts also impede the accumulation of funds for health care.
- The territories' still-developing health care management systems have not efficiently allocated the limited health care resources that are currently available.
- A lack of political will in the executive and legislative branches of territorial governments to impose health care cost recovery on patients either through direct billing or through the utilization of health insurance translates into fewer health care resources.

As these observations indicate, the Pacific territories face intimidating health care challenges -- some are extraordinary and not of the territories' own making, and some the territories are responsible for. The bottom line is that the territorial governments function much like state governments, which means that solutions to problems rest with the territorial governments themselves. Unlike the states, Medicaid reimbursements to the territories are subject to caps. Guam receives a maximum of $6.68 million a year, American Samoa $3.95 million, and the CNMI $2.38 million.

The Department of Health and Human Services (HHS) provides a number of grants for specific purposes to each of the territories. Most HHS grants are targeted in the areas of public health, primary care and preventive services, maternal and child health, and bio-terrorism preparedness.

Alarmingly High Rates of Diabetes, Hypertension, Obesity and Cancer

Like the general United States population, island communities suffer diseases related to the cardio and cerebrovascular system, cancer and injuries. Smoking is certainly a factor for heart disease, as are high blood cholesterol, hypertension, and physical inactivity. Nutritional diseases such as diabetes and obesity are also leading causes of death in the islands. Poverty often exacerbates nutritional diseases such as diabetes and obesity.

Lifestyle Choices

Of the serious diseases faced by the residents of the Untied States territories, many are chronic diseases precipitated by lifestyle choices. A number of the health problems I just discussed are related to diabetes and obesity. Diabetes is an insidious disease, which, if left uncontrolled, can kill. It kills adults in the most productive years of their lives. The chronically ill are burdens on both their families and their health care system. Obesity is one of the major causes of diabetes and other life-threatening diseases in the islands. Over the last 50 years, our island populations have increasingly adopted our mainland diet, with its emphasis on processed foods that are high in fat, high in carbohydrates, and low in fiber. Island residents have also moved toward more sedentary work.

Smoking is another major risk factor. While there is little concrete information on smoking in the United States territories, anecdotal information may show it to be quite prevalent. It, of course, is widely known to cause lung cancer and other disease.

The good news in all this discussion of diabetes, obesity and smoking is that lifestyle choices can eliminate the diseases for many and moderate them for others. Thus public education, including saturation public service announcements like those in the fifty states against smoking, could have a salutary effect, over a period of time, on the health of island residents. Educational efforts, therefore, could produce positive health results.

Problem: Isolation and Distance

As I discussed earlier, the lack of funds dedicated to health care is an overarching problem. Isolation and distance from metropolitan centers contribute significantly to this

deficit in resources. In the territories, problems are magnified due geographic isolation:

- Shipping costs are vastly increased for all things needed by island health care systems.
- It is difficult to attract off-island doctors, nurses and other personnel to the respective islands on a long-term basis.
- Off-island medical referrals for specialized treatment consume large portions of a territory's health care budget.
- The acquisition of technical assistance for solving health care problems usually involves inordinate delays and complications.

The Effect of Migration

In addition to the diseases I noted earlier, air travel makes the territories more vulnerable to infections from the outside that further burden already overburdened health care systems. Approximately 17,700 persons born in the country of Samoa live and work in our territory of American Samoa. Under CNMI law, 30,000 citizens of Asian countries (now 43 percent the CNMI population) have been admitted for work in the Commonwealth. While these alien populations bring benefits to the territories in which they reside, they also bring health care concerns and burdens. Their health care is costly for the territories. In addition, diseases such as tuberculosis and measles, which are less controlled in third world countries than in the United States, make appearances from time to time in the territories. They must be dealt with on an emergency basis.

Eighteen years ago, under the then-new compacts of free association, citizens of the freely associated states (FAS) began entering Guam and the CNMI for work and residence. Approximately 6,900 FAS citizens are now in Guam and 2,100 in the CNMI.[1] FAS citizens appear to suffer similar causes of death as residents of the United States territories: heart and vascular disease, cancer, and accidents. Additionally, respiratory disease seems to be more prevalent in the FAS than in the United States territories. Marshallese women have five times the breast cancer of Caucasian women in the United States and 75 times the cervical cancer. With FAS migration, the health problems of the FAS become the health problems of Guam and the CNMI.

Over the next twenty years, the Office of Insular Affairs will provide assistance to the Federated States of Micronesia (FSM) and the Republic of the Marshall Islands (RMI) that we believe will provide an indirect benefit to Guam and the CNMI. The amendments to the compacts of free association for the FSM and the RMI include a special sector grant for health for each country. Health, along with education, will get top priority. For fiscal year 2004, the amounts dedicated to health will be $15.4 million for the FSM and $6.9 million for the RMI. These targeted health funds are intended to

[1] These FAS citizens are post 1986 entrants and do not include children born in a United States jurisdiction.

improve the health of the citizens of the FSM and RMI in their home countries. Assuming that compact funding brings improved health, education and economic opportunity to the FSM and RMI populations, there will be two correlative benefits for the United States: (1) fewer FAS citizens may find it necessary to migrate to United States jurisdictions like Guam and the CNMI, and (2) those FAS citizens who do migrate will likely be healthier and less of a burden for the United States jurisdiction in which they live.

INTERIOR ASSISTANCE

The Office of Insular Affairs in the Department of the Interior administers a technical assistance program to benefit territories. For fiscal year 2004, $10.4 million was appropriated for the program. The funds are used for a wide variety of requests, usually from the territorial governors, including health care. Our technical assistance grants are supplemental funding, not major sources of funding for the territories' medical or public health systems. Our technical assistance program is intended to provide funding for urgent needs where local funding is not available.

The following technical assistance has been provided by the Office of Insular Affairs in the field of health care:

- For American Samoa, funding has been provided to improve financial management with links to patient records and billing.
- For Guam, funding has been provided to help the territory, in times of economic crisis, to care more efficiently for the medically indigent.
- For Guam and the CNMI, funding has been provided to improve the health screening of new alien workers for diseases such as tuberculosis.
- For all Pacific territories, funding has been provided for five years to prevent and control viral hepatitis infections, and to refine and integrate hospital and public health emergency plans and develop plans for bio-terrorism alerts and drills.

Interior's technical assistance program is well received in the territories. Our assistance programs and HHS grants, however, are only a small part of an individual territory's health care financing. Mr. Chairman, I hope that the information I have provided today is of aid to the Subcommittee in its consideration of health care in the U.S. Pacific island territories. Their situation geographically, and in the American political family, is indeed unique. Your interest in the territories' challenges is very welcome.

Mr. BURTON. Thank you, David. I hope you don't mind me calling you David instead of Mr. Secretary, since we were traveling together and everything over there.

Mr. COHEN. I much prefer it.

Mr. BURTON. Thank you.

Dr. Stinson.

Dr. STINSON. Thank you very much.

Good afternoon. My name is Nathan Stinson, Deputy Assistant Secretary for Minority Health and the Director of the Office of Minority Health in the Department of Health and Human Services. Thank you for the opportunity to testify today on the Department's activities on Guam, American Samoa and the Commonwealth of the Northern Mariana Islands. I will refer to them as the Pacific Island Territories in our oral remarks. A complete written testimony is submitted to the committee for the record.

I appreciate the committee's interest in this region. The people of the Pacific Islands have many serious health problems and are medically underserved. Let me start with some of the particular barriers and challenges, many of which, Mr. Chairman, you are aware. The remoteness of the Pacific Islands, as well as the wide difference in the time zone redefines the term difficulty in access to care. The inadequate nature of the basic health infrastructure, as well as the manpower shortages, are factors complicating their ability to deliver quality of care to more than 180,000 residents.

In order to better understand the Department's programs for the Pacific Island Territories, I would like to mention some of the other obstacles faced by providers and their patients alike. I will share with you a few examples of some of the stories that we have heard as far as issues that complicate their ability to provide the level of care they are interested in.

There are oftentimes where medicines are in short supply or are routinely unavailable. For example, we heard the story of lack of the availability of insulin on American Samoa, that created a situation where a woman who was pregnant and diabetic could not receive the necessary insulin during the time of delivery. Specialists in tertiary care are severely limited. In Guam, a woman with breast cancer is much more likely to undergo a mastectomy as opposed to the possibility of breast conserving therapy, such as lumpectomy and radiation. The breadth of the treatment options that we have available in this country really aren't available to many of the jurisdictions in the Pacific Islands.

Also, the lack of tertiary care generates enormous cost. As was just mentioned, many patients who need the attention of a specialist must be sent off-island for treatment. This consumes a significant share of the health budget.

As far as the Department of Health and Human Services programs, they really are intended to focus in three specific areas. The areas of access, the areas of quality of care, and also to help educate and inform individuals on how to take charge of their health and what are the things they can do to improve their health, such as exercising and eating the proper diet.

The Medicare and Children's Health Insurance Programs run through CMS work closely with the three territories to assure the provision of high quality health care and provide significant fund-

ing for pregnant women, families with children and people with disabilities. In fiscal year 2003, the Pacific Island Territories received through Medicaid $2.3 million and through the Children's Health Insurance Program $1.9 million. The Centers for Medicare and Medicaid Services, as well as the San Francisco regional office staff of the Department of Health and Human Services provides ongoing technical assistance to the territories, especially on eligibility, services and billing. And recently there were discussions around such priority areas as the provision of screening services, off-island referrals and the federally qualified health centers.

The community health center program funded through HRSA's Bureau of Primary Health Care has established health centers in Guam and American Samoa. The community health centers experience incredible challenges in the recruitment and retention of providers, especially ones who come from or are knowledgeable of these communities. Qualified nurses are frequently recruited to higher paying jobs in Hawaii, as well as other States. And Mr. Chairman, as you know, even with the continental United States, we are currently under an incredible shortage of qualified nurses for our health care system.

To meet these particular challenges, there has been a utilization of non-physician medical officers on the islands that are utilized for the provision of health care services, instead of fully licensed physicians. Many of the doctors who have come to the islands have come through the National Service Corps, which is a program funded through HRSA.

One of the particularly innovative programs that the Department has in the Pacific Islands is its Special Populations Network for Cancer Awareness Research and Training. This is administered by the National Cancer Institute Center to Reduce Cancer Health Disparities in the National Institutes for Health. The goal is really to build the relationships between large research institutions and community based programs to address the burden of cancer in minority communities.

A particular part of this is the Pacific Island Cancer Initiative, which has assembled a team to articulate the health needs of indigenous Pacific Islanders, and to focus on strengthening and sustaining community capacity and increased involvement of Pacific Islanders in the National Cancer Institute Program and Services is also envisioned.

The community health centers, through their National Diabetes Collaboratives, as you mentioned, diabetes is just an incredible problem of the population in the Pacific Territories, in Guam, approximately 40 percent of the patients have a hemoglobin A1C with an average of 10, far above the goal of 7. And as a participant in the diabetes collaborates Pacific West clusters, clinicians in Guam have made a commitment to improving the quality of diabetes care. In addition to intense training on the elements of quality treatment, assistance is provided in communication and maintaining registers, which is important in tracking the development of complications.

The last program I want to mention just very briefly is the State based diabetes prevention and control program. Again, designed to

really talk about the ways to prevent the development of the illness by proper care, proper diet and proper exercise.

In conclusion, I hope this brief overview of the Department's activities has been helpful to the committee in considering ways to improve the health care to the Pacific Islands. The task is considerable. But it is doable, and we must accomplish this. If we are willing to accommodate the unique aspects of the region, work with the territory leaders and residents in their culture and traditions while respecting the governing entities and policies, I believe that we can find solutions that will strengthen the capacity of the health care system and in turn the health status of the people of the Pacific Islands.

Thank you for the opportunity to testify before you today.

[The prepared statement of Dr. Stinson follows:]

Testimony
Before the Subcommittee on Human Rights and Wellness
Committee on Government Reform
United States House of Representatives

HHS Health Care Activities in the Pacific Island Territories

Statement of
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Deputy Assistant Secretary for Minority Health,
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U.S. Department of Health and Human Services

For Release on Delivery
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I. INTRODUCTION

Good afternoon. I am Dr. Nathan Stinson, Deputy Assistant Secretary for Minority Health and Director of the Office of Minority Health (OMH) in the Department of Health and Human Services (HHS). I want to thank the Committee for the opportunity to testify today on the Department's activities in the United States Pacific Island territories (USPIT), primarily Guam, Commonwealth of the Northern Mariana Islands (CNMI) and American Samoa. In addition, I will provide information on health disparities and the unique challenges associated with delivery of health care and improving the health of the people in this region. The Department sees this hearing as an important opportunity to identify collaborative strategies and actions that can have a positive impact on disease control and prevention in the Pacific Basin.

One cannot stress strongly enough the region's remoteness from the continental United States and the wide time zone differences across the region. This reality is coupled with the characteristics of the population including its youthfulness. A map of the USPIT appears in Appendix 1. Background on the region's demographics and geography is included in Appendix 2.

As I brief you on the Department's activities to address health disparities in the Pacific Basin, it is important to bear in mind that they are being carried out in the context of Secretary Thompson's national commitment to "close the health gap."

II. BACKGROUND of DISPARITIES and COMMON CHALLENGES in the PACIFIC BASIN

Over the years, racial and ethnic minorities, including Asians and Native Hawaiians and Pacific Islanders, often have been characterized as "*hard to reach*," largely due to the socioeconomic, geographic, cultural, and linguistic barriers that can inhibit the communication, receipt of information and services, and understanding of critical health messages.

The 2003 issue of *Health, United States*, the annual report card on the health status of the American people, documented significant progress in the overall health picture of the Nation, but reinforced the fact of the continuing health-related burdens experienced by the racial and ethnic minority populations compared to the U.S. population as a whole. Unfortunately, those communities experiencing disparities suffer worse health status and higher rates of death and disease. This is unacceptable. The real challenge for HHS and the Pacific Basin jurisdictions is not debating whether disparities exist, but in developing and implementing programs to improve the outreach efforts and knowledge, accessibility of appropriate health services, and quality of care.

Cancer and cardiovascular disease (CVD) are typically among the top three leading causes of death in the jurisdictions, but this is not uniform across entities.

- Guam (1995 - 2001): CVD; cancer; accident/trauma
- Northern Marianas (1997 - 2001): CVD; cancer; other
- American Samoa (1998 - 2000): heart disease; neoplasms; diabetes
- United States (2000): heart disease; malignant neoplasms; cerebrovascular diseases

The estimated infant mortality rates for 2003 (CIA World Fact Book):

- Guam 6.46 deaths per 1000 live births
- Commonwealth of Northern Mariana Islands 5.52 deaths per 1000 live births
- American Samoa 9.82 deaths per 1000 live births
- United States 6.75 deaths per 1000 live birth

The total reported AIDS cases in 2002 include:

- Guam 76
- Commonwealth of the Northern Mariana Islands 3
- American Samoa (2001) 1
- United States 42,745

According to the national Behavioral Risk Factor Surveillance Survey (BRFSS), in 2001 the obesity rate in Guam and the United States was 59 percent and 56 percent, respectively. Because the island of Guam is and continues to be the only entity of all the U.S. affiliated jurisdictions included in this survey, data from the other jurisdictions are not available for comparison.

Before describing some of HHS's programs to improve health services and health status in the USPIT, which attempt to respond to the specific challenges in a given jurisdiction, it is important to note common challenges across all jurisdictions, including inadequate health care delivery, the poor infrastructure, limited resources, and isolated location. While these challenges exist in the continental U.S., they are of much greater magnitude in the Pacific Basin. The following observations and anecdotes are from health care experts in Hawaii, the USPIT, and HHS's Health Resources and Services Administration's (HRSA) Community Health Centers based in the Pacific. These startling stories demonstrate the significant challenges confronting the health care systems and residents:

- Depleted medical supplies and an extended back order is common, which can be attributed to pharmacies not being paid so no orders are delivered, one person doing multiple tasks, distance between the islands, migration of persons from one island to another island to obtain services, and other factors. For example, a physician in American Samoa could not provide

insulin to a pregnant diabetic woman because there was no insulin in supply.

- Lack of specialists and tertiary care limits treatment options and quality of care thereby impacting the quality of life. Factors include the low salary, the remoteness of the jurisdictions, the living conditions, and the lack of housing. Health professionals are so profoundly difficult to come by, that organizations in the Pacific Basin must draw from a variety of health education systems in Fiji, Southeast Asia, as well as the United States. As a result, cultural and linguistic differences between patients and providers are not uncommon. In some cases non-physician Medical Officers, rather than fully licensed physicians, are used. The Pacific Islands often recruit National Health Service Corps providers (another HRSA funded program). Qualified nurses are often quickly recruited to jobs in Hawaii or other states which pay higher salaries than the jurisdictions can afford.

Women with breast cancer who are treated on Guam are more likely to undergo mastectomy as opposed to breast conserving therapy (lumpectomy and radiation). Therefore the "treatment options" are not "real options" to the women in this jurisdiction. American Samoa, for example, provides dialysis but has no resident nephrologist. Other island jurisdictions have limitations regarding basic services—mammography, for

instance, is frequently not available on the island of Saipan because often a properly trained technician is not available for months at a time.

The lack of tertiary hospitals generates enormous costs involved with sending patients off the island for specialty care. For example, because radiation therapy, chemotherapy, and oncologist services are by and large unavailable, cancer patients frequently need to travel to another jurisdiction or Hawaii. The costs associated with such referrals consume a large part of the health budget and benefit only a few patients. Because of unpaid bills for services provided in Hawaii and California, physicians cannot refer many patients off island to these locations for necessary tertiary care.

In particular, the health care systems of the Federated States of Micronesia and the Republic of the Marshall Islands are inadequate to meet the needs of the population, giving rise to inter-jurisdiction travel in order to receive appropriate health care. An extensive GAO Report (GAO-02-40, October 2001), *Migration from Micronesian Nations Has Had Significant Impact on Guam, Hawaii, and the Commonwealth of the Northern Mariana Islands*, found that in 2000, 43 percent ($4 million) of all identified Commonwealth of the Northern Mariana Islands impact costs were related to health care. A Commonwealth of the Northern Mariana

Islands' Department of Public Health Services official noted that neonatal intensive care was a key issue for the Freely Associated States (FAS) migrants—which are the Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI), and Palau—and that expectant mothers often have no insurance and no prenatal care until they arrive at CNMI Community Health Care.

As a result of the Compact of Free Association between the United States and FAS, these residents are allowed to freely enter the United States, including its insular areas. The House Joint Resolution 63, the Compact of Free Association Amendments Act of 2003, was signed into law December, 2003. The legislation includes "compact impact" funding earmarked for Guam, Hawaii, American Samoa, and the Northern Marianas, all of which have been burdened by costs associated with migration. Poor education and health care facilities in the Marshall Islands and the four FSM states made migration to locations such as Hawaii and Guam more attractive. Furthermore, not only could FSM and RMI citizens work and study on U.S. soil, they could also use healthcare facilities, as well as apply for public assistance and put their children into CNMI, Guam, and Hawaii schools.

In its 2000 assessment, Guam identified unpaid services by Guam

Memorial Hospital to FAS patients, totaling over $5.4 million, as its largest single area of health impact. Officials reported patients' reliance on the hospital's emergency room for primary health care and not urgent conditions. Although FAS represented approximately 5.0 percent of Guam's population, they accounted for approximately 12.0 percent of the emergency room patients per month. Similar to CNMI, expectant FAS mothers arrive at the hospital close to delivery with no prior prenatal care. The Governor, at the time of the GAO report, stated that the U.S. naval hospital on Guam was underutilized and could provide care for FAS migrants.

- Long distances must be covered to provide care to individuals in remote areas.

- Lack of potable water, fluoridation of the water supply, and sanitation services.

- Lack of non-profit entities. All health center grants in the Pacific are awarded to the jurisdiction's government which administers the grant and employs the health center staff. Most jurisdictions are heavily reliant on Japanese tourism as its major source of revenue. The weakened Asian economy and reduced tourism in the Pacific jurisdictions have resulted in

the plummeting of the government's general fund revenues. As a result, some governments, such as Guam, have implemented hiring freezes, reduced hours, or reduced salary, which affects health center staff. Because most jurisdictions are not set up to accommodate non-profit entities, the government is the only provider of care or services.

- Data may undercount mortality and morbidity. For example, American Samoa reported 9.82 deaths per 1000 live births in 2003. However, many pregnant women from Western Samoa go to American Samoa for the delivery and then return home. The births would be counted in American Samoa data but subsequent deaths would not appear in the infant mortality statistics.

- In Guam, physicians must participate in a "house call" rotation as condition of having hospital privileges. This burden is becoming increasingly problematic with repeated threats from the physician community to refuse to take "house calls." For example, in the Department of Obstetrics and Gynecology, approximately 40 percent of the deliveries are for "house patients." The physicians, who are primarily in private practice and dependent on the generated revenue, are concerned about the level of uncompensated care they provide.

- The physical terrain of the Pacific Basin itself poses a threat to residents in receiving care. A physician recently reported in American Samoa that there was one road, parallel with the shore that leads to the hospital. Storms and typhoons cause mud slides that would block transport of health care providers and patients to the facility.

III. HHS-FUNDED PROGRAMS in the U.S. TERRITORIES OF THE PACIFIC BASIN

HHS's funded programs do contribute to breaking down some access barriers and connecting people to the services they need; informing and educating people to take charge of their health status; and uncovering new knowledge to help prevent, detect, diagnose, and treat disease by improving the quality of health care delivery.

Examples of HHS-funded programs include the following:

A. ACCESS

1. ***CMS Funding and Grant Programs*** - The Social Security Act specifies the relationship of the Centers for Medicare & Medicaid Services (CMS) with the territories. CMS works closely with the territorial governments to help them in their efforts to provide high

quality health care. Medicaid and the State Children's Health Insurance Program (SCHIP) provide significant health care funding for pregnant women, families with children, people with disabilities, and individuals over age 65 in the U.S. territories of American Samoa, Guam, and CNMI. Unlike the funding received by U.S. states, the Medicaid and SCHIP funding for these territories is capped. Federal funding for services to individuals covered by Medicaid and SCHIP in Federal fiscal year 2003 totaled:

	Medicaid	SCHIP
Samoa	$ 3,727,000	$ 396,900
CNMI	$ 2,255,000	$ 363,825
Guam	$ 6,321,000	$1,157,625
Total	$12,303,000	$1,918,350

The total amount of Federal Medicaid and SCHIP funding for each of the U.S. Territories is set by law. The Medicaid and SCHIP programs require that Federal funds be matched with State and Territorial funds, and the law sets a specific Federal Medicaid matching rate for the territories. Each of the three Pacific territories provides significant additional territorial funds, beyond Federal matching requirements, to fund additional services.

In addition, CMS awarded competitive grant funds in the Pacific territories to help build the infrastructure needed to assist aged and disabled individuals who live in the community. Guam received both a Community Integrated Personal Assistance grant for $300,000 and a Real Choice Systems Change grant of $673,106 in 2001 to improve community long-term care support. CNMI received a Real Choice Systems Change grant for $1.385 million in 2002 to build a support system for people with developmental disabilities.

American Samoa, CNMI, and Guam operate their Medicaid programs with broad flexibility to accommodate their smaller, public health dependent systems. Medicaid State Plans of all three Pacific Territories specify that they cover the following services: inpatient hospital services, outpatient hospital services, laboratory and x-ray services, nursing facility services, physician services, home health care, medical and other types of remedial care, optometrist services, other practitioner's services, clinic services, dental services, physical therapy, prescribed drugs, dentures, prosthetics, eyeglasses, and health-related transportation. Additional Medicaid services are provided by some of these territories, such as private duty nursing, occupational therapy, and speech, language, and hearing services.

Medicare also provides significant resources for health services, to elderly and disabled beneficiaries, although data for FY 2003 are not yet available.

Each year for the past several years, CMS has held a territorial summit with the Directors of the Medicaid programs in the territories. CMS staff in the San Francisco Regional Office, including a Pacific representative at our Hawaii Field Office, have developed expertise and provide ongoing technical assistance to address the unique needs of the Pacific territories, most frequently on Medicaid and SCHIP eligibility, services, and billing issues. More recently, CMS established one National Account Representative in the Regional Office and one in Central Office for each territory and state, to devote additional attention to the needs of their jurisdictions. These initiatives focused CMS efforts on issues of interest and concern to the territories. Discussions have centered on the impact of Federal requirements on the territories and the ways health care services can be prioritized when resources are limited, including the provision of Early Periodic, Screening, Diagnosis and Treatment (EPSDT), off island referrals, and Federally Qualified Health Center (FQHC) services. CMS staff assist the territories in obtaining additional Federal funds within the statutory limits of the programs. For example, technical assistance

and additional funding were provided to the territories for Y2K preparedness.

The Medicare Modernization Act (MMA) contains special provisions for the U.S. territories. The three Pacific territories plus the Caribbean territories of Puerto Rico and the U.S. Virgin Islands are eligible to share a special pool of funding in proportion to each territory's share of the total number of Medicare beneficiaries living in all five territories. These funds will be used by each territory for Transitional Assistance to help low-income Medicare beneficiaries pay for prescription drugs purchased through the temporary drug discount card program. Each territory has broad flexibility to design a Transitional Assistance program that best suits its unique circumstances. To receive a portion of the funds, the territory must submit a plan to CMS by March 12, 2004. CMS held conference calls with the territories to provide information on these provisions and developed a template for the territories to assist them in the design and submission of their proposals. Two of the territories (Guam and CNMI) have already submitted their draft plans for CMS review. The MMA contains similar special pools with flexible funding for the territories to share to provide assistance to low-income Medicare beneficiaries under the permanent Part D Medicare drug benefit that begins in 2006. The law gives the

Secretary authority to waive Part D requirements to the extent that may be necessary to assure access to Part D drug coverage for Medicare beneficiaries living in the territories.

2. ***Community Health Centers***-- HRSA's Bureau of Primary Health Care (BPHC) funds the Community Health Centers (CHC) in the Pacific. CHCs provide family-oriented primary and preventive health care services for people living in rural and urban medically underserved communities. CHCs exist in areas where economic, geographic, or cultural barriers limit access to primary health care for a substantial portion of the population, and they tailor services to the needs of the community. Guam and American Samoa received $403,470 and $416,663, respectively, in fiscal 2003.

The Pacific Basin health centers have clinical issues that are very different from those in the continental U.S. Prevalent health conditions of Pacific Islanders include those typical for developing countries (e.g., tuberculosis, dengue fever, cholera) as well as health conditions that plague developed countries (e.g., diabetes, heart disease, cancer). Despite these challenges, the health center program is a key part of access to health care in the Pacific. In many jurisdictions, the CHCs are the only providers of care for uninsured patients or the CHC is the sole provider of health care.

4. ***Children's Services Program***: Funded by the Center for Mental Health Services (Substance Abuse and Mental Health Services Administration - SAMHSA), Guam received $1 million in fiscal 2002 for a six year project. Guam plans to develop and implement a child-centered, family-focused system of care that delivers effective, comprehensive, community-based, culturally competent mental health and related services for children and adolescents with serious emotional disturbance and their families and to ensure longitudinal studies of service systems outcomes. The system will honor the community's commitment to live true to the island heritage of "taking care of our own" and filling gaps by providing supports on the Island, rather than sending children thousands of miles away to off-island placements or not serving them at all.

5. ***Maternal and Child Health Services Block Grant (Title V):*** Administered by HRSA's Maternal and Child Health Bureau, the largest portion of Title V goes to the States and territories through a formula-based block grant process. The Federal/State partnership develops service systems to meet challenges in reducing infant mortality, providing and ensuring access to comprehensive care for women, and promoting the health of children through primary care services. All three of the U.S. Pacific jurisdictions received fiscal 2004 allocations, ranging between $506,369 to $886,000.

B. HEALTH STATUS

1. **Special Populations Network for Cancer Awareness Research and Training:** Administered by the National Cancer Institute's (NCI) Center to Reduce Cancer Health Disparities, National Institutes of Health (NIH), the purpose of the Special Populations Networks (SPN) is to build relationships between large research institutions and community-based programs and to find ways of addressing important questions about the burden of cancer in minority communities.

   The major goal of the SPN is to establish a robust and sustainable infrastructure to promote cancer awareness within minority and medically underserved communities, and to launch from these communities more research and cancer control activities aimed at specific population subgroups. The SPN projects cover three phases. In the first year, cancer awareness projects were implemented in the community and project plans were developed. In the second and third years, partnerships between the project and NCI sponsored groups should enhance minority training and minority participation in cancer trials. In the last two years, investigator-initiated research grant applications will be developed.

Examples of projects the SPN is funding in the Pacific territories include:

- **Pacific Islander Cancer Control Network:** Two centers of the University of California, Irvine (the Chao Family Comprehensive Cancer Center and the Center for Health Policy and Research) in collaboration with the National Office of Samoan Affairs (NOSA) and eight community-based organizations propose to establish the Pacific Islander Cancer Control Network (PICCN) that will improve cancer awareness, enhance recruitment to clinical trials, and increase the number of cancer control investigators among American Samoans, Tongans, and Chamorro/Guamanians in the United States. The community-based organizations (CBOs) are located in California, Washington, Utah, American Samoa, and Guam, where the large majority of Pacific Islanders reside. The CBOs, with the University's centers, NOSA, NCI, and other voluntary groups, comprise a Steering Committee that coordinates the network activities. Some project activities include assessing existing cancer education materials aimed at Pacific Islanders and developing new culturally-sensitive materials when appropriate, enhancing recruitment of Pacific Islanders to clinical trials by establishing relationships with cancer

centers, and promoting participation of Pacific Islander scientists in research by identifying candidates and developing a new training opportunity at the University.

- **`Imi Hale, the Native Hawaiian Cancer Research and Training Network**: This project aims to reduce cancer incidence and mortality among Native Hawaiians through the establishment of a sustainable infrastructure to:

  1) promote cancer awareness within Native Hawaiian communities; and
  2) initiate cancer research, training, and control activities. In Hawaii, the target population are Native Hawaiians who reside in the State of Hawaii.

Through an administrative supplement to the `Imi Hale SPN grant from the Center to Reduce Cancer Health Disparities and the NIH National Center on Minority Health and Health Disparities, a project entitled **"Pacific Islands Cancer Initiative"** was funded in 2002 to begin addressing the cancer health needs in all the U.S. associated Pacific Island jurisdictions. The strategy to achieve the goal depends on creating a team that can articulate the cancer health needs of indigenous Pacific Islanders, strengthening and sustaining community capacity, and including Pacific Islanders in NCI

and NIH programs and services that address those needs. Accomplishments to date include completed cancer assessments in all the jurisdictions that document current capacity in cancer prevention and control, convening of three meetings with clinical and public health representatives from the jurisdictions to discuss and set priorities in cancer prevention and control, establishment of the Cancer Council of the Pacific Islands with elected officers, and adoption of implementation plans based on regional priorities (i.e., increase laboratory capacity, develop resources, improve cancer care services, and establish cancer registries) and jurisdiction/state-specific actions.

2. ***State-Based Diabetes Prevention & Control Program*** (DPC): Administered by HHS's Centers for Disease Control and Prevention's (CDC) Division of Diabetes Translation (DDT), this program operates in all jurisdictions. Several of the recent activities supported by the territorial DPC program include:

- **Guam** is preparing a program to identify and conduct meetings with pertinent partners, as they are required to complete an assessment and prepare a program improvement plan for DDT. Pacific Diabetes Today training continues for community based diabetes prevention and control program activities.

- **Northern Mariana Islands** developed a diabetes prevalence registry of persons receiving diabetes care by age, sex, ethnic group, insurance coverage, and complications, thus providing information on the burden of diabetes among the Chamorro and Carolinians, the CNMI's indigenous population. A conference for Primary Care Provider and Community Members was held October 17-18, 2003. Standards for Diabetes Care and how to perform a complete foot exam were the focus of the conference for the providers, and food demonstrations and physical activity was the focus for community members. The Northern Marianas also participated in an immunization program to assure that at least 100 influenza vaccinations will be given on Saipan and 50 doses for each of the outer islands. Another accomplishment was development of a diabetes awareness education program for the media and lay person leadership.

- **American Samoa** improved a patient registry through collaborative efforts between the DPC Program coordinator, the hospital diabetes coordinator, hospital dietitian, the medical clinic staff, and the hospital quality management. They address sharing responsibilities for the entry, maintenance, and sharing of data collected through the Diabetes Care Monitoring System. The DPC Program has completed the Diabetes Guidelines for use in

hospital-based physicians' offices, private clinics, and dispensaries, which improved the adherence to care standards. Continuing media outreach efforts aim to increase public awareness and diabetes information in the community. The DPC Program, in collaboration with the National Diabetes Education Program (NDEP) representative facilitates a weekly 30-minute TV Program of care improvement topics, which are drawn from quarterly reports of the Diabetes Care Monitoring System.

3. ***HIV Prevention Projects for the Pacific Islands***: The CDC is providing funding to support HIV Prevention Projects for the U.S. associated Pacific Island jurisdictions. Six awards are expected to be made this April. Project activities focus on delivering evidence-based HIV prevention interventions, including preventing perinatal HIV transmissions; increasing the proportion of HIV-infected persons who know they are infected by increasing the number of providers who routinely provide HIV screening in health care settings, increasing the proportion of HIV-infected people who are linked to appropriate prevention, care, and treatment services; and strengthening the capacity of health departments and community-based efforts to implement effective HIV prevention programs and evaluate them.

C. QUALITY

1. ***Disparities Collaborative***: The CDC is working with HRSA's BPHC and the Institute for Healthcare Improvement to improve diabetes care within federally funded health centers. To increase access and decrease health disparities among medically underserved populations, Centers participating in this collaborative agree to adopt shared national measures, as well as local measures based on proven guidelines. Guam has been of the Pacific West cluster since 2000, and has completed the 12 months of intensive learning sessions on the elements of providing good chronic care and on a method for testing and implementing changes. Some of the preliminary results show challenges. For example, approximately 40 percent of patients' seen at the participating health centers in Guam have a hemoglobin A1c average of 10.0, which is above the goal of 7.0 average. Less than 20 percent of the patients received the annual dilated eye exam.

   As part of the collaboratives, the teams noted some strengths and challenges. Strengths include using locations and communities where people congregate and collaborating within their own communities. Several of the challenges are similar to those previously mentioned, as well as:

- Diabetes is much more prevalent in these populations compared to those in continental U.S. Diets have moved away from the "traditional" Pacific diet towards a more "westernized" diet consisting largely of tinned/packaged convenience and fast foods. Difficulty with technology, including cost and reliability of phone and Internet connections, affects the collaborative teams' ability to communicate as well as maintain their registries.
- Problems in getting some medications and test reagents also persist.

2. ***Data Infrastructure Grants***: The Commonwealth of the Northern Mariana Islands, Guam, and American Samoa each received $50,000 in FY 2002, which was awarded by the Center for Mental Health Services in the Substance Abuse and Mental Health Services Administration (SAMHSA). The Commonwealth of the Northern Mariana Islands will develop its capacity to produce information to assess and improve the quality of care for mentally ill adults and children with emotional disturbances. Guam is committed to the development and implementation of an automated information system that will provide statistical data to be used to improve community mental health services for its residents.

3. ***Office of Minority Health Resource Center (OMHRC) HIV Team***: The OMHRC HIV Team has extended its programmatic efforts to the Pacific Island Jurisdictions with its sessions on Guam during FY 2004. Two regional capacity building trainings will be held, as well as direct technical assistance (TA) to agencies working in the field of HIV/AIDS prevention and treatment. The trainings will include:

- Obtaining salient information to perform TA services through a *needs assessment process*;
- Working with local providers and other government agencies and federal partners who already have a presence on the islands;
- Identifying what type of technical assistance can be provided;
- Creating a strategic plan to implement services with local partners; and
- Finding appropriate resource persons to provide these services.

The TA will cover: 1) organizational infrastructure; 2) cultural competence; 3) community outreach; 3) programmatic design; 4) training initiatives; 5) communications assistance.

4. ***Ryan White CARE Act***: The Ryan White Comprehensive AIDS Resource Emergency (CARE) Act, enacted in 1990 and reauthorized in 2000, is administered by the HIV/AIDS Bureau, HRSA, and provides funding to states, territories, and other public and private nonprofit entities to develop, organize, coordinate and operate more effective and cost-efficient systems to people living with HIV/AIDS and their families.

- Title II helps health departments improve the quality, availability, and organization of HIV/AIDS health care and support services. This title also contains the AIDS Drug Assistance Program (ADAP), which provides low income individuals with life-prolonging medications. In FY 2003, Guam received $142,612, which includes a proposed $91,319 for ADAP. As of February 2003, Guam's ADAP faced capped enrollment and four people are on the waiting list. In FY 2002, for the first time, the other two Flag Territories, American Samoa and the Commonwealth of the Northern Mariana Islands, received Title II awards. In FY 2003, each of the two jurisdictions continued to receive approximately $50,000 in funding.

- Title IV focuses on the operation and development of

primary care systems and social services for women and youth, two groups that represent a growing share of the epidemic. In FY 2002, the Northern Mariana Islands were awarded $50,000 under Title IV.

5. ***Inclusion of the Pacific Islands in Vital Statistics Data and National Surveys***: In 2003, the National Committee on Vital and Health Statistics' (NCVHS) Subcommittee on Populations held two hearings on health data needs for the Asian and Native Hawaiian and Other Pacific Islander (ANHOPI) populations. The hearings were attended by academic researchers and community representatives. Each group stressed the need for developing statistical methodologies that would increase the numbers of ANHOPI in national surveys so that data could be reported yet avoid survey participant disclosure. The NCVHS' recommendations for HHS action are relevant for Pacific Basin populations. They include:

   a. Develop a long- term data collection, analysis, and dissemination plan to ensure that the Nation's system for monitoring the health status and health care of its subgroups, especially those concentrated in geographically distinct areas.

b. Devise sampling frames for national health surveys that would increase sample sizes for racial and ethnic minority groups that would support appropriate analysis and information dissemination.

c. Conduct targeted surveys to collect detailed, timely, and accurate data on specific subgroups of specific racial and ethnic minorities, especially those concentrated in geographically distinct areas.

The Subcommittee also urged collaboration with States, territories, Tribal governments, private foundations, and other stakeholders to develop methods, procedures and resources to accurately collect health data that ensures that the diversity of the U.S. population is fully reflected.

Also, the ANHOPI community has expressed frustration over what they perceive to be the Federal agencies' noncompliance in collecting racial and ethnic data in accordance with the revised Office of Management and Budget categories. The HHS Data Council's Working Group on Racial and Ethnic Data is developing a data primer that will be written in plain language to assist all, including the general public, to better understand the data collection and reporting process. The data primer will provide

clarifying information regarding how data are collected, factors that impact the release of data, and the meaning of some key terminology, (e.g., data not statistically reliable, data not stable, data not collected, etc.). The data primer is planned to be disseminated widely and could be useful for the USPIT.

As previously mentioned, Guam is the only jurisdiction included in national surveys, such as BRFSS. Including the other territories for track and comparison would also be useful for the USPIT.

6. In 2001, President Bush signed **Executive Order 13216**, entitled "Increasing Opportunity and Improving the Quality of Life of Asian Americans and Pacific Islanders," which extended the White House Initiative on Asian Americans and Pacific Islanders (AAPIs) and the President's Advisory Commission for another two-year term. The EO calls for a government-wide effort to address the unmet needs of Asian Americans and Pacific Islanders and increase AAPI participation in federal programs where they may be underserved. The Interagency Working Group (IWG) advises the President through the office for the White House Initiative on AAPIs, currently housed in HHS. In 2002, the IWG developed an inventory of programs affecting Asian Americans and Pacific Islanders and a FY 2002 performance report. Additionally, each agency is

responsible for developing an annual plan for achieving the mandates of the EO.

Finally, HHS is a focal point in the areas of coordination and collaboration with public/private sector groups, including the Federal Emergency Management Agency, whenever a federal disaster proclamation is issued, and the Pacific Island Health Officers Association. Additionally, HHS chairs both the Federal Regional Council in Region IX and its Outer Pacific Committee. These collaborations enhance discussions of regional issues and concerns, promote interagency resolutions, and improve communication.

IV. CONCLUSION

There are clearly significant health and health care challenges facing the U.S. Pacific Island territories, such as the poor infrastructure of the health care system; limited health care providers, specialists, and resources; limited technology; dearth of community-based organizations; isolated location; and limited funding. These contribute to documented health disparities.

HHS's efforts are concentrating on improving the accessibility and quality of health care and health status of these populations. It seems that our challenge, in a collective sense, is to use strategies that can accommodate the unique aspects of the region—using broader and more flexible approaches, working with the leaders and

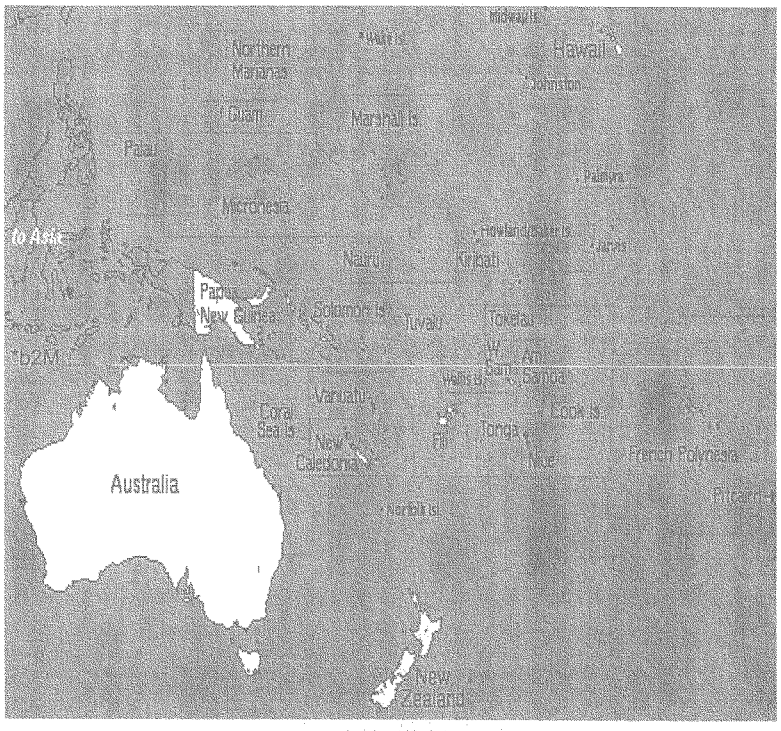
residents of the Pacific Basin, respecting the governing body and policies, cultures and traditions of the people, to improve the capacity and infrastructure of the health care system and, in turn, the health status of the people.

Again, thank you for the opportunity to testify before you today. I would be happy to answer any questions.

Appendix 1

Geographic Location of the U.S. Pacific Island Territories (Guam, Commonwealth of the Northern Mariana Islands, and American Samoa)

Source: http://www.nsrc.org/OCEANIA/oceania.html



Appendix 2

GEOGRAPHY and DEMOGRAPHICS

The United States Associated Pacific Basin territories (USAPBT) consist of six island jurisdictions, including the main focus of today's hearing—Guam, Commonwealth of the Northern Mariana Islands, and American Samoa—which are considered U.S. flag territories. The other three jurisdictions—Federated States of Micronesia (FSM), Republic of the Marshall Islands (RMI) and Republic of Palau (Palau)—are independent countries but are freely associated with the United States, meaning they are politically independent but each has signed a Compact of Free Association with the United States establishing specific rights and responsibilities. These latter three territories are collectively known as the Freely Associated States or FAS.

Guam is Micronesia's largest and most populous island and is the southernmost island. Guam has a total land area of 210 square miles and is 30 miles long and 9 miles wide. According to the 2000 Census, Guam's population is approximately 155,000. The indigenous Chamorro population comprise approximately 50 percent of the population, followed by Filipino (25.0 percent), White (8.9 percent), and African American (1.1 percent). Approximately 31 percent of the residents are under age 20.

The Commonwealth of the Northern Mariana Islands (CNMI) consists of about 14 islands with a total land area of approximately 477 square kilometers, which is approximately 2.5 times the size of Washington, D.C. Approximately 21 percent of the population is Chamorro and 4.0 percent Carolinian, 56.0 percent Asian, and 2.0 percent White. About 90 percent of the population speak a language other than English at home.

American Samoa is in the South Pacific Ocean, approximately half-way between Hawaii and New Zealand. It is approximately a five hour plane ride from Hawaii to American Samoa. The total land area is approximately 77 square miles (199 square kilometers), which is slightly larger than Washington, D.C. Tutuila is the large island, covering approximately 55 square miles. Of this population (2000 Census), approximately 88.2 percent are Samoan and the remaining population includes Tongan, White, Filipino, and other Asian. Approximately 58.3 percent of all families in America Samoa are below the poverty level.

The Federated States of Micronesia is unique in that it has 607 islands, of which there are four constituent island groups, Yap, Chuuk, Pohnpei, and Kosrae. The four islands fall into three different time zones, as displayed below. These islands cover approximately 270 square miles (702 sq kilometers) and the population is comprised of nine ethnic Micronesian and Polynesian groups.

The Republic of the Marshall Islands land area covers approximately 70 square miles (181 square kilometers), scattered over 500,000 square miles of the Western Pacific.

Approximately 90 percent of the population is Marshallese. Two-thirds of the population live in Majuro and Ebeye. Direct U.S. aid accounted for 55 percent of the Marshalls' $98.5 million budget for FY 2003.

The Republic of Palau is approximately 190 square miles (458 square kilometers) in eight main islands plus more than 250 islets. Population is less than 20,000 and the racial/ethnic composition is primarily Micronesian. It is the furthermost jurisdiction—less than 500 miles from the Philippines—and is a 16-hour plane trip to Hawaii. Only eight islands are inhabited and approximately 70 percent of the Palauan population lives in the capital city of Koror on Koror Island. About 40 percent of the residents are under the age of 20 years, and 73 percent of the total population is below the poverty level.

In addition to the distance from the Pacific Basin relative to the United States continent, as well as among themselves, they are located in separate time zone that is up to six hours behind and up to 17 hours ahead of the eastern standard time (EST). For example, if it is 12:00 pm/noon (EST) Monday in Washington, D.C., it is:

- 9:00 am Monday in California
- 7:00 am Monday in Hawaii
- 6:00 am Monday in American Samoa

The other four Pacific Islands are significantly ahead of the EST:

- 2:00 am Tuesday in Palau
- 3:00 am Tuesday in Guam, Commonwealth of the Northern Mariana Islands, Chuuk (FSM) and Yap (FSM)
- 4:00 am Tuesday in Pohnpei (FSM)
- 5:00 am Tuesday in the Republic of the Marshall Islands and Kosrae (FSM)

Mr. BURTON. Let me start the questioning by asking you, Dr. Stinson, how do the health agencies decide how much money goes to those territories out there in the Pacific? Is there a formula that they use, or do you know?

Dr. STINSON. I'm not aware of there being any particular formula, or some type of quota, as it decides on how to utilize the resources that will go to the Pacific Island Territories, as well as other parts of the other funded programs throughout the Nation as a whole. The general tendency really has been to try to look at the development of specific programs, what would be the appropriate cost of those interventions as well as how you can buildupon the existing infrastructure and work with other partners to help in some of those programmatic aspects.

Mr. BURTON. Well, I hope today, this hearing will convey that back to our health agencies and maybe my colleagues and I can write a joint letter to the Secretary of Health and Human Services, our concern about the lack of resources out there. When you go out there and you see first and people stacked up in the halls to get dialysis treatment, and they're running those dialysis machines 24 hours a day, people are coming in the middle of the night, because they don't have the capability to take care of all of them, it's almost unconscionable.

I was not aware until today that they are second class citizens, American citizens, second class citizens as far as Medicare and Medicaid is concerned, as far as the moneys that are available to them to take care of their health care needs. And our health agency, you know, HHS gets billions and billions of dollars. It's one of the largest appropriations of any agency of Government. I think it is the largest. We need to make sure that American citizens, not only here in the United States, but in the territories around the world where we have American citizens, get the same quality of care or as close as possible to it as they're getting here in the United States.

Secretary Cohen, is there anything you think we ought to be doing that we're not doing that could help get additional resources and funding over there for the territories?

Mr. COHEN. I guess I can only speak for my own department.

Mr. BURTON. Well, but you can go on beyond that if you want to, because you've seen first hand the facilities over there, and you've been with me at some of them.

Mr. COHEN. Sure. And Mr. Chairman, I very much concur with the observations that you've made in terms of the lack of resources for health care in the Pacific. I'm sure we're going to hear a lot more about that today.

One thing that we would like to initiate from the Interagency Group on Insular Areas, and that is an interagency group re-established by Executive order by President Bush in May to have all the agencies of the Federal Government come together to coordinate policy of the executive branch toward the insular areas, that's the four flag territories other than Puerto Rico, is to have a working sub-group so that HHS, Interior and others that might have something to contribute to this discussion can, No. 1, see if we can get better information or create better information on the health care needs of the territories, get a fuller picture of what the situation

is building on some of this anecdotal evidence, and trying to get hard data, which is desperately needed, and then perhaps talk about solutions to these problems.

But step one has to be getting better data. Of course, we don't need better data to see people stacked up in the hallways, or as the Governor of American Samoa will tell you about the sorry condition of the hospital there, and its propensity to be flooded, the over-use of dialysis machines and the lack of trained medical personnel, the difficulty of attracting proper medical personnel, both for financial reasons and getting people to remote islands.

So all of these problems are things that I think we would like to get a better handle on, on the magnitude of them, and then talk to the various agencies to see if there are ways to work together to improve the effectiveness of the Federal resources that are brought out there.

Mr. BURTON. I hope that working group will, and I'm sure you will be working with the health officials on the islands to make a recommendation to the administration and our health agencies to increase the funding. Because I thought it was deplorable, the situation over there. When you go through those hospitals and you see the problems that they have, it's just heart wringing in many cases.

I'd like to ask you one more question on another subject before my time runs out. There are about 30,000 citizens of Asian countries that are in the CNMI. Can you tell us how that's affecting the economic problems over there, and the unemployment?

Mr. COHEN. Well, it's very complicated situation in the CNMI, because a lot of industries are almost entirely staffed, as you and I saw together, by the guest workers. So to the extent that guest workers are brought in, generally there is a need for them, and they are taking jobs that the locals, because of the lower pay rates for these jobs, may not be willing to take.

But it certainly does create an added burden on the health infrastructure, as well as other infrastructures in the CNMI. And certainly the volume of foreign workers is something that has been very difficult for the health care infrastructure in Saipan and the rest of the CNMI to adjust to.

And also the different nature, different types of diseases that may be brought in, there are health checks that are done in connection with granting entry permits. But still, the large migration of foreign workers does increase, it's widely believed that it does increase the propensity of certain diseases to show up in the CNMI, more than would be the case otherwise.

Mr. BURTON. The working group is working on that as well. Yes.

Ms. Watson, you didn't make an opening statement, so if you'd like to make an opening statement, that will be fine.

Ms. WATSON. I want to thank you, Mr. Chairman, and I want to welcome Secretary Cohen and Dr. Stinson. It's good to see you both.

I want to thank you, Mr. Chairman, and tell you how pleased I am that you have traveled to the Pacific Island Territories of Guam and the Commonwealth of the Northern Mariana Islands. It's really good when you have a first hand look yourself in this area. I was

so honored to serve as the U.S. Ambassador to the Federal States of Micronesia.

I would also like to thank my colleagues, Representative Faleomavaega of Samoa and Representative Bordallo of Guam, for being here at the hearing and contributing to the hearing, and their leadership in the Pacific Island Territories. As well, I'd like to welcome the Governors of Guam and the CNMI and American Samoa, and I appreciate your coming this distance to be here today.

As Americans, we should be aware of all the United States Territories, Guam, the Commonwealth of Northern Mariana Islands, American Samoa, Puerto Rico and the Virgin Islands. In addition, the United States has a very special compact with the Freely Associated States of Micronesia, the Marshall Islands and Palau. Due to the geographic distance from the continental United States, some aspects of our social responsibility seem to fall through the cracks. The territories and the Freely Associated States are really out of our sight, but they should not be out of mind.

As Americans, we take pride in our diversity. And it is our greatest achievement that based upon that diversity, whether it is economic, political, or cultural diversity, we have built a Nation that is dedicated to providing equal opportunity for all. But much needs to be done before we can say that we have accomplished that goal, most notably in the field of health care. Racial, ethnic and geographic minorities too often are denied the high quality care that most Americans receive.

The Federal Government has recognized this serious problem and has set a goal of eliminating national health disparities by the end of the decade. House and Senate Congress Members have introduced legislation, the Health Care Equality and Accountability Act of 2003, that takes an important step toward making this goal a reality.

We may have the finest health care system in the world, but too many of our people receive too little health care and are denied the right to lead full lives. The reality is that the health care needs of minority Americans are often greater than those of white Americans. The populations of the U.S. Territories are eligible for Federal assistance and suffer from similar situations to minorities in the continental United States of America.

Minority populations disproportionately suffer from many varied diseases. Minority groups have greater rates of acute conditions, i.e,. tuberculosis and HIV/AIDS, chronic diseases such as diabetes, heart disease and stroke and many forms of cancer. In addition, minority women are at a greater risk than White women for pregnancy related complications and their babies are at higher risk of dying during their first year of life.

Despite a substantial need for health care, minority groups often encounter obstacles in obtaining health care. Minority groups are less likely to have health insurance and less likely to receive appropriate health care services.

So the testimony today will provide us with information on the territories that can be contrasted with trends across this Nation. According to a study by the Kaiser Family Foundation in June 2003, minority populations have substantially higher uninsured

rates than white Americans, 12 percent. Hispanics are at 35 percent, Native Americans around 27 percent, and African Americans 20 percent, while Asian and Pacific Islanders are somewhere around 19 percent.

In addition, while racial and ethnic minorities represent only one-third of the non-elderly U.S. population, they represent more than half of uninsured Americans. These numbers are exacerbated in the islands.

So Mr. Chairman, our focus today on the Pacific Island Territories is a necessary focus. And I'm looking for the testimony from the Governors of the three Pacific Territories, and from the Pacific Island Health Officers Association, which can provide us a picture of the Freely Associated States.

I commend the vision of this subcommittee and the dedication of this Chair to address and investigate these health care disparities. The people sitting up here in front of you are the dedicated and committed ones, to see that not only our citizens but those of you in our territories are not victims of being neglected. We, some of us really know the problems personally. And you are here to assist in telling your story so that we can make the policies that will improve the health care of all Americans, either in the continental United States or in our territories.

I yield back the balance of my time, Mr. Chairman, and thank you very much.

Mr. BURTON. Thank you, Representative Watson.

Mr. Faleomavaega.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman, and I want to thank Dr. Stinson and Secretary Cohen for their fine statements. I do have a couple of questions I want to raise. I think it's important to get a sense of perspective or history on the evolution of how insular areas have been treated historically by our country, and what has always been the traditional Federal agency that has been the chief administrator of the needs of these territories, whether it be the Pacific or the Caribbean.

And I make specific reference, of course, to Secretary Cohen's responsibility, a tremendous responsibility in overseeing the needs of the insular areas. I just wanted to ask Mr. Cohen a couple of questions. There's no question that the health care needs of the insular areas are different, perhaps even worse conditions than many of the areas that we have here in the United States. Testimonies have borne out this afternoon a reference to distance, sense of isolation from mainstream America simply because of our location and difficulty in accessibility to services and programs that are easily provided or can be provided if necessary here in the continental United States.

As Mr. Cohen had alluded to earlier, we have established an interagency, inter-governmental work group, hopefully, to be composed of chief policymakers of the various Federal agencies that deal with insular areas or with the Pacific Territories. In fact, it was just a couple of days ago that we had this meeting with Secretary Norton for which we are very grateful, that we have some kind of a conduit or a way that we can express what our needs are.

The problem I always have been faced with, this interagency working group says it's fine that we talk about the issues, but then

when it comes to giving some sense of finality or results, this is where things get lost in the cracks, and then we go back again and we still discuss the very same issues that we've been discussing for the past several years.

It's a tremendous gain on the part of the insular areas, we've become more politically developed, we've elected our own Governors, we've elected our own congressional delegates. We don't have two Senators. And for this very sake that we don't have Senate representation, for those of us who represent the insular areas, Mr. Chairman, I think we have to work about 10 times harder. A lot of times it's been with the compassion and the interest taken by some, such as yourself, to date to help us bring out the issues, not only just for public discussion but hopefully to find results.

As I had mentioned to Secretary Cohen in our meeting with the IGIA, and I want to ask Secretary Cohen, will the Department of Interior be willing to work with us as congressional delegates in crafting appropriate amendments to Federal laws that perhaps are not helping us? Because I always perceived the Department of the Interior as our partner in working, in providing the appropriate forum. Because unless if I'm wrong on this, Mr. Secretary, I would like a response.

Or in each instance, if we have a problem with HHS, we've got to go to them. In other words, we end up having to go to about 50 or 100 different agencies before we have some sense of finality in resolving the problems? I wanted to ask Secretary Cohen that.

Mr. COHEN. Sure, thank you, Congressman. You raise a lot of very good and important points. I think your questions, especially about the process, now that we have an interagency group on insular areas [IGIA], these are very good questions. I'd like to share with you some of the optimism I have about how the IGIA can address some of the concerns you've raised.

As you pointed out, the Department of Interior has traditionally been the Department within the Federal Government that is responsible for the day to day relationship with all the territories. But also, all the agencies have independent relationships with each of the territories. So there's sort of a disparity between our knowledge of the territories, because we're the only office, my office, the Office of Insular Affairs, is the only office that is focused on the islands 24/7. So it's a disparity between that and then the other agencies in the Federal Government that often make very large investments in the territories, but are not focused on the special needs of the territories.

So it's always been our task, which has been a very challenging on, to work with each of the different agencies to try to raise the profile of island issues in each territory. To do that one agency at a time is very difficult. So one reason that I'm very excited about the reestablishment of the IGIA is it creates a forum that's mandated by the President of the United States for top policy officials, as you pointed out, from each of the agencies to come together and focus on the particular needs of the insular areas.

Now, that in and of itself will not result in problems being solved, as you correctly pointed out. But it addresses the initial threshold problem of getting insular area concerns, the particular problems of the islands, on the radar of top policymakers in each

of the executive branch agencies. That is really a major hurdle, because we have found, when people become familiar with the disparities, and when they become familiar with the particular issues, just as Congressman Burton, who took his first trip out with me to Guam and the CNMI, they start to have an understanding of, No. 1, the uniqueness of the problems, and No. 2, what each agency can perhaps do to address it.

So the process isn't complete in that it won't result, it will not guarantee that all of these problems will be solved. But we'll guarantee that all the problems will be focused on and studied.

Mr. FALEOMAVAEGA. Mr. Secretary, my time is running out, I'm sorry. I just want to cite a classic example. When the Northern Marianas established this covenant relationship with the United States, one of the most unique features of this covenant relationship, Mr. Chairman, and thanks to a gentleman that I'm sure all the insular leaders are well aware of his contributions, for the tremendous help that he gave, was that the Northern Mariana Islands became beneficiary to the SSI benefits, simply because the late Congressman Phil Burton was very much a key player in working that covenant relationship, for which NMI, God bless them, are beneficiaries to the SSI programs.

But American Samoa does not get SSI benefits, Guam does not get SSI benefits. And every time we've made an effort, and Puerto Rico does not get SSI benefits. And I only use it in the sense of endearment, you've got a 900 pound gorilla with 3.8 million Americans living in Puerto Rico. Every time they put us together with Puerto Rico, we are dead on the spot.

So for years we've been trying to work out, how can these small, little insular areas, let's just not discuss Puerto Rico, where we have tried every way to include American Samoa and Guam for SSI benefits, but it's an impossibility. And for some reason or another, we say that they're not Americans. I suppose I can qualify that, we're U.S. nationals, we're not U.S. citizens. But we do fight and die in our wars, I suppose that might be a consolation, in our contributions to our national defense.

But this has been the problem. And I'd like to ask Secretary Stinson, I've introduced legislation to give the Secretary of HHS discretionary authority that they can work in MOU relationship between Guam and American Samoa, so that in our own unique way, with 150,000 in Guam and 60,000 in American Samoa, we're not asking for the moon. Just enough so that it's practical and the services, and we need critically, for example, SSI benefits for many of our mothers or our residents that have this critical need.

And God bless NMI, thanks to Phil Burton, they got the benefit, but we don't. And this is why I wanted to ask Dr. Stinson and Secretary Cohen, will you be willing to help us if we introduce legislation, even if just to give the Secretary of HHS discretionary authority to give us some of that benefit?

I'm sorry, Mr. Chairman, I know my time's up.

Mr. BURTON. That's OK, we'll let them answer the question and we'll go to——

Dr. STINSON. Yes, but essentially around the specific around working with you in relationship to SSI, that's, you know, SSI is really part of the Social Security Administration, which is not part

of HHS any more. There was a time where it was part of it, but it did become its own separate agency.

But I want to answer the bigger question that you really posed, and when we look at the needs and what really needs to be done to improve the health of the people in the Pacific Island Territories, it really does need to be looked at from a very, very comprehensive way, and it needs to be looked at across the organizational lines of the different agencies.

To have the type of discussions and the type of engagement between Interior, Department of Energy also is a stakeholder out there in the Pacific Islands, HHS, Department of Justice. To sit down and really determine what are the things, what are all the components that adversely affect the likelihood that the individuals there can live a long and healthy life, and put everything on the table as options and develop some type of strategy, some type of plan to do it in a very, very comprehensive way. And the Department is very committed to doing that.

Mr. BURTON. Let me, before I yield to the delegate from Guam, just say that I'd be happy to work with all of my colleagues here in drafting a letter, we might have to take this one point at time, but to start off with the health issues and see if we can't make sure that American citizens and those who are from a territory that we control get fair treatment as far as health is concerned. That's the thing that bothered me the most when I was out there, seeing the deplorable conditions.

With that, we'll go to Delegate Bordallo.

Ms. BORDALLO. Thank you very much, Mr. Chairman.

We've spent quite a bit of time on discussing the processes, so I think I'd like to get to the substance. I'd like to ask you, Mr. Cohen, would you agree with me that utilization of the Medicaid program to cover Guam's providing of health care to citizens of the Freely Associated States who travel to Guam would be good public policy worth pursuing? This would and should be outside our current cap and with 100 percent Federal matching assisted percentage. I'd just like to get your views on that.

Mr. COHEN. Sure. As you know, Congresswoman Bordallo, I'm here representing the administration and would have to do as I always do, work quietly with my colleagues within the administration to actually get an official response to very specific questions such as that. But the larger point, of course, is that we are aware of the problems Guam has had for so many years, addressing the medical needs and other needs of those who migrate from the Freely Associated States pursuant to the compacts of free association.

When I heard that proposal from your staff, I thought it was a very creative proposal. We would certainly work with you on a proposal like that. I'm very happy that we've taken what I think is a historic major step to addressing compact impact issues and now having an annual permanent mandatory appropriation of $30 million, of which Guam almost got half this year, and I guess maybe for the next 5 years, $14.2 million, doesn't address the concerns that Guam has raised for going back to the beginning of the compact. But hopefully going forward, we'll do a much better job of addressing those needs.

That is one proposal, and you know, we're certainly willing to work with you.

Ms. BORDALLO. So would you get back then on that?

Mr. COHEN. Certainly. And of course, this isn't just something that Interior would approve, but it would be an administration wide issue.

Ms. BORDALLO. There is one further followup, Mr. Chairman, if I could. This is both to Secretary Cohen and Dr. Stinson. I would appreciate any comment that you could offer to us on the administration's position with respect to the Medicaid caps. Any thoughts on how we could best collectively and constructively begin to really address this disparity in treatment? I'd like to get your opinions. I suppose you're going to come back and say that, well, you'll have to check with the administration.

Mr. COHEN. I would just say briefly, just because we've had a chance to address this issue through the auspices of the IGIA, that I guess HHS, well, HHS is here, so I won't presume to speak for HHS. But the issues that were raised in terms of linking Puerto Rico to the equation, which increases the costs by orders of magnitude, is an issue. And of course at the meeting yesterday, some other ideas were tossed out as interim solutions.

But you know, the initial issue of whether caps are lifted for all five territories of course presents major cost issues, as I understand it, from the administration's standpoint. So if there are other creative solutions, it might provide a better scope for us to work together to address the problem.

Ms. BORDALLO. Dr. Stinson.

Dr. STINSON. Yes, first of all, let me say I'm not an expert in Medicare and Medicaid. And as we're all aware, the provisions of the cap are really grounded in the statutory history here, even if there have been some modifications over the years. But I would like to say that clearly, the Department looks at the services that are provided through the Medicaid program as a mechanism of providing access to care. And it's certainly interested in the development and the support of solutions that will really maximize the ability for all U.S. citizens to be able to get the type of care that they need and that they deserve.

Ms. BORDALLO. Thank you very much. I'm just, when I was listening to my colleague here, Representative Faleomavaega, mentioning the SSI and how our neighbors benefit from this, and of course Guam, just being a short distance away, we do not have this benefit, nor does American Samoa nor Virgin Islands. I just wonder if we consider the three of us alone rather than bringing in Puerto Rico. They did it with CNMI, so could that be looked at, Mr. Secretary?

Mr. COHEN. I'm sure it could be looked at, and of course, it's quite a different issue when it's framed in that way.

Ms. BORDALLO. Thank you.

Mr. BURTON. Well, we'll excuse you, gentlemen, but before you go, I hope that you'll stick around to hear what the Governors and the health officials have to say from the territories that we're going to be discussing. So if you wouldn't mind staying around a little bit, I'd really appreciate it.

The one thing that I'd like to stress before you leave the table is that although some of the things we've discussed today may take legislative action to make positive changes, and sometimes that's very difficult, especially with the budgetary problems we have, HHS has a lot of money. And HHS has the ability to put more money into these territories if they so choose. That doesn't require legislative action.

And I hope that the executives at HHS and your working group get together and say, look, we can't have these people in American Territories who are American citizens or live in the American Territories, we can't have them being second class citizens. They at least ought to get quality health care, and I'm going to tell you right now, from first hand visual evidence, I can tell you they're not getting it. That's just not right.

But with that, thank you very much for your testimony.

We'll now call to the table the Honorable Governor Camacho of the Territory of Guam; the Honorable Governor Babauta of the Northern Mariana Islands; and the Honorable Governor Tulafono, of the Territory of American Samoa. If my colleagues want to make any kind of introductions for these gentlemen, I'd be happy to have them do it.

Mr. Faleomavaega.

Mr. FALEOMAVAEGA. Thank you, Mr. Chairman.

I want to offer my apologies, we up here on the dais, I got so nervous I forgot to even notice my good friend Felix Camacho, and I want to apologize. But I do want to thank Governor Camacho and Governor Babauta and Governor Togiola for the beautiful reception that we recently received, when Secretary North and Chairman Pombo and several members of our delegation visited these insular areas.

I would like at this time, Mr. Chairman, to introduce, it's my honor to introduce our Governor. This gentleman is a homemade product, successful in getting his training as a member of the Honolulu police department. He was a law enforcement officer. And several years served as judge in our territory, and also served as senator and chairman of the various committees. He has been practicing law for the past 25 years, and a graduate of Washburn Law School from Topeka, KS. Would you believe, Samoans living in Kansas, Mr. Chairman?

And due to the untimely death of our late Governor, Governor Togiola had to take the reins since last April. Mr. Chairman, I'm very, very happy that he's here with us, and I look forward to hearing his testimony as it pertains to the health care needs of our territories.

Mr. BURTON. Very good. Would any other Members like to speak? Ms. Bordallo, do you have any comments?

Ms. BORDALLO. May I introduce my Governor?

Mr. BURTON. Sure.

Ms. BORDALLO. All right, thank you.

My Governor is Governor Felix Camacho, and there are some very interesting twists and turns to his political life. He served as the civil service director, I think, correct me if I'm not right, Governor, with the Government of Guam for a number of years as di-

rector. He served many terms and he was my colleague in the Guam legislature as a Senator.

What makes him most unique is that several years ago, his father, the late Governor Carlos G. Camacho, served as Guam's first elected Governor. And now these many years later, we have his son serving in this very high position.

So Governor Camacho, we welcome you to Washington and we look forward to your testimony. Thank you.

Mr. FALEOMAVAEGA. Mr. Chairman, I forgot to mention that our Governor has about a five handicap, if you really would like to play a round.

Mr. BURTON. I don't want to mess with anybody with a five handicap. [Laughter.]

He would own my house.

And I'll personally introduce Dr. Babauta, who is a good friend of mine. We had an opportunity to get to know each other in a more personal way, along with Governor Camacho, when I was visiting in that region. So Governor Babauta, welcome to you as well.

Would you please stand so I can swear you in?

[Witnesses sworn.]

Mr. BURTON. We'll start with you, Governor Camacho, and just go right on down the table there. Do you have an opening statement you would like to make? You can read your testimony or make an opening statement, whichever you would prefer.

STATEMENTS OF FELIX PEREZ CAMACHO, GOVERNOR OF U.S. TERRITORY OF GUAM; JUAN BABAUTA, GOVERNOR, COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS, ACCOMPANIED BY DR. JAMES U. HOFSCHNEIDER, SECRETARY OF HEALTH; TOGIOLA TULAFONO, GOVERNOR, AMERICAN SAMOA; JEFFERSON BENJAMIN, SECRETARY OF HEALTH, DEPARTMENT OF HEALTH, EDUCATION, AND SOCIAL AFFAIRS, FEDERATED STATES OF MICRONESIA, PACIFIC ISLAND HEALTH OFFICERS ASSOCIATION; AND DR. WILLIAM MCMILLAN, ADMINISTRATOR, GUAM MEMORIAL HOSPITAL AUTHORITY

Governor CAMACHO. First of all, I would like to thank you very much for inviting me and my fellow Governors, the territorial Governors, here to Washington to provide testimony. We very much appreciate this opportunity, again.

And the mere fact, Mr. Chairman, that you have personally been able to see for yourself the territories with your visit, to see first hand the situation of our health care on our islands and the many challenges we face. I think it makes a big difference. It's not too often that we have Members of Congress come out to the far distances in the Pacific to see for themselves the many challenges we face. We truly appreciate the visit you made there. And with that, I would like to begin my testimony.

Mr. Chairman and members of the committee, Congresswoman Bordallo, Congressman Faleomavaega and Congresswoman Watson, thank you for inviting me to participate in your hearings on the disparities of health care in the Pacific Island Territories. I would like to express my appreciation to you for providing this op-

portunity to address the needs and concerns of the Pacific Islands on this most important issue.

Our peoples' health is one of the highest priorities, and we are constantly striving to improve the quality of care available on the islands. However, in addition to facing many of the challenges that States are grappling with, Guam and our Pacific Island neighbors also have certain concerns that are unique to our region.

Like many communities, we have difficulty in recruiting and retaining health care professionals, and providing basic health care in the face of skyrocketing costs and ensuring that every member of the public has access to quality health care services. But the challenges we face on Guam go far beyond these issues. Our small population base, relative isolation and constant mix and influx of people from areas with even fewer health options are among the many circumstances that contribute to the serious health care concerns on Guam.

With our Department of Public Health and Social Services, it provides basic medical care and public assistance to our indigent population. The Department is additionally responsible for immunizations, health education, disease screening and monitoring, tracking the health status of Guam residents and safeguarding the vital statistics registry.

Guam's public health department receives both Federal and local funding for indigent care. But Federal caps on Medicaid benefits to the island have resulted in the need for the government of Guam to bear an unusually large burden for indigent care. In fiscal year 2003, Federal funds paid for just $8 million of the total Medicaid bill of $15 million. The Government of Guam spent an additional $17 million on the medically indigent programs that were developed to cover the needs of our poor.

Now, the influx of patients from the Freely Associated States [FAS], further burdens our public health system. Public health provided more than 188,000 services to residents in 2003. And of these 24 percent were provided to FAS citizens. Citizens from these areas also have exceptionally low rates of insurance coverage, 29.4 percent of the FAS citizens surveyed in 2003 had no form of health insurance compared to Guam's uninsured rate of 21 percent of the adult population. By comparison, the uninsured rate for the United States as a whole was 14 percent in fiscal year 2002, the last year that U.S. statistics are available.

Now, with an economy still struggling to recover from years of typhoons, geopolitical events, economic problems in Asia, the Government of Guam simply cannot afford to continue over-matching Medicaid. We must have additional funding to provide the level of services needed by the population.

I listened with interest, as you had mentioned, Congressman Faleomavaega, about the need to somehow separate Guam and the Northern Marianas and American Samoa from Puerto Rico as the equation. Because you can combine all our islands, land mass, population, even people that come and visit as tourists, and still we cannot match the level of population and impact of Puerto Rico.

And it's convenient for policymakers, or those that are responsible in administering the programs to say, well, we simply can't give it to you in all fairness, because if we do, then we must also

give it to Puerto Rico. But I think in all fairness, we understand the impact of that, but we must be given some reasonable exception to the equation and be separated out in consideration of Medicaid.

This lack of funding has also led to serious deficiencies in our local facilities which are aging and in need of repair or replacement. These facilities have been built decades ago with the Hill-Burton funding. And as time has progressed and population has grown, our public health department is challenged to find adequate space to provide the myriad of health services it is mandated to provide.

In May 2003, a local law was passed requiring clients in the medically indigent program to receive their primary health care services through the community health services. This was done to try and alleviate the impact upon our hospital. My administration, with the support of the Guam legislature, recognizes our obligation to provide basic primary health care services to our people. And because private health care providers are currently turning MIP and Medicaid patients away. We must identify a point of access for these patients.

The need for expanding current facilities and acquiring additional funding for programs provided by our public health and social services department is reflected both in the department's difficulties and the health of our population. Guam has a high prevalence of both communicable and chronic diseases, as you well pointed out, Chairman Burton, which well funded and aggressive public programs would best be equipped to address.

Again, you mentioned, Congressman Burton, that our diabetes rate for adult population ranges from 25 to 46 percent higher than adults in the United States. And while the Pacific Islands Health Officers Association meetings in 2003 led to the declaration of a war on diabetes, the $200,000 budget for that fiscal year seems a small amount to battle a disease that conservatively affects more than 10,000 adults on Guam.

Communicable diseases also remain a major concern because of our proximity to Asia, where many new alarming diseases such as SARS and the more recent avian influenza outbreak originated. Despite our vulnerability to such outbreaks, Asian border States and territories were overlooked during a recent initiative to increase surveillance in border States for bioterrorism agents and emerging infectious diseases.

With the Guam Memorial Hospital, Guam is served by one civilian hospital, which is a fully autonomous entity of the government of Guam. As the island's only hospital, GMH is mandated to provide treatment to every individual, regardless of ability to pay. This has caused serious financial problems for the institution, as 80 percent of its patients were uninsured self payors, 80 percent of its patients were uninsured in the hospital. They were uninsured self payors or recipients of medical assistance from the department of public health.

Our hospital provides 1.1 inpatient acute care beds per 1,000 population, a situation that will deteriorate with 0.92 beds per 1,000 population by 2010. This is still less than half of the 2.1 inpatient beds per 1,000 population in division nine hospitals, according

to a 2003 American Hospital Association report. The hospital's chronic financial problems, combined with challenges inherent to a relatively small population base, has forced the government of Guam to limit services available at the facility.

However, unlike mainland U.S. patients who can simply drive to an appropriate facility, Guam's patients face the expensive prospect of flying between 3 to 8 hours to another medical center. You mentioned our Speaker, who had to fly off, and many thousands of others. The discomfort and cost of such trips, to say nothing of the hardship of such a flight on critically ill patients, makes access to care extraordinarily difficult for many families. Massive family fundraising projects are commonplace when a family member needs surgery or cancer treatment. And some individuals are unable to get appropriate care because of the high cost.

Honestly, you may have seen it yourself, Mr. Chairman, you'd be driving down the highway and you'd find in the medians of our highways by the stop lights people with buckets and hats, and signs saying, my mother's sick and she needs a kidney treatment or open heart surgery, can you donate money. They knock on the doors of every politician, asking, can you personally help, can you appropriate money. Everywhere you look on this island, people have been gravely affected, without the ability to pay for medical care.

The lack of certain services on Guam is perpetuated by the need for patients to seek care off-island. More than $30 million in local insurance premiums each year is spent at facilities outside of Guam, robbing our hospital of the capital needed to develop and expand services. And to date, GHM per capita budget is one-third lower than district nine Pacific States, leading to an absence of critical services.

GMH has no radiation oncology, no cardiac surgery, and despite mortality and morbidity rates that significantly exceed national averages, we have no kidney donor program or transplant service, despite higher than average diabetes rates and end-state renal diseases. In addition to the need to expand services and make care more affordable for all patients, GMH also seeks assistance in Medicare programs.

A participant since 1986, GMH was granted an exemption from the prospective payment system. However, our hospital's reimbursement has slipped from cost based to less than cost, resulting in the loss of approximately $3 million from Medicare revenues of $12 million annually. Critical access hospitals receive 101 percent cost reimbursement, and special mechanisms are available for disproportionate share hospitals, rural referral centers and sole community hospitals. We believe that GMH can meet all of the criteria for these special categories, if reimbursement regulations can be modified slightly to recognize Guam's unique circumstance.

I just have three other categories, and I'm done. Staffing concerns, across the Nation communities have grappled with shortages of nurses, medical technologists and other medical specialties. This situation is exacerbated on Guam, where it is often difficult to recruit and retain health care providers.

As an example, I would like to share a brief story that occurred a few years ago. The island's only gastroenterologist decided to re-

turn to the U.S. mainland. In the weeks before his departure, his clinic was crowded until after 11 p.m., and later crowded with other physicians on-island who rushed in for checkups and treatments before he left the island.

With increasing Federal grant funds to Guam, our geographic isolation and paucity of human and natural resources contribute to a higher cost of doing business on Guam. We believe that this cost could be addressed when Federal grants funds are allocated to Guam by raising the floor amounts of grants that use them, and instituting a minimum floor amount for those that do not, and then applying population based formulas for the distribution of the remainder of the grant funds.

In summary, clearly there are a number of issues that need to be resolved to place Guam on par with other U.S. jurisdictions. And there must be a commitment by the Federal Government to help all Pacific Island Territories deal with the shortcomings that face each one of us in improving and providing the quality health care to our people.

I thank you for your attention.

[The prepared statement of Governor Camacho follows:]

Testimony of the

Honorable Felix Perez Camacho
Governor of Guam

Before the
Subcommittee on Wellness and Human Rights
Committee on Government Reform
United States House of Representatives

The Honorable Dan Burton,
Chairman-Subcommittee on Wellness and Human Rights

February 25, 2004

Investigation into Health Care Disparities in United States Pacific Island Territories

Testimony presented to the Wellness and Human Rights Subcommittee, House Committee on Government Reform

by

Felix Perez Camacho
Governor of Guam

Mr. Chairman and Members of the Committee, thank you for inviting me to participate in your hearings on the disparities of health care in the Pacific Island Territories. My name is Felix Perez Camacho, Governor of Guam.

I would like to express my appreciation to you for providing this opportunity to address the needs and concerns of the Pacific Islands on this most important issue. Our people's health is of the highest priority and we are constantly striving to improve the quality of care available on the islands. However, in addition to facing many of the same challenges that states are grappling with, Guam and our Pacific neighbors also have certain concerns that are unique to our region.

Like many communities, we have difficulty in recruiting and retaining health care professionals, providing basic health care in the face of skyrocketing costs, and ensuring that every member of the public has access to quality health care services. But the challenges we face on Guam go far beyond these issues. Our small population base; relative isolation; and a constant influx of people from areas with even fewer health options; are among the many circumstances that contribute to serious health care concerns on Guam.

Department of Public Health and Social Services

The Guam Department of Public Health and Social Services provides basic medical care and public assistance to our indigent population. The department is additionally responsible for immunizations, health education, disease screening and monitoring, tracking the health status of Guam residents, and safeguarding the vital statistics registry.

Guam's Public Health Department receives both federal and local funding for indigent care, but federal caps on Medicaid benefits to the island have resulted in the need for the Government of Guam to bear an unusually large burden for indigent care. In Fiscal Year 2003, federal funds paid for just $8 million of a total Medicaid bill of $15 million. The Government of Guam spent an additional $17 million on local Medically Indigent Programs that were developed to cover the needs of the indigent population.

The influx of patients from the Freely Associated States (FAS) further burdens Guam's public health system. Public Health provided more than 188,000 services to residents in 2003; of these, 24 percent were provided to FAS citizens. Citizens from these areas also

have exceptionally low rates of insurance coverage: 29.4 percent of FAS citizens surveying in 2003 had no form of health insurance, compared to Guam's uninsured rate of 21 percent of the adult population. By comparison, the uninsured rate for the U.S. as a whole was 14 percent in 2002, the last year that U.S. statistics are available.

With an economy still struggling to recover from years of typhoons, geopolitical events, and economic problems in Asia, the Government of Guam simply cannot afford to continue overmatching Medicaid. We must have additional funding to provide the level of services needed by the population.

This lack of funding has also led to serious deficiencies in our local facilities, which are aging and in need of repair or replacement. These facilities were built decades ago with Hill-Burton funding. As time has progressed and population has grown, the Department of Public Health is challenged to find adequate space to provide the myriad of health services it is mandated to provide. In May 2004, a local law was passed requiring clients in the Medically Indigent Program receive their primary healthcare services through the Community Health Centers.

My Administration, with the support of the Guam Legislature, recognizes our obligation to provide basic primary healthcare service to our people. Because private healthcare providers are currently turning MIP and Medicaid patients away, we must identify a point of access for these patients.

The need for expanding current facilities and acquiring additional funding for programs provided by the Guam Department of Public Health and Social Service Department is reflected in both the department's difficulties and the health of our population. Guam has a high prevalence of both communicable and chronic diseases, which well-funded and aggressive public health programs would be best equipped to address.

Our diabetes rate for the adult population ranges from 25 percent to 46 percent higher than adults in the U.S. While the Pacific Islands Health Officers Association meetings in 2003 led to the declaration of a "War on Diabetes," the $200,000 budgeted for that fiscal year seems a small amount to battle a disease that conservatively affects more than 10,000 adults on Guam.

Communicable diseases also remain a major concern, because of our proximity to Asia, where many new alarming diseases such as SARS and the more recent avian influenza outbreak originated. Despite our vulnerability to such outbreaks, Asian border states and territories were overlooked during a recent initiative to increase surveillance in border states for bioterrorism agents and emerging infectious diseases.

Guam Memorial Hospital

Guam is served by one civilian hospital, which is a fully autonomous entity of the Government of Guam. As the island's only hospital, Guam Memorial Hospital is mandated to provide treatment to every individual, regardless of ability to pay. This has

caused serious financial problems for the institution, as 80 percent of its patients were uninsured self-payers or recipients of medical assistance from the Department of Public Health.

Guam Memorial Hospital provides .85 inpatient acute care beds per 1,000 population, a situation that will improve slightly with .92 beds per 1,000 population by 2010. Even with the improvements, this is still less than half of the 2.1 inpatient beds per 1,000 population in Division 9 hospitals, according to a 2003 American Hospital Association report.

The hospital's chronic financial problems, combined with challenges inherent to a relatively small population base, has forced the Government of Guam to limit the services available at the facility. However, unlike mainland U.S. patients, who can simply drive to an appropriate facility, Guam's patients face the expensive prospect of flying between three (3) to eight (8) hours to another medical center. The discomfort and cost of such trips – to say nothing of the hardship of such a flight on a critically ill patient – makes access to care extraordinarily difficult for many families. Massive family fundraising projects are commonplace when a family member needs surgery or cancer treatment, and some individuals are unable to get appropriate care because of high cost.

The lack of certain services on Guam is perpetuated by the need for patients to seek care off-island. More than $30 million in local insurance premiums each year are spent at facilities outside Guam, robbing the hospital of the capital needed to develop and expand services. To date, GMH's per capita budget is one-third lower than District 9 Pacific States, leading to an absence of critical services.

GMH has no radiation oncology and no cardiac surgery, despite mortality and morbidity rates that significantly exceed national averages. We have no kidney donor program or transplant service, despite higher-than-average diabetes rates and end state renal disease.

In addition to the need to expand services and make care more affordable for all patients, the Guam Memorial Hospital also seeks assistance in the Medicare program. A participant since 1986, GMH was granted an exemption from the prospective payment system. However, the hospital's reimbursement has slipped from cost-based to less than cost, resulting in a loss of approximately $3 million from Medicare revenues of $12 million annually.

Critical Access Hospital receives 101 percent cost reimbursement, and special mechanisms are available for Disproportionate Share Hospitals, Rural Referral Centers and Sole Community Hospitals. We believe that GMH can meet all of the criteria for these special categories if reimbursement regulations can be modified slightly to recognize Guam's unique circumstances.

Staffing Concerns

Across the nation, communities have grappled with shortages of nurses, medical technologist, and other medical specialties. This situation is exacerbated on Guam, where it is often difficult to recruit and retain health care providers. As an example, I would like to share a brief story that occurred a few years ago. The island's only gastroenterologist decided to return to the mainland U.S. In the weeks before his departure, his clinic was crowded until 11 p.m. and later – crowded with other physicians on island who rushed in for check ups and treatments before he left island.

For the hospital and the Department of Public Health, much of the challenge in recruiting professionals stems from funding problems. The local government is unable to offer compensation attractive to professionals who are in demand elsewhere. While we are working to address this issue, the people of Guam continue to lack the breadth of services available in other similar-sized communities.

Increasing Federal Grant Funds to Guam

Our geographic isolation and paucity of human and natural resources contribute to a higher cost of doing business on Guam. We believe that this cost could be addressed when Federal grant funds are allocated to Guam by raising the floor amounts of grants that use them, and instituting minimum floor amounts for those that do not, then applying population-based formulas for the distribution of the remainder of the grant funds.

An example would be the Centers for Disease Control's Bioterrorism Preparedness and Response Grant funds. In Fiscal Year 2002, each state was allocated a floor of $1 million, then more based on population; each Pacific Territory was allotted $150,000 as a floor amount. In Fiscal Year 2003, these floor amounts were increased to $5 million and $500,000, respectively. While not completely leveling the playing field, minimum floor amounts begin to address geographic and resource disparities faced by Guam.

Summary

Clearly there are a number of issues that need to be resolved to place Guam on par with other United States jurisdictions and there must be a commitment by the federal government to help all Pacific Islands Territories deal with the shortcoming that face each one of us in providing quality healthcare to our people. Thank you for your attention. God bless Guam. God bless America. I am pleased to answer any questions.

Mr. BURTON. That's a very, very good statement.

We have two votes on the floor, and I have to run to the floor. This is unusual to ask this, but I think I'll ask Mr. Faleomavaega if he would to conduct the meeting in my absence. I'll be back in about 10 minutes, and then we'll get into questions and answers.

So we'll go to Governor Babauta, we'll go to you next, and I'll be right back.

Mr. FALEOMAVAEGA [assuming Chair]. Most unusual situation, that the good chairman has been so kind as to allow the minority to preside over a hearing. It's unheard of. But I know for his graciousness, and Governor Babauta, I know you have some very precious statements that you want to share with the chairman. I'm sure that the good staff director that we have here will take every word of your statement and make sure that Chairman Burton gets it.

By the way, Governor, you've been here long enough to know that this is how the Congress and the congressional committees operate, and I know it's not lack of sensitivity, it's just the reality of the nature of the beast. This is how the Members have to be, on the floor to vote. They cannot vote by proxy.

But please proceed.

Governor BABAUTA. Well, you know, years ago I called you Mr. Chairman. And although it didn't work out, I can truly call you today Mr. Chairman, at least temporarily.

Just as a way of opening remarks, I sat here thinking, when you and Congresswoman Bordallo were introducing your Governors, how totally unfair it was that I do not have a delegate up there to introduce me as well.

Mr. FALEOMAVAEGA. How great an honor you had, in the fact that the chairman was introducing you, and the congressional delegates certainly don't have the same rights and privileges. [Laughter.]

I think, Governor, you could not have gotten a better person to introduce you, in a much higher capacity than us humble congressional delegates. Please don't feel that bad.

Governor BABAUTA. Let me get back to you on that point.

Today, I'm honored to be accompanied by a number of elected officials from the CNMI. I want to recognize them by name, because I want their names to appear on the record as having borne witness to this very important hearing that Chairman Burton called for.

We have the Senate President, Joaquin Adriano, and Senator Joseph Mendula, Senator Henry Senicholas, and Senator Tom Villagomez, Senator Louie Christastimo, and Congresswoman Janet Maratita. Just for the record also, Congresswoman Janet Maratita is the only female representative in the entire legislature. So we're very proud of her.

Mr. FALEOMAVAEGA. Governor, I know exactly where you're coming from. It is annoying at times, when you feel like you're not really part of the team, or as a full fledged member. Just like when we have roll calls, we're left here, and the others get to go vote on the floor. You feel like perhaps you're a second class citizen in that respect, but that's just the way things are here in Washington. I know that every Member here doesn't feel we're being slighted, it's

just the fact that as territorial delegates, we don't have the full rights and privileges allotted to Members who represent the various districts from each State. We understand that's just the way things are.

As I had raised earlier the question with Secretary Cohen, traditionally the Department of Interior has always been our main advocate, I suppose, over the years, with the Federal agencies, with the White House, even with the Congress. I wanted to pursue that line of questioning, wanted to know if there's any disagreement with you in that regard.

I know Dave is very good in being elusive and not saying exactly how he feels about some of these issues. But I was just wanting to know what your thoughts are.

Governor BABAUTA. Mr. Chairman, I totally agree with you. I think legislation is part of the equation in addressing a lot of the discrepancies that the insular areas experience. The Medicaid, for example, and the equation of Puerto Rico, every time we talk about the territories, Puerto Rico having a population of about 6 million people, and the costs associated with the population of Puerto Rico is just, there's no comparison to us smaller ones. I think a special legislation would be absolutely in order for that.

Mr. FALEOMAVAEGA. I think Congresswoman has a comment.

Ms. BORDALLO. Yes, thank you, Mr. Chairman.

I'd like to mention to those in the room that we had two Members of Congress who had to leave abruptly, Congresswoman Watson, who was here, and I don't know if you noticed the gentleman at the end of the table, Congressman Cummings, who is the chairman of the Black Caucus. They were just called to an emergency meeting because of the situation in Haiti. I'd just like to say that they were interested and were present at the hearing. Thank you.

Governor TULAFONO. Congressman, if I could add to that dialog while we're preserving the time to assure the presentation by Governor Babauta there in the presence of the Chair, my attitude toward this whole thing is, first, it took a visit from the chairman to come to grips with the real situation, and with reality that we live with day in and day out. I think some of the testimonies that have been offered so far do provide some good suggestions. I think one of those suggestions is, I think we need to take a comprehensive look at these conditions.

I don't think there's any question, and I will say that in my testimony again, that the fact that this hearing is convened and the recognition of the disparity is sufficient. For the first time in my estimation, we are here to provide some of the causes that we know from our respective jurisdictions to try and help the committee fashion perhaps some of the legislation, or some of the assistance to help us deal with the situation, help all of us deal with these situations in our jurisdictions.

I also feel that as a result of what has come up, I think in addition to look at the situation itself, with respect to health care, I think also we need to look at the mechanism of financing health care in the territories. We have very unique situations that require considerations that are not common to everybody else. And I think that is sufficient reason to want to address those issues in a special way. I think that comes in the way of fashioning a financial mecha-

nism or financial scheme, so that the issues of the territories are addressed specifically.

Because if we continue to deal with them in a global sense across the Nation, they will never be addressed. They can never be addressed. And I don't know if there's any way that you can fashion anything from the existing schemes of today. But I think the fact that this hearing convened, I think it's the first time that I am aware of that a problem is identified, and we are here just to provide information to help, instead of trying to convince Congress that we have a problem. I don't think we need to convince Congress any more that there is a problem.

Mr. FALEOMAVAEGA. You could not have stated it better, Governor. The problem that Madeleine and I have always had over the years is to have Members interested in issues relating to the territories. This is one of the things we always struggled with, is to get as many Members to come to our respective districts. Because that is the only way these Members are going to have some sense of attention, just as the fact that Chairman Burton was able to visit, and I suppose it wasn't just Guam and NMI, it was probably part of an overall delegation that he led to other areas of the Asia Pacific region.

But the fact that this caught his attention, this is just the nature of how things operate here. I'm just so grateful that Chairman Burton has taken this initiative to do this.

Now, we can make our requests, the fact that finally we're able to get the chairman of our House Resources Committee to come and visit the insular areas, and the fact that some of these Members have never heard of these insular areas, is an accomplishment in itself. I don't know how else I could relate to the difficulty there is in even getting anybody to come down. It's always a problem with Members even here in the continental United States to have other Members come and visit their districts, it's a very difficult situation.

So again, our being here, like I said, and thanks to Governor Babauta and Governor Camacho for really getting the chairman's ear on issues related to health care needs of NMI and also Guam and American Samoa has also become a beneficiary because of this, and we have a chance to express our feelings about these needs. I sincerely hope that as a result of this hearing, we're going to come up with some strong recommendations, even by way of hopefully maybe even offering amendments to current Federal law that will be helpful in addressing some of these serious needs that we have as far as health care needs are concerned.

Governor Babauta, I think Chairman Burton should be here in another couple of minutes. Maybe you can go ahead and proceed in that regard. But save your punch line for him when he's here. Does that sound OK?

Governor BABAUTA. Sure, that's perfectly fine.

Mr. Chairman, the names of the elected officials that I enumerated, it is good to have somebody other than myself come to this hearing to know just how much Chairman Burton means to all of us for his visit to the islands. This hearing is truly historic, because I have not seen a hearing in Washington held specifically on health issues in years that I have been here in Washington.

Years ago, we had the Hill-Burton dispensaries. These were dispensaries that were constructed under the federally funded program, the Hill-Burton program. So a lot of dispensaries were built throughout the CNMI.

Then came Philip Burton, of course, he singlehandedly gave CNMI the Social Security, the Supplemental Security Income. So we're grateful for the late Congressman Philip Burton. Then of course, Chairman Burton having come out to CNMI and then holding this historic hearing, I just want to say to the chairman that the people of CNMI are grateful, very grateful to individuals with the last name Burton. We are very honored and pleased with the chairman's visit to the islands. We appreciate his taking the long flight to the islands.

And when he was there, taking the time to speak with individuals, both elected leaders and health officials and our ordinary people that he met, he took the time to have conversations with them. That was just extraordinary on his part.

The CNMI has been a U.S. commonwealth since 1976. We had virtually no health care capacity when we entered the U.S. family about a quarter of a century ago. At that time, our main hospital facility consisted of an outdated Naval facility, long abandoned by the United States. Then in 1982, with the assistance of the United States, we developed a new hospital facility, that's the Commonwealth Health Center today. That facility is now 20 years old, overburdened and in need of critical repair, upgrade and expansion. It provides services to a much higher population of patients than was ever anticipated.

In addition, our remote location poses other challenges. Our closest U.S. tertiary medical referral center is in Hawaii, some 3,000 plus miles away. We have issues regarding the adequate provision of health care services to a scattered population on three major islands, Rota, Tinian and Saipan. And occasionally, we have challenges with health care needs in the northern islands. Each island, although rural in nature, requires the development of a certain level of emergency and preventive and primary health care services.

Mr. Chairman, we have a diabetes epidemic on our islands. The No. 1 health issue facing our commonwealth is the treatment of this disease. The prevalence of a CNMI person having diabetes is 300 percent more than a person in the 50 States, 300 percent more. We have children developing Type 2 diabetes, and these children will require treatment for the rest of their lives. We need $3 million in assistance from this Congress to combat and treat this disease.

Mr. Chairman, the advent of September 11, homeland security priorities and the emerging highly infectious diseases such as SARS, we have had to cope with upgrading and repair of our rapidly aging hospital facility. We need your assistance in funding $6 million in air circulation and water treatment improvements to the Commonwealth Health Center. We take issue with the way the Medicaid funding is provided for the CNMI, just as the other territories do.

We receive millions less in Medicaid reimbursement than we would if regular State funding formulas were applied. This situa-

tion results in the CNMI being less able than the States to meet the health care needs of our people, again burdening not just the way we deliver health care, but our capability in terms of cost. We want the same Medicaid funding as States enjoy, and we ask, I ask this committee to end this funding discrepancy.

We also are faced with the fact that many patients with complicated medical problems, such as cardiovascular diseases, must be referred off-island for definitive diagnostic and therapeutic services. We transport patients to Hawaii and other distant locations at increasing costs. Patients being referred off-island consume a significant portion of our health care budget. And with the help of Congress, we can reduce the cost of health care, and we can do this by developing a truly reasonable health care delivery system. We can do it by improving our capacity and with the blessing, with my good Governor from Guam, we can make Guam a reasonable health care center for the region.

I ask for this committee's support in developing this regional health care program for the people of the CNMI and for the people of the region.

Thank you, Mr. Chairman. I am accompanied today by the Secretary of Health, Dr. Hofschneider, to answer any specific and detailed questions that you may have. Thank you.

[The prepared statement of Governor Babauta follows:]

TESTIMONY OF

GOVERNOR JUAN N. BABAUTA

AND

DR. JAMES U. HOFSCHNEIDER

COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS

TO

THE UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON GOVERNMENT REFORM AND

SUBCOMMITTEE ON WELLNESS AND HUMAN RIGHTS

Hearing Date: February 25, 2004

"This ... is about people--children and adults who are sick, poor, and vulnerable--for whom life, in the memorable words of poet Langston Hughes, 'ain't been no crystal stair'. It is written in the dry and bloodless language of 'the law'--statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children, AIDS patients unable to get treatment, elderly persons suffering from chronic conditions like diabetes and heart disease who require constant monitoring and medical attention. Behind every 'fact' found herein is a human face and the reality of being poor in the richest nation on earth."
Salazar v. District of Columbia, 954 F.Supp. 278 (D.C.1996).

INTRODUCTION

I am Juan Babauta, Governor of the Commonwealth of the Northern Mariana Islands (CNMI), a small chain of islands located in the western pacific islands, just northeast of Guam. We have been a United States Commonwealth since 1976.

Mr. Chairman, the provision of health care in the CNMI is a subject close to my heart. I was educated and trained as a health care planner. My first job upon returning to the CNMI from receiving my master's degree at the University of Cincinnati was as the director of the CNMI health planning agency.

In terms of health care, we had virtually no capacity when we entered the United States family. At that time, our main hospital facility consisted of an outdated naval facility, long abandoned by the US. In 1982, with the assistance of the United States, we developed a new hospital facility. That facility is now 20 years old, overburdened, and in need of critical repair and upgrade. It provides services to a much higher population of patients than was ever anticipated.

In addition, our distant, remote location poses other challenges. Our closest U.S. tertiary medical referral center is in Hawaii, some 3,000+ miles to the east. We have issues regarding the adequate provision of health care services to a scattered population on the three major islands with changing health care needs. Each island, although rural in nature requires the development of a certain level of emergency, preventive, and primary health care services. We provide certain basic services on all three islands, with our inpatient care being provided on Saipan. We also are faced with the fact that many patients with complicated medical problems, such as cardiovascular diseases must be referred off-island for definitive diagnostic and therapeutic services. We transport patients to Hawaii and other distant locations at increasing cost and scope. This subset of patients being referred off-island consumes a significant portion of our healthcare budget.

With the advent of 9/11, homeland security priorities, and emerging highly infectious diseases such as SARS, we have had to cope with upgrading and repair of our rapidly aging only hospital facility in the entire NMI, the Commonwealth Health Center. The tropical weather, with its high temperature and humidity, salty air, and unpredictable typhoons, has been unforgiving to our critical health infrastructure. The hospital's entire dilapidated air handling system and boiler need to be replaced and upgraded. The leaking roof needs resurfacing. The rusted, leaking medical supply office needs to be replaced. In terms of response to infectious disease threats such as SARS or intentional release of agents of bioterrorism such as anthrax, we have insufficient resources in part due to the limitations of our health care physical infrastructure. So in terms of facilities, we still have much to do and we must do improvements and upgrades on the health infrastructures on all three major populated islands.

I would like to introduce Dr. James U. Hofschneider, the Secretary for the CNMI Department of Public Health and a practicing physician with the Commonwealth Health Center in Saipan.

Dr. Hofschneider grew up in Tinian, one of the four inhabited islands in the CNMI and was educated at the University of Louisville for college and then at the University of Hawaii for medical school. He did his residency at the University of California in San Francisco and has practiced at the Commonwealth Health Center in Saipan since 1986. During that time, he has witnessed a lot of sophistication and improvement in health care in the United States in general, and in the CNMI in particular.

Unfortunately, the CNMI started out far behind mainland America in meeting the medical needs of the poor, and continues to lag far behind the rest of the country even today. That is why we need your help.

We are providing written reports to the committee regarding the CNMI delivery of health care. Our verbal report today will focus on 4 issues:

- first, our largest health problem, namely the advent and proliferation of diabetes in the CNMI;
- second, the circumstances surrounding the provision of Medicaid services in the CNMI;
- third, our infrastructure challenges in the age of 9/11; and,
- finally, some thoughts on the provision of regional health care, which I consider a key solution to many of the issues we will raise today.

DIABETES

Rate of Diabetes in Indigenous People of the CNMI

The rate of diabetes is disproportionately high among Pacific Islanders and is a overwhelming medical, social, and financial burden. The indigenous Chamorros and Carolinians of the CNMI rank third in the world among adult populations with Type 2 Diabetes; only the Pima Indians and the people of the Pacific island nation of Nauru rank higher. The burden of diabetes in the CNM is high. A significant percentage of the indigenous population suffers from severe diseases related to diabetes and diabetic complications (heart, kidney, and eye diseases). This situation, coupled with the Commonwealth's dwindling financial resources, makes the situation even more desperate.

Rise of Diabetes in the CNMI

The rising incidence of diabetes among the indigenous people of the CNMI can be traced to the rapid outside influence on the islands during and soon after World War II that caused a dramatic departure from traditional living and eating habits. Prior to World War II, the indigenous Chamorros and Carolinians consumed a diet consisting mainly of locally grown fruits and vegetables, fish, seafood, and meat from livestock. During the Japanese times, rice became established as the preferred starch food for ordinary meals as well as party fare, at the expense of tortillas made from locally grown corn. Today, it is not unusual to hear older women complain that young women do not know how to make tortillas properly, nor do they wish to learn. Tortilla making is considered arduous, as one would have to rise at 4:00 A.M. to begin making the tortillas for breakfast. The older people are not as accustomed to a rice diet when compared to the young adults of today. Among the former, corn is preferred above all other starch foods, followed by taro, bananas, sweet potatoes, yams, cassava, and breadfruit. However, today breadfruit is seldom used by Chamorros or Carolinians, an indication of how far their diet pattern has diverged from the longstanding Oceanic norm.

The results of the war forever changed the topography of the main island of Saipan, Tinian, and to a lesser degree, Rota. Leaving the islands practically defoliated, all native plants and crops were destroyed and the most basic agricultural activities were suspended indefinitely. After the islands were secured, the American military forces housed the surviving Chamorros and Carolinians in resident camps, where they were cared for and first introduced to the same processed foodstuffs that were meant for fighting soldiers. Though originally provided for survival, processed foods eventually replaced pre-war diets and basically became a staple in the diet of the Chamorros and Carolinians. Throughout the 1950s and 1960s, the convenience of canned foods and other pre-packaged products reinforced the new "westernized" diet and the reliance on processed foods for the Chamorros and Carolinians.

With the "westernized" diet came a larger variety and abundance of food. These key factors are linked to the increased consumption of food at social rites such as novenas, fiestas, Christenings, weddings and funerals and to a family's status in the community. The new diet and sedentary lifestyle of a non-agrarian economy significantly contributed

to the alarming rate of diabetes, hypertension, heart disease, obesity, and other lifestyle-related diseases.

Not only has the diet changed, but also the physical activity of the local populations changed. During the Japanese occupation of WWII, the native population was thought of more as a hindrance than an asset, yet the Japanese were fairly conscientious of the local population's physical welfare. The Japanese administration expanded health services both in the native communities and in the schools. They drilled the children in calisthenics and encouraged the young men to participate in Japanese wrestling and other sports. Bicycles filled the streets and railroads traversed the islands. Post World War II, owning a vehicle was an indication that one had achieved higher economic status within the community. Today, if someone needs transportation a vehicle is necessary since there is no mass transit system, and there are few sidewalks for walking.

Chamorro and Carolinian peoples, like other Micronesian cultures, stress the importance of interdependence within the extended family and village over individualism. This concept is repeatedly seen in language, customs, social organization, family, and law; it expresses itself in many qualities that were valued by their ancestors. Thus, health care initiatives such as practicing preventive medicine through education are focused on teaching the extended family as a whole. While the many Americans value individualism, our community's approach to controlling and preventing diseases such as diabetes centers on the family unit and is then reinforced by strong community support systems.

The Burden of Diabetes

Type 2 Diabetes is a major health concern for the indigenous population. Latest statistics reveal that there are 3,128 persons with diabetes in the CNMI. It is a leading cause of illness and shortened life span for adults over 20 years of age, resulting in frequent outpatient clinic visits and hospitalizations. 11% of indigenous adults over 25 years of age have diabetes and this percentage steadily increases with age. In the indigenous adults over 40 years old, 26% have diabetes and by 65 years and over, the rate is 32%.

In one published study conducted by the Department of Public Health, the prevalence of diabetic retinopathy in 339-screened persons with diabetes was 70%, which surpasses the estimated 54% prevalence rate seen in mainland U.S. diabetics. This same study also noted that 40% of all cases of blindness in the indigenous population are due to diabetes. These alarmingly high numbers of diabetic retinopathy were confirmed by the results of one eye clinic where 221 diabetic patients were screened in 2002 and 54% had diabetic retinopathy.

Research conducted at the Commonwealth Health Center reveals that diabetic nephropathy is responsible for 75% of the patients who have end stage renal disease and are receiving hemodialysis treatments. This figure compares to that of the mainland United States average of 25%.

In the CNMI, nine out of 100 people with diabetes are admitted to the hospital for pneumonia every year, but in the U.S., that number is only three per 100. In the CNMI, among 1000 people with diabetes, 12 people undergo limb amputation each year. This rate is much higher than the U.S. national rate of 8.3 per 1000 diabetics. The rate of diabetes-related death is 67 per 100,000, in comparison to the U.S. national average of 79 diabetes-related deaths per 100,000 diabetics.

As these numbers suggest, the costs related to on-island medical care as well as off-island medical care have severely impacted the financial structure of the Commonwealth of the Northern Mariana Islands. In 1997, the Centers for Disease Control and Prevention (CDC) funded the CNMI's Diabetes Prevention and Control Program at $85K. During that year there were 1,812 persons diagnosed with diabetes. The following chart shows the grant funding by the CDC and the diagnosed persons with diabetes from 1997-2003, when the incidence of the disease greatly increased but the funding did not.

Year	CDC Funding	# Diagnosed with Diabetes
1997	$85,000	1,812
1998	$86,700	2,032
1999	$86,700	2,239
2000	$88,438	2,495
2001	$88,438	2,746
2002	$88,399	3,019

Hemodialysis Expansion

To meet the needs of the increasing number of renal-care patients in the community, the CNMI government is expanding the CHC to include a new facility, which would house additional hemodialysis stations and accommodate a peritoneal dialysis program. The current facility in the hospital is authorized for 14 hemodialysis stations, far less than is needed by the 103+ renal patients under dialysis care and future needs (16% growth rate per year in ESRD patients).

While most hospitals run two shifts of dialysis for patients, the CHC is forced to run four shifts, often necessitating patients to come in as late as one or two in the morning. The demand has been too great, and the government has responded by authorizing the new dialysis project.

Unfortunately, the local funding for the new building fell desperately short of what would ultimately be needed to open the new dialysis center. Funding only included construction of the new building itself, while not taking into consideration the cost of furnishing the building, or equipping it with the necessary medical equipment.

Our people are being robbed of family members' best years due to diabetes. Not only does it affect our children by not having the cultural heritage passed down from one generation to the next but also it robs our community of the most productive years of labor and job experience.

With the increasing incidence of diabetes among the indigenous population (Chamorros and Carolinians) as well as other Pacific Island and Micronesian populations, we are asking for your assistance to adequately fight this traumatic disease negatively affecting our islands. Please consider the following requests to help us treat and effectively lower the incidence of diabetes.

- **Funding to equip our expanded dialysis center now under construction, including required standby and isolation stations (two parts: 42 hemodialysis stations @ $25,000 per station; 5 automated peritoneal dialysis units @ $14,000/ unit). $1,120,000**
- Technical assistance to conduct research projects aimed at children, focusing on prevention efforts.
- Funding for resources to provide families who are affected by diabetes such as pamphlets, informational conferences, and trained diabetes prevention educators to conduct a grass roots campaign to prevent and/or control diabetes.
- Funding for supplies to screen persons in the CNMI who are at risk for diabetes. With the increased focus on screening, we will be able to catch persons with diabetes before the complications arise.
- Funding for physicians who are specialists in diabetes complications. These specialists will assist us in decreasing our outstanding debt related to off-island medical referral.
- Funding to improve local staff capability.

MEDICAID

Title XIX of the Social Security Act[1] establishes the federal medical assistance program ("Medicaid"). Medicaid is a cost-sharing arrangement under which the federal government reimburses a portion (up to 77%) of the expenditures incurred by states that elect to furnish medical assistance to individuals whose income and resources are insufficient to cover the costs of their medical care.[2]

States are not required to participate in the Medicaid program, but if they voluntarily choose to do so and accept federal funds, they must adopt a "state plan" that delineates the standards for determining eligibility and identifies the extent of Medicaid benefits. The state plan adopted must comply with the federal Medicaid statute and implementing regulations. If the state plan meets minimum federal

[1] 42 U.S.C. §1396 et seq.

[2] Skandalis v. Rowe, 14 F.3d 173, 174-75 (2nd Cir. 1994); 42 U.S.C.A. §1396a et seq. The purpose of the Medicaid program "is to help provide medical treatment for low income people," Elizabeth Blackwell Health Center for Women v. Knoll, 61 F.3d 170, 172 (3rd Cir.1995), cert. denied, 516 U.S. 1093 (1996).

requirements, the Secretary approves it and state expenditures under the plan qualify for federal funds.[3]

Under federal Medicaid law, if a state chooses to participate in Medicaid (as all states do), then every resident of the state who meets the state's Medicaid eligibility requirements for either mandatory or optional services is entitled to have payment made on his or her behalf by the Medicaid program for those services.[4]

The federal Medicaid program requires that certain categories of medical care must be included in every state's Medicaid plan (mandatory services).[5] Other categories of medical assistance are "optional," and each state has the discretion to choose whether to cover any particular optional service in its program.[6] However, when a state elects to provide an optional service, that service becomes part of the state Medicaid plan and is federally funded in accordance with federal program requirements.[7]

Medicaid Population and Costs

Our population is growing. Every day, 3 new Americans are born in the CNMI. Unfortunately, most of these Americans are poor. From FY2002 to FY2003, the number of Medicaid recipients in the CNMI grew from 7,202 to 8,723, a net 1,500 increase.

The cost of medical care for our Medicaid population is now almost $13.5 million per year. Of that amount, the federal government contributes about $2.5 million or 19% of the total expenditures. If we were treated like a state instead of a territory, federal financial contribution would be almost 3 times that amount or about $6,765,000.[8]

Medicaid Services and Federal Financial Participation

For the states, there are 8 kinds of mandatory Medicaid services[9] and 5 kinds of optional services,[10] for which federal financial participation ranges from 50% in the wealthiest states to 77% in the poorest.

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[3] See 42 U.S.C. §1396a; Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981); Harris v. McRae, 448 U.S. 297, 301 (1980); Elizabeth Blackwell Health Center for Women, 61 F.3d at 172.

[4] Kaiser Family Foundation, The Medicaid Resource Book (July 2002), p.51.

[5] Elizabeth Blackwell Health Center for Women, 61 F.3d at 173.

[6] Elizabeth Blackwell Health Center for Women, 61 F.3d at 173.

[7] Tallahassee Memorial Regional Medical Center v. Cook, 109 F.3d 693, 698 (11th Cir. 1997).

[8] For some purposes, such as the Americans Disabilities Act, the CNMI is treated like a state and has the same obligations and rights as a "state".

[9] Mandatory Medicaid services include:

A. hospital care (inpatient and outpatient);

B. nursing home care

C. physician services

D. laboratory and x ray services

E. immunizations and other early periodic screening, diagnostic, treatment (EPSDT) services for children

In the CNMI, we receive 19% federal financial participation in the Medicaid program. The federal Medicaid program separates CNMI Americans from other kinds of Americans and provides less Medicaid assistance to them. This is done in four ways:

A. by "capping" federal fiscal participation to a set amount;[11]

B. by limiting the federal-CNMI match to a significantly lower percentage than for the states (50% in the CNMI vs. up to 77% in the states);

C. by limiting the types of services that are subject to reimbursement; and

D. by prohibiting disproportionate share public hospital (DSH) payments to the CNMI's only hospital.[12]

Because of the disparate federal financial participation, CNMI Americans receive federal assistance for only the following services: pharmacy; limited off island acute medical care; and dental/optometric/ophthalmology services.

This compares to the 13 categories of assistance Americans living in the states can receive, both for local care and out of state care, when it is required. As distinguished from any state, all of the cost of the CNMI on island hospital and clinic care (preventative care, prenatal care, immunizations, psychiatric care and counseling, long term care, support services that allow individuals with disabilities to remain at home or work in the community, etc.) is borne solely by the CNMI local government without federal contribution.

The Claimed Rationalization for Disparity in Treatment

F. family planning services
G. health center and rural health clinic services
H. nurse midwife and nurse practitioner services.
The Medicaid Resource Book, Kaiser Family Foundation, July 2002, p. 50.

[10] Optional Medicaid services include:
A. prescription drugs
B. intermediate care for individuals with mental retardation
C. home and community based services for individuals with disabilities
D. personal care and other community based services for individuals with disabilities
E. dental care and vision care for adults.
The Medicaid Resource Book, Kaiser Family Foundation, July 2002, at p. 50.

[11] Territorial governments such as the CNMI have a federally imposed capitation on Medicaid service funds received from the federal government. Territorial governments must provide a 50-50 match for services up to the cap and then pay 100% for all services over the cap.

[12] See Section 4116 of PL 100-203, 42 CFR 431.56, Sections 1902(j), 1108(f), and 1905(a)(1)-(27) of the Social Security Act; Dr. Vernon K. Smith, Making Medicaid Better: Options to Allow States to Continue to Participate and to Bring the Program Up to Date in Today's Health Care Marketplace (Prepared for the National Governor's Association), p.14-15.

What is the rationalization for this disparity in which even the richest American states receive proportionately more Medicaid assistance from the federal government than the poorest territories? We are told it is because we do not pay federal income taxes. However, this justification falls apart on closer examination. 60% of CNMI residents are so poor that they would pay no federal income taxes, even if the CNMI were subject to federal taxation. The remaining 40% of the CNMI population consists principally of the working poor and their children, who can ill afford to support the growing medical needs of the islands' poorest citizens. 37% of our children live below the poverty line.

Comparison of Federally Funded Benefits in States vs. the CNMI

Please compare the following benefits under federally funded state Medicaid programs and under our CNMI program.

Type of Service	Federal Contribution to States	Federal Contribution to CNMI
Nursing home care or home health care to elderly persons	50-77% of cost	0
Intermediate group home care or home and community services to developmentally disabled adults	50-77% of cost	0
Inpatient psychiatric care for children	50-77% of cost	0
Personal care assistance for physically disabled adults to live at home	50-77% of cost	0
Any CNMI locally provided medical care (i.e. preventative or acute care, physician, mid-wife, nurse practitioner, physician assistant, hospital, lab, x-ray, screening, diagnostic, treatment, immunization, family planning, or other medical services	50-77% of cost	0
Transportation to/from medical care	50-77% of cost	0
Pharmacy[13]	50-77% of cost	50%
Off island acute care	50-77% of cost	50%
Dental/optometric/ophthalmology services	50-77% of cost	50%

This demonstrates the inadequacy of the existing federal support for the CNMI Medicaid program and its indigent clients.

[13] Medicaid pharmacy expenses are $1.9 million per year.

Examples of Problems Caused By Lack of Adequate Federal Support

Finally, in real life terms, what does this disparity mean for the people of the CNMI?

When patients in the CNMI must be sent elsewhere for heath care, they must be sent not to another city, but off island for care, usually Guam, Hawaii or California. The cost of medical care in both Hawaii and California is among the highest in the U.S., and likely in the world. Transportation and logistical costs for off island care in Hawaii and California are likewise extremely high. (Because of federal funding requirements, Medicaid patients cannot be sent to cheaper and closer destinations like the Philippines, Australia, New Zealand, Japan or Thailand.)

Because the Medicaid program is so under-funded, it is extremely difficult to obtain competent on and off island care for very ill people (especially children). Providers do not want to accept CNMI Medicaid patients because of the delay and difficulty in securing payment from CNMI Medicaid. No new providers want to enter the market of being CNMI off island Medicaid providers. Rates are not what they could be if we could offer timely and sure payment and if there were some competition for CNMI Medicaid business.

CNMI has tried to reduce costs by bringing locum physicians from Hawaii and other states to the CNMI to run periodic specialty clinics. Recently, one of the long time locum providers refused to come to see CNMI patients in Saipan because of the poor Medicaid payment history. He is not the first and he will not be the last to give up on us. The loss of or decrease in locum services means either lack of timely care or even more expensive off island referrals for care, which the CNMI cannot afford.

The CNMI Medicaid program has had Hawaii facilities refuse our patients due to our inability to pay our bills timely. One of our assistant AGs had to actually threaten to file a lawsuit to get a Hawaii hospital to take back its 7 year old leukemia patient who had relapsed shortly after discharge from the hospital in Hawaii. The hospital had demanded that the patient and her family pay up front $100,000 in cash to return for care. Matters got even worse. The little girl could not get a hearing aid in her last months of life because hearing aid vendors would not trust the CNMI Medicaid program to pay for it.

In another case a few years ago, a CNMI hospital administrator could not get an LA hospital to take a critically sick child without promising to pay rates between 2 and 3 times what the California Medicaid program would pay for the same care. When the collection agency came to call due to delayed and disputed payment, the administrator had to admit that yes, he did agree to pay the amount demanded because he could not find any other hospital willing to take the boy and he would have done or said anything at that point, to get the child the emergency medical care he needed to survive.

The CNMI has also been over charged by off island hospitals and physicians (e.g. between 40-100%) because CNMI Medicaid lacked sophisticated staff and the technical

expertise and computer resources which would have shown that the amounts demanded were excessive, inaccurate, unreasonable and illegal for the services delivered.

CNMI physicians and the local hospital are not paid for their care of Medicaid patients due to the absence of sufficient federal funds. This means new providers will not enter the market and the few that are in the market will eventually leave. The burden of the cost of this local Medicaid care on the CNMI government is crushing.

Request for Assistance with Medicaid

We ask that you **eliminate the cap on federal contributions to our Medicaid program and raise the federal contribution to up to 77% of the cost of Medicaid services. In short, we ask you to give us equal treatment with the states**. This would mean additional federal financial participation of $4.5 million per year.

Alternatively, if you feel you cannot do so, we ask that you **increase federal financial participation to pay for a 50% share of mandatory Medicaid services already being provided without federal financial participation through the CNMI's Commonwealth Health Center for local inpatient hospital and outpatient care**. That would be an additional $3.1 million in federal funds. Either alternative would greatly improve our ability to meet the health needs of our poor patients.

THE COMMONWEALTH HEALTH CENTER

Capacity, Number of Patient Visits, and Cost

The Commonwealth Health Center ["CHC"] is the only hospital for a community of 70,000 people. It has a 74-bed capacity and was originally designed and built in the early 1980's to serve a maximum population of 36,000. The facility is now over-burdened and in need of systems repair, upgrade, and hardening for security purposes.

The Emergency Room in the CHC handles over 20,000 visits/year. 60% of visits are pediatric patients. Out patient visits exceed 76,000/ year. The number of hemodialysis patients receiving treatment in 2003 totaled 103. Of those, 41 patients were forced to take hemodialysis treatments late into the night, due to overcrowding and the limited number of hemodialysis units.

The 74-bed hospital has, on average, 6,000 admissions per year. There were 1,400 deliveries in 2003. Patients that are seriously ill, or need further diagnostic and therapeutic procedures not available at CHC, are sent, at CNMI government expense, to off-island referral centers. Off-island care has been averaging over $5 million per year and is a tremendous burden to the CHC budget, which is currently funded at a near record low due to the economic downturn following September 11.

The CNMI spends over $40 million a year to support the Department of Public Health to provide critical medical and health related services. We spend several million dollars a year in order to hire quality professional clinical staff from outside the CNMI, including North American-trained doctors at competitive salaries and over 150 nurses and ancillary personnel to provide the best possible service on island for all residents and visitors.

We are spending several million dollars to expand the infrastructure to increase the number of hemodialysis stations and to increase the ambulatory care space for better access to primary care as well as to care for patients with tuberculosis. In addition, we have opened and enhanced two wellness centers for women and children to improve access to immunization and prenatal services. Yet payment for services rendered has always been lacking, with total collections decreasing with the sluggish economy as the number of indigent patients increase.

In 2003, over 60% of the unpaid accounts receivable at the CHC were from the indigent population (Medicaid, Medically Indigent Assistance Program, self-pay or uninsured.) However, we have and must continue to provide services, regardless of inability to pay. The CNMI needs the help of the Congress and the federal government now to keep the CHC a sustainable and viable center for care.

Despite CHC's relatively small size, it is required to accommodate an excessive number of facilities and services, since it is the only hospital in all of the CNMI. The physical plant design is intelligent and the construction was well executed when it was built. This combination has resulted in the ability of the building to provide an excellent service to its community for the past almost 2 decades. However, there are some critical issues that must be addressed if this facility is to continue to function and perform well into the 21st century.

Emerging Infectious Disease Response Capacity

The CNMI is the closest U.S. territory to Southeast Asia, and is prone to a myriad of potentially deadly infectious diseases of enormous public health significance. The largest and most threat to the CNMI is Severe Acute Respiratory Syndrome (SARS), which broke out in the region during 2002-2003, and may be recurring. Luckily, during last season's outbreak, the CNMI was spared from any cases of SARS, and the local health infrastructure did not have to deal with containment and treatment of SARS. **Because of our proximity to China where the epicenter of the SARS epidemic started and the number of travel between Asia and the CNMI, our risk for importation of SARS from Asia was judged by WHO and local officials as moderate to high but yet our local capacity to respond to a SARS outbreak was minimal. Had a single case of highly infectious SARS reached the CNMI and spread, the island's health infrastructure and clinical staff would have been severely crippled.** The community has limited resources and immediate capacity to control, contain, and treat the

disease. Potential disaster might have ensued had a single case of highly infectious SARS been brought to the CHC.

With the hospital's lack of proper ventilation, and no quarantine units, the entire hospital itself would have turned into one massive quarantine site. All medical staff, ancillary staff, administration and patients breathe the same air, and would be potentially exposed to aerosolized infectious agent.

Our intensive care unit only has four beds, with virtually zero surge capacity. The hospital's structure itself is an 'open air' structure, where it would be a near impossibility to monitor all incoming and outgoing traffic.

The CNMI is a tourist destination for Asia and receives over 1500 passengers per month via direct flights from China through China Southern Airlines, and several indirect flights per week from China (including Hong Kong SAR, Taiwan) via other airlines. The CNMI also is home to a non-resident labor pool of almost 30,000 workers, a significant portion of which live in close-quarter dormitories and 'barracks' located adjacent to the garment factories where they work.

The risk of transmission of SARS, once on island, in close-quarter dormitories used by workers, could result in an epidemic of enormous proportions, quickly overwhelming the local health resources and the only hospital and crippling the staff. There is not alternative hospital facility to quarantine and care for the patients severely affected by SARS.

Furthermore, while there is no human-to-human transmission reported, Avian Flu is nonetheless a threat to the Asian and Pacific region. Avian influenza A(H5N1) has spread among chicken populations in China, and Vietnam, and cross-species transmission (from infected birds to people) has proved to be more fatal than SARS, with a mortality rate reportedly as high as 75%. Should the virus mutate, acquire the capacity to spread from human to human, and gets introduced into the CNMI, the CHC is unable to adequately handle the spread of this, or other emerging infectious diseases, based on the hospital's aging infrastructure, and limited capacity, and improper ventilation system.

Currently, any major outbreak of a dangerous emerging infectious disease would result in lost of many, many lives, devastate the health infrastructure and local economy, and necessitate the intervention of outside government agencies, costing an enormous amount of dollars to respond, contain, and treat any epidemic. Enhancing and hardening of the CHC and its capacity to prevent the spread of any such outbreaks would greatly improve the health care environment, save lives, and mitigate the cost of outside intervention that would otherwise be required.

Bioterrorism Response Capacity

The CNMI is very close to a region of the world associated with an increasing level of political terrorist activities. As a U.S. Flag Territory, the CNMI is a potential

target of terror in the Pacific. With the advent of bombings in Bali, Indonesia, and the potential links to other terrorists through the Asia and Pacific regions, the risk of terror in the CNMI has never been so great. Similar to emerging infectious diseases, our capacity to prevent and handle intentional release of agents of bioterrorism is severely limited by the hospital facility's "open-air" structure allowing multiple accesses to the building and the original design limitations of the ventilation and air handling system (resulting in a closed ventilation system with re-circulation of potentially contaminated air).

Infrastructure Status

Because of age, harsh temperatures, high relative humidity (79% average), rain, and inclement weather like typhoons and tropical storms, the CHC has been battered and beaten over its 20-year existence. The main concern with the structure is the leaking roof, deteriorated state of certain critical equipment and systems such has HVAC (heat, ventilation, and air conditioning), boiler, etc have corroded and reached the end of service life and need replacement. In addition, because of the hemodialysis building expansion project, the entire water supply system needs to be upgraded and enhanced (potable water, medical grade water, water for fire suppression, and decontamination).

Three reports were published in recent years analyzing the functionality and sustainability of the CHC. First was a Facilities Assessment done by Casey Conner, CPE, CHFM, CEM, who was the hospital's Plant Engineer and Maintenance Manager. The second was a Structural Analysis by SSFM Engineers Inc, of Hawaii (May 2000). The third was an Energy Audit and Technical Analysis sponsored by the CNMI Energy Office, and done by Conner Incorporated.

All three reports were focused on different areas of the CHC's infrastructure, but all resoundingly agreed on a common theme: **to continue functioning over the next several years, the CHC must upgrade, repair/renovate, and harden its infrastructure and critical facilities**. The reports were succinct in noting that **without the needed upgrades and renovations, the building will not be viable for continued safe hospital operations.**

Request for Assistance

The critical infrastructure upgrade needs of the CHC are detailed in the Facilities Assessment Report and supplemented by the Energy Audit and Technical Analysis. The total cost of these upgrades and repairs is estimated to be $12 million plus dollars (2002). The CHC administration has identified funds for development of a Master Plan. Although we have begun to replace and upgrade some of the key utility components (such as oxygen machine, telemetry system, phone system, the x-ray equipment, and telemedicine), much more remains to be addressed. **The necessity of speeding up capital improvement funding is becoming critical, as equipment failures are evident.** Furthermore, certain projects will, while solving other issues and concerns (such as space

and patient accessibility and service), in fact exacerbate others. The new hemodialysis building is such an example. While solving the problems of patient access and service, it will create severe water shortage issues once the facility is open. Also the existing CHC infrastructure cannot support the required demands of this project in several other areas.

In summary, the CNMI's one and only hospital facility is urgently in need of systems upgrade, redesign, repair/renovation in order to continue to provide critical medical services to our isolated community in the Western Pacific Basin. The infrastructure and its systems are being pushed far beyond their intended limits, and some are also at risk of system failure. Although our needs are lengthy, **the most critical needs are for upgrade of the water system and the ventilation/space cooling systems. We respectfully ask this Committee to assist the CNMI in funding for upgrade of the Water System, essential for support of the hemodialysis expansion and the entire hospital, and secondly, for funding of the Ventilation/Space Cooling redesign, equipment, and renovation, to protect our community for the risks of immerging infectious diseases such as SARS.**

CHC Structural Projects the	Estimated Cost in 2002 Dollars
Water system (include medical grade, potable water, rainwater catchment, fire suppression, waste)	***$3 Million***
Ventilation/space cooling	***$ 3Million***
Replacement of steam system	$300,000
Medical Supply building	$3 Million
Replacement of medical vacuum system	$150,000
Resurface of roof and its structures	$500,000
Medical air	$100,000
Parking design and construction	$1.5-$ 3 million
Telecommunication (nurse call, security, fire alarm, bioterrorism, and homeland sec. upgrade)	$200,000
Energy management/lighting (after the above changes are made, then lighting will be the primary concern)	$300,000
Total Infrastructure Improvements	**$12,050,000-13,550,000**

CONCLUSION

These needs are substantial. We would appreciate any help you can give us in meeting these challenges. In so doing you will lessen the wide disparity in the quality and quantity of hospital services between the indigenous people of the CNMI and other Americans. Thank y

REGIONAL HEALTH CARE

- Every year, millions of dollars are spent by all the Micronesian island states for off-island medical treatment of patients in Hawaii, the US Mainland, and the Philippines. The CNMI alone spent over $5 million for off-island referrals in one fiscal year. How much does Guam spend? How much does Palau spend? How much does the FSM spend? Simply, we are spending too much.

- It is not simply cost. Patients and families have to travel long distances, and be away from home for prolonged periods of time in a culturally challenging environment. In addition to government expenditures, families also spend a significant amount of financial resources at these referral centers. Travel cost alone for the CNMI exceeded $1 million

- It may be that in an earlier day, off–island referrals were the proper choice. Today, however with the advent of diagnosis via telemedicine, with enlarging populations creating economies of scale in the provision of services, and perhaps more importantly with the increasing number of indigenous persons who are doctors or other medical professionals, new solutions for the delivery of health care are feasible and must be explored.

- Further, high quality health care services are a critical component of the infrastructure needed to attract the more capital intensive activities we see as the next stage of economic development in our region.

- My vision is to develop our own regional health care centers for example, to redirect all our tertiary care patients to Guam, rather than the PI or Hawaii. My vision is for Guam to build on and strengthen the delivery of services in specialized areas so as to accept and receive patients referred from the CNMI. With this support and understanding the CNMI would turn its attention toward becoming the regional center for pediatric care. My vision is for the FSM and Palau to also develop regional facilities in certain areas

- My vision is simply to re-direct part of all of our government and private expenditures to the development of our health resources in a regional manner; a form of re-investment in the neighborhood.

- My vision already exists in the State of Alaska. As Governor Murkowski stated in a letter on this subject

"There are villages and communities in Alaska that are as remote from centers for specialized health care as the most isolated islands and atolls in Micronesia, yet we have taken advantage of technology to markedly improve the ability of the local communities to provide care. In the case of the governments in Micronesia, that technology, as well as a better-focused use of facilities, could provide far better levels of care within the island than is possible now even with off-island referrals. A coordinated approach could also relieve some of the local governments of the maintenance costs for facilities and services that are duplicated on neighboring islands".

- My vision already exists in a small way today here in Micronesia. We are already sharing some resources. Today, 2/3 of all our referral patients already go to Guam and we share some specialties (e.g. CNMI - ENT, ortho, ID, plastics/reconstruction surgery, ophthalmology, nephrology, urology); But we must go farther.

- I propose that we all embrace (buy in) this regional network concept. We must begin to develop new ideas and new concepts.

- We need long-term regional commitment from everybody. Goals must be clearly defined. We must think regionally. The CNMI supports the development of a Veterans Hospital in Guam because this type of regional approach is the best way to address those needs.

- Health care costs have sky rocketed. We are spending more and more resources on health care and projections are that costs will increase.

- My vision changes the way we have looked at medical referral. I propose that united as a region, we can best address our individual needs as well as our neighbors.

CONCLUSION

I *know that these are substantial requests for assistance and that you have many worthy competing concerns. However, we would appreciate any help you can give us in meeting these challenges to improve the medical care we provide. In so doing, you will lessen the wide disparity in the quality and quantity of medical services between the indigenous people of the CNMI and other Americans. Thank you.*

Mr. FALEOMAVAEGA. Thank you, Governor.

Governor Togiola.

Governor TULAFONO. Thank you, Mr. Chairman.

Before I go on, I would like to thank you, sir, for that great introduction, and for conveying a handicap that I can't very well live up to. I just wish that number could be translated to some kind of a formula for obtaining funding to build a new hospital for American Samoa. I would just be right out of here. [Laughter.]

Talofa to the Honorable Chair Burton and to the temporary chair, our own Congressman from American Samoa, the Honorable Faleomavaega. Thank you.

I would also like to especially greet the Honorable Congresswoman Bordallo. It's been a pleasure serving with you as lieutenant Governors in the NCLG. And I'm very happy to see you in that chair.

I am very honored to be here, and I would like to thank Chairman Burton for the opportunity and the honor to testify in this hearing on the issue of health care disparities from a U.S. Pacific Island territory, in this case American Samoa. The health care and medical issues faced by small islands such as American Samoa are insurmountable, due to our isolation and remoteness from specialized services unavailable on-island, retention and recruitment of medical staff and overburdened and outdated medical facilities.

In addition, our dollars just aren't worth a dollar any more, especially in a remote location. And also, due to the very low percentage of Federal assistance dollars per capita that we receive in direct assistance.

Mr. Chairman, I sincerely thank you for your humanity and initiative. If nothing else, the preamble to this hearing really is the recognition of the problem we face. There is a serious disparity in health care in these U.S. Territories in the Pacific. I would like to state for the record that in the treaties of cession involving the islands of American Samoa, to take care of the welfare of the people is a promised recognition that is enshrined in those documents. It's sad to say that it's very difficult for us to deliver and take care of that welfare when we cannot deliver appropriate medical and health care services to the people of American Samoa in an adequate way.

It's always a struggle to meet the rising costs of health care in American Samoa. Our only hospital, the Lyndon Baines Johnson Tropical Medical Center, is 40 years old. It has been upgraded and expanded over the years, but it falls short of meeting the health care needs of our territory. It is one of the best facilities in the South Pacific region. However, it falls short in standards compared to health care in Hawaii and the mainland.

Just May of last year, in 2003, during torrential rain, the whole facility was covered with mud, even including the patient wards. The cleanup was done around the patient beds while the patients were sitting on the bed, to try and remove the mud from the facility. We have unique problems that will require unique solutions to overcome. And I thank you for this hearing. I believe the recognition that is given to the problem gives us a little easier task today. That is not to come here to convince you that we have a problem; rather, we've been invited to try and help you recognize why there

is a problem and try to help foster and forge solutions that will be beneficial to the U.S. Pacific Territories.

The first of those issues I want to bring up to you is, our own natural environment, being a tropical climate increases the risk of diseases subject to natural disasters, as evidenced by recent flooding, mud slides and cyclone Heta in January, and in a very hard to reach island location.

Second, our health care system is plagued by understaffed agencies, and a portion of staff is underskilled or inadequately trained to perform up to acceptable standards. Three, even our trained staff to maintain adequate care levels is difficult to attract, even at high salary levels, due to our isolated location and limited facilities. A classic example of that is, we offered recently $150,000 compensation package to hire a nephrologist. No one is interested. Nobody is responding.

No. 4, the health care system is not adequately meeting the needs of the public, because the health care work force is not sufficiently trained to deliver high quality service. As identified by Dr. Stinson, we're constantly relying on medical officers to work as doctors, which they're not qualified to deliver. But that's the limit of the ability that we have.

No. 5, medical equipment purchases and maintenance costs and pharmaceutical supplies are high, and have risen significantly during the last decade. No. 6, funding from local fees and Federal resources is continuing not to be sufficient to meet operational needs for a sound health care system. And efforts to bring in a reasonable health insurance program have failed due to low patient volumes and unreasonable offers from insurance providers. We put out an offer last year, and only one company responded, offering us a premium of $18 million a year, which is almost more than our whole health care system.

No. 7, an underlying issue is our high growth rate also in American Samoa, which leads to increasing demands that will outstrip existing and planned improvements to health facilities. Last, due to limited tertiary care on-island, there is an unacceptably large proportion of health care dollars from the territory's budget absorbed by off-island medical care referral cases, especially to the State of Hawaii medical centers.

The great percentage of total health dollars are spent on tertiary care overseas, and too small a sum is spent on preventive health programs and services in American Samoa. What are some of the causes of these disparities? It could be summed up quickly by saying that rapid population growth and changes in migration patterns has led to an escalation of immigrant families with greater health needs coming into American Samoa. That's document in our population report of the year 2000. Population growth and increased service demand has resulted in insufficient resources to meet public demands.

The ever-increasing cost of health care due to inflation and the emergence of new technologies and equipment to support them are pushing the LBJ Tropical Medical Center past the point of being able to support its essential medical services for the community. A question arises whether improved health services encourages this immigration, thus helping to cause the stress on facilities and serv-

ices. Also, we have improved our health and family planning education programs and services. But with our high end migration pattern, do these programs reach the people causing high birth rates and result in decline?

A portion of the users of hospital services have limited funds, and are not able to pay increased fees to support improved health care. Is our responsibility to continue to provide health services, even if clients are unable to pay fees? And if we do so, how do we pay that cost? Only limited local revenue exists to expand our health facilities, and the territory is increasingly becoming dependent on limited Federal expenditures, such as funds from DOI, CBDG grants, and the CIP program.

In 1996 to 2000, the expenditure was $40 million, or $8 million per year. Presently, we receive $12 million for health care, $10 million from DOI and $3 million from Medicaid. Medicare provides at a one to one ratio to the mainland, even though the costs are much higher in American Samoa. The reality is that our government collects much less than it expends, and we face a serious dilemma on how to finance our needed service providers, and an expanded infrastructure to support our health delivery system.

The lack of health and medical insurance in American Samoa further compounds our financial dilemmas in operating the services to the territory. All the respondents to our last offer, RFP, came from off-island. There are no insurance companies available on the island.

The current financing method is both socially inequitable and unsustainable as the hospital authority can no longer support health care to a level that meets public expectations, standards of quality and scope of services. If health care costs are increased further and the health system continues to divert a large proportion of health care dollars for off-island tertiary care, the hospital will ultimately have to raise fees to the point that low income individuals will find basic health services inaccessible and essential health services will become eroded due to a lack of funding.

Our remoteness and expensive, infrequent air service between American Samoa and Hawaii also adds to the difficulties in medical tertiary care. The passing of our late Governor Sunia last year is a case or testament of not having adequate tertiary care on-island, limited medical resources and flights that could have abated his untimely demise. He was forced to catch a flight to a foreign country to catch a flight to try and reach Honolulu in time. He passed away enroute.

To meet the causes of these disparities, we have taken a number of actions in American Samoa. However, the reality is that it is difficult to provide quality health care in this environment, to deal with our natural disasters and overcome the attraction of being a U.S. territory to our neighboring countries. The late Governor Sunia formed a task force to investigate the effects of the rapid population growth we are experiencing. This included impacts and ways to overcome these problems, including those to our health delivery system. We have a committee to address population growth issues through implementing the recommendations of that population task force report in 2000.

We need to work with our environment and the climate and natural disasters to which we are subjected. I ask you to understand that our challenge is greater than in other locations, and our needs are also greater. Remember that American Samoa represents the United States in this region. It is important that we put our best face forward.

We look for assistance in terms of funding, but it is not just about money. We need help to recruit qualified health professionals, incentive programs to attack our staffing problems, and enable us to attract qualified physicians to come and provide the services so needed in the territory. We also need to develop and implement a health and medical insurance program in American Samoa to subsidize health care in order to operate, upgrade and deliver top health care to our residents.

Finally, I cannot also negate the need to reevaluate and assess the current facilities if the capacity and staffing issues are resolved for much needed upgrades to medical buildings, technological improvements and to develop high tertiary care services to be made available to all residents of American Samoa.

I hope this information will give you a perspective of the issues that we confront in American Samoa, as other Pacific Island Territories. It is my hope that you can assist us in the areas I have outlined that continue to plague us in providing health care services to all who reside in the territories.

Thank you for your attention and I appreciate this opportunity to be here with the committee and share a perspective from a U.S. territory in the South Pacific. Again, we thank you for convening this hearing, and thank you for having us today.

[The prepared statement of Governor Tulafono follows:]

Congress of the United States
House of Representatives

HEARING BEFORE THE COMMITTEE ON GOVERNMENTAL REFORM

"Investigation into Health Care Disparities in the United States Pacific Island Territories"

Statement by the Honorable Togiola T. Tulafono, Governor
Territory of American Samoa

INTRODUCTION

Talofa Honorable Chair and members of the Committee on Government Reform, I am honored to be here to testify on the "Health Care Disparities from a US Pacific Island Territory" in this case, American Samoa. The health care and medical issues faced by small islands such as American Samoa, are insurmountable to those faced by states within the contiguous US due to our isolation and remoteness from specialized services unavailable on island, retention and recruitment of medical staff, and overburden and outdated medical facilities. In addition to this, we have a low standard of living compared to the US mainland and other island jurisdictions and low percentage of federal assistance per capita. I would like to share with you some of the issues that are further exacerbated by our location, size and high population growth in the Territory.

ISSUES

Current Health Care Disparities:

It is struggle to meet the rising costs of health care in American Samoa. Our local hospital, the Lyndon Baines Johnson (LBJ)Tropical Medical Center, is 40 years old. It has been upgraded and expanded over the years, but it falls short of meeting the health care needs of our territory. It is one of the best facilities in the South Pacific Region however it falls short in standards compared to health care in Hawaii and the mainland. We have unique problems that will require unique solutions to overcome. Some of these disparities include:

1. A natural environment that is not conducive to good health care, being a tropical climate with increased risk of disease, subject to natural disasters (as in recent flooding, mudslides and Hurricane Heta) and in a hard to reach isolated location.
2. Our health care system is plagued by understaffed agencies and a portion of staff is under-skilled or inadequately trained to perform up to acceptable standards.
3. Trained staff (doctors, nurses, etc.) to maintain adequate care levels is difficult to attach, even at high salary levels, due to our isolated location and limited facilities.

4. The health care system is not adequately meeting the needs of the public, because the healthcare workforce is not sufficiently trained to deliver high quality service.
5. Medical equipment purchases and maintenance costs, and pharmaceutical supplies are high and have risen significantly during the last decade.
6. Funding from local fees and federal resources are continuing not to be sufficient to meet operational needs for a sound health care system, and efforts to bring in a reasonable health insurance program have failed due to low patient volumes and unreasonable offers from insurance providers [$18 million was our best offer!]
7. An underlying issue is our high (3.7) growth rate, which leads to increasing demands that will outstrip existing and planned improvements to health facilities.
8. Due to limited tertiary care on island, there is an unacceptably large proportion of health care dollars from the Territory's budget absorbed by off-island medical referral cases. A great percentage of total health dollars are spent on tertiary care overseas and too small a sum is spent on preventative health programs and services in American Samoa.

Causes of Disparities

Rapid population growth and changes in migration patterns has lead to an escalation of immigrant families with greater health needs. (Population Report – 2000). Population growth and the increased service demand has resulted with insufficient resources to meet public demands. The ever increasing cost of health care due to inflation and the emergence of new technologies and equipment to support them are pushing the LBJ Tropical Medical Center past the point of being able to support its essential medical services for the community.

A question arises whether improved health services encourages this in-migration, thus helping to cause the stress on facilities and services. Also, we have improved our health and family planning education programs and services, but with our high in-migration pattern, do these programs reach the people causing high birth rates and result is declines? A portion of the users of hospital services have limited funds, and are not able to pay increased fees to support improved health care. Is our responsibility to continue to provide health services even if clients are unable to pay fees? And if we do so, how do we pay the costs? Only limited local revenues exist to expand our health facilities and the Territory is increasingly becoming dependence on limited federal expenditures, such as the DOI, CDBG and CIP Programs. [1996-2000 expenditure $40.3 million or $8 million per year. Presently we receive 12 million for health care; 10 million from DOI and 3 million from Medicaid]. Medicare provides at a 1 to 1 ratio to the mainland, even though cost are much higher here. The reality is that our Government collects much less then it expends and we face a serious dilemma on how to finance our needed service providers and an expanded infrastructure to support our health delivery system.

The lack of health and medical insurance in American Samoa further compounds our financial dilemmas in operating services in the Territory. The current financing method is both socially inequitable and unsustainable as the Hospital Authority can no longer support health care to a level that meets public expectations, standards of quality and

scope of services. If health care costs are increased further, and the health system continues to divert a large proportion of health care dollars for off-island tertiary care, the hospital will ultimately have to raise fees to the point that low income individuals will find basic health services inaccessible and essential health services will become eroded due to a lack of funding.

Our remoteness and infrequent air service between American Samoa and Hawaii also adds to the difficulties in medical tertiary care. The passing of our late Governor last year is a case or testament of not having adequate tertiary care on island, limited medical resources and flights that could have abated his untimely demise.

Actions needed to overcome disparities

To meet the causes of these disparities, we have taken a number of actions. However, the reality is that it is difficult to provide quality health care in this environment, to deal with our natural disasters and overcome the attraction of being a United States territory to our neighboring countries. The late Governor Sunia formed a task force to investigate the effects of the rapid population growth we are experiencing. This included impacts and way to overcome these problems, including those to our health delivery system. We have a committee to address population growth issues through implementing the recommendations of the Population Task Force Report.

We need to work with our environment and the climate and natural disasters to which we are subject. I ask you to understand that our challenge is greater then in other locations, and our needs are also greater. Remember that American Samoa represents the United States in this region. It is important that we put our best face forward. We look for assistance in terms of funding, but it is not just monetary. We need help to recruit qualified health professionals. Incentive programs to attack our staffing problems and enable us to attract qualified physicians to come and provide the services so needed in our territory.

We also need to develop and implement a Health and Medical Insurance program in American Samoa to subsidize health care in order to operate, upgrade and deliver top health care to our residents.

Finally, I can not also negate the need to re-evaluate and assess the current facilities after capacity and staffing issues are resolved for much needed upgrades in medical buildings, technological improvements, and develop high tertiary care services to be made available to all residents in American Samoa.

I hope this testimony gives you a perspective of our issues in American Samoa. It is my hope that you can assist us in the areas I have outlined that continue to plague us in providing heath care services to all who reside in the Territory.

Thank you for your attention and I appreciate this opportunity to be here with your committee to share a perspective from a US Territory in the South Pacific. Soifua ma ia Manuia!

Mr. BURTON [resuming Chair]. Thank you. I want to thank Representative Faleomavaega for carrying on while I was gone.

Let me just ask a few questions, then after they ask their questions, we'll go to your medical experts and try to find out exactly what in the way of money and other things we can do to help solve this problem.

I'm just curious, Governor Tulafono, what did your predecessor die from? You said he died on the airplane.

Governor TULAFONO. Yes, he did. He was being evacuated to Honolulu because our hospital could not continue to treat his illness.

Mr. BURTON. Was it a heart condition, or cancer?

Governor TULAFONO. Well——

Mr. BURTON. If you'd rather not go into it, that's OK. But it was something that could have been treated had they had the facilities on the island?

Governor TULAFONO. I think he eventually suffered from a heart failure. But it was due to other medical conditions.

Mr. BURTON. And is it pretty certain that had they had the proper facilities on the island, he would have been able to survive?

Governor TULAFONO. That's correct. If the facilities had adequate treatment and physicians competent to treat his condition, he would have survived.

Mr. BURTON. That's really a tragic story, chief executive of a territory like that not even being able to get adequate treatment.

Governor Camacho, your island had I guess a problem with the Guam Memorial Hospital Authority. They had a $20 million debt and they had to declare insolvency, I guess. Can you tell me a little bit about how that happened, how that occurred?

Governor CAMACHO. I have our hospital administrator, Bill McMillan.

Mr. BURTON. We can wait until the next panel. I think he's going to be testifying, is he not?

Governor CAMACHO. Yes, the hospital has not filed for bankruptcy.

Mr. BURTON. Oh, that's not true.

Governor CAMACHO. They're still financially solvent.

Mr. BURTON. But they're having a tough time right now?

Governor CAMACHO. Yes, the government had to step in and take money out of our general fund, and I believe even a portion of some grant money and money that we had available and bailed them out a couple of times for them to even make payroll.

Mr. BURTON. Is that right. The request that I presume you're going to be making, along with the other territories, will talk about how that can be dealt with?

Governor CAMACHO. Yes, sir.

Mr. BURTON. I think you said, Governor Camacho, that over 24 percent of the 188,000 medical services were rendered to patients from the Freely Associated States who are not American citizens or nationals. How do you compensate, how do you take care of those expenses?

Governor CAMACHO. That's a very good question, Mr. Chairman. Basically it has to be absorbed by our medically indigent program. In fact, the amount of money owed to the hospital for uninsured

services provided to our citizens and also others from other countries is absorbed by the general fund. Part of the problem or reason why they have not been able to make payroll or come close to not making payroll or paying their obligations, it's a burden that's been absorbed by the hospital and public health. And certainly it is a growing problem.

We have, because it's only one civilian hospital, there is a responsibility we have to accept all patients, no matter what. And the funding and the payment for their care and services leaves a big dent and big hole in the hospital's finances. Their accounts receivable amount has been tremendous, and I give a lot of credit to our board and Mr. McMillan in his administration of the hospital. They've made great strides in running it as it should be run.

But there are some problems that simply cannot be overcome. How do you tell a person, sorry, we can't provide services for you because you have no insurance or you have no way of paying for it. We simply take them in and somehow or other we will eventually try and find payment out of the general fund. But we have a growing problem under what's called the medically indigent program. Again, government and policymakers come forward with every good intention to provide for the needy and those that cannot afford medical care or medical insurance. And somehow or other, it's the government that has to bear that cost.

Mr. BURTON. And the Medicaid ceilings there are below what they are on the mainland?

Governor CAMACHO. Definitely. Much, much lower. We have a cap and we continue to pay over and above. We've spent an additional $17 million just on the indigent care program, for those that don't have any insurance.

Mr. BURTON. Let me ask one more question to Governor Babauta. That diabetes Type 2, I think you alluded to that in your statement. I wasn't here, but I think I read that in your statement. Did you refer to that?

Mr. BABAUTA. Yes, Mr. Chairman.

Mr. BURTON. What I wanted to find out, CNMI is third in the world among populations with that kind of diabetes, it's one of the worst places in the world as far as that's concerned, and what exactly do you need to compensate for that or deal with that?

Governor BABAUTA. We definitely need to complete the extension of the hospital that is now under construction, adding additional 27 units for dialysis to treat the overflowing dialysis center that we now have, and making sure that the entire extension of the new hospital is well equipped with air circulation suitable for patients that are critically ill.

Mr. BURTON. And the total cost of that would be about how much?

Governor BABAUTA. We're looking at a total cost of about $12 million, Mr. Chairman, all in all.

Mr. BURTON. That would be a one time cost for the expansion and taking care of the air handling and everything else?

Governor BABAUTA. Yes, sir.

Mr. BURTON. Mr. Faleomavaega.

Mr. FALEOMAVAEGA. Mr. Chairman, listening to the statements from our Governors, I think there is a common thread here in

terms of the health care issues that we have, sharing together with the territories. I think diabetes, hypertension, and obesity are probably among the three or four top killers as far as the health care situation that we have. I can certainly speak on behalf of American Samoa, we have the same situation.

And I don't have any questions for the Governors, except I want to commend them for their statements. As I've said earlier, Mr. Chairman, the issues and the problems are out there. And as you have expressed an interest in saying, funding is critically needed to provide for these, to take care of the problems that we have, and hopefully somewhere, somehow, we might be able to provide some assistance in that regard.

Again, I want to thank our Governors for their fine statements and being here with us this afternoon to share their statements. Thank you.

Mr. BURTON. Ms. Bordallo.

Ms. BORDALLO. Thank you, Mr. Chairman.

I too would like to thank the three Governors for their testimonies, and as I listened intently to each of the problems, it just seems so bleak. Certainly we in Congress will have to address this.

I want to mention, there's someone in the audience, I think, who hasn't been introduced. That's Ambassador Jesse Marholou from FSM. He's been sitting through the entire afternoon. Ambassador, welcome to the hearing.

Mr. Chairman, I just for the record want to mention that since we've heard all the problems, what are we doing. Well, there is some legislation that's been sponsored and is moving through the process here in Congress. One is H.R. 675, that's a bill that was introduced by Congresswoman Christensen and co-sponsored by Eni and myself. The territories are all in this together. That has to do with lifting the Medicaid cap. That's H.R. 675.

Then we have H.R. 3459, it's called the Health Care Equality and Accountability Act. This was introduced by the gentleman that came for a moment but was called away, Congressman Cummings, and co-sponsored by the members of three minority caucuses. That addresses health disparities of our minority population, which includes specifically the Medicaid caps for the territories.

Then the third one is H.R. 3750, that's the Pacific Insular Areas Rural Telemedicine Act that I recently introduced, which is also sponsored by our sister territory, which would enable the Pacific Territories greater access to funding for telehelp and telemedicine applications. So I just want you to know that there is some movement now, but certainly it's just the beginning, it's the tip of the iceberg. We've got to continue to work very hard.

And Mr. Chairman, I was hoping that maybe when we see these bills move through, that your support of them would certainly be helpful as they move along in the process. And of course, anything else that we can develop after this public hearing.

Again, thank you to the three Governors, all very good friends of mine and it's nice to see you. Welcome to Washington. I know you're anxious to get home to warmer weather. Thank you.

Mr. BURTON. Thank you. Let me just say that I'll sure take a look at the legislation to see if I can be of help. During a time of severe budgetary problems like we're facing in the Congress, get-

ting new legislation passed that is going to have a price tag attached can be rather difficult.

What I would like to see, and maybe with all of us working together we can get it accomplished, is to talk to Health and Human Services initially and get them to get off the dime and appropriate the moneys that are necessary for the immediate problems, expansion of the hospitals, the dialysis treatment centers, and whatever else is needed, so that we can make sure that the quality of health care is improved very quickly. Then as far as the legislative proposals are concerned, we'll work on those as well.

Ms. BORDALLO. Thank you.

Mr. BURTON. So with that, Governor, did you have one more comment you wanted to make?

Governor CAMACHO. Yes, I wanted to thank you, Mr. Chairman, and Congressman. As I listened to all our problems again, there are many common themes. In talking to Governor Babauta and talking to President Tommy Remegasal, Governor Oraecho from Yap, Peter Christian and also president from FSM, we all agree that we're trying to find ways, we understand as leaders that we're problem solvers. We're trying to find solutions and find ways to make things happen.

So we have agreed that one approach we're taking is to try and work and help each other together as a region in the western Pacific, with the limited resources we have, we're going to find ways to help each other out, one way or the other. We have pride, we have dignity of our people.

As we come to you, and as we come to Congress, it's with the idea that we're not necessarily blaming anyone, we're simply here, as my colleague Governor Tulafono had mentioned, we're here to express that yes, we do recognize the problems, but we're also trying to find solutions and help you in that way. From our perspective, we can point out the key areas where we definitely need the help and how you can help in legislation, working together we can resolve a lot of things.

But we do have our pride, we do have our dignity. And working together as a region, we're going to make things happen. So we're doing everything we can on our end. We do need a little help from this end, too.

Mr. BURTON. We really appreciate that attitude. But I have to tell you that every State in the Union, every city in the Union, they come here on a regular basis with problems that need to be addressed to help their constituencies. It's not out of line for you to ask for fair treatment as well, any of you. So I think it's imperative that we do what we can while you're doing what you can to help make this thing work better.

Let me now have the next panel come forward. I want to excuse this panel, thank you very much for your testimony. We'll have the Honorable Jefferson Benjamin, M.D., the Secretary of Health for the Department of Health and Education and Social Affairs for the Federated States of Micronesia. He's speaking for the Pacific Island Health Officers Association. I guess he's going to be the spokesman.

But I'd also like to have Dr. Stevenson Kuartei, public health officer, Palau, come forward; Dr. William McMillan, who's the administrator of the Guam Memorial Hospital Authority; and Dr. James

Hofschneider, Secretary of Health for CNMI, who's with Governor Babauta.

Mr. FALEOMAVAEGA. Mr. Chairman, I have to go with my Governor right now, but I will come right back.

Mr. BURTON. Oh, sure. We'll receive his testimony.

Gentlemen, will you raise your right hand? I'd like to have you sworn before answering questions.

[Witnesses sworn.]

Mr. BURTON. Be seated.

Since you're the spokesman, Dr. Benjamin, we'll let you give the overview, and then we'll go to questions.

Dr. BENJAMIN. Thank you very much, Mr. Chairman. My name of course is Jeff Benjamin. And of course with me are Dr. Hofschneider, Dr. Kuartei, members of the PIHOA. We are Pacific Islanders who live in the Pacific and are here on behalf of the Pacific Island Health Officers Association.

PIHOA is the association of the ministers, secretaries and directors of health for the U.S. Pacific Island jurisdiction, which includes Guam, American Samoa Commonwealth of the Northern Mariana Islands, Federated States of Micronesia, Republic of the Marshall Islands and the Republic of Palau. I want to thank you for this opportunity to tell the Pacific story.

The U.S. Pacific insular areas are unique because of the challenges posed by the fast and isolated geographical setting, an area of the Pacific the size of the continental United States. At least nine distinct ethnic cultures, with varied socioeconomic and political conditions. A population of about half a million people, scattered over five time zones.

Most of the things discussed are health indicators that are associated with health disparities in the region such as the rate of people living on the poverty line, which ranges from 25 percent in Guam to as high as 91 percent in the FSA. Infant mortality rate, some as high as 37 per 1,000 compared to 6.8 per 1,000 in the United States. Life expectancy is about 7 years lower than in the United States, and in some areas, the difference is 10 years or more.

All of the U.S. associated Pacific island jurisdictions are going through a state of transition, health morbidity and mortality. We stand in double jeopardy, having to do with illness of antiquity, such as leprosy and elephantiasis, as well as having to deal with issues of modernity, diabetes, heart disease, stroke and others. With globalization, our borders can no longer protect us from SARS, avian influenza and the ever-present threat of terrorism and global warming.

These islands are also vulnerable to natural disasters. Because many of them are located along the Pacific Ring of Fire and the Pacific typhoon belt, which predisposes them to earthquake and typhoons.

I am told that the U.S. Pacific Island jurisdictions score up to a maximum of 25 on the health professional shortage area score, something we are not proud of. This shortage is significant because the access to health is not only dictated by remote geography and limited financial resources, but also the lack of appropriate service delivery, availability such as basic primary health care.

To further develop our population base and primary care services in this jurisdictions will require a realistic development and allow for them to attain an even playing field in terms of competing for Federal assistance with those of the U.S. based health care services.

All tertiary care patients are referred out of the region for treatment. This does not only drain the jurisdiction's limited health budget, but also causes significant sociocultural dysfunction in the health care delivery for these patients who access such services. In some years, up to 30 percent of the country's health budget has been spent on tertiary care, out of the region to Hawaii or the Philippines. Less than 1 percent of the population uses tertiary care, and yet this 1 percent consumes up to 30 percent of the total health budget, which places a significant burden on primary population base health care services.

The disparities in health in the U.S. affiliated Pacific jurisdictions becomes more intense when it is eclipsed by the stagnated education system that is unable to produce students who are able to matriculate in health related fields, such as medical, dental, nursing and allied health schools. The shortage of physicians, dentists, nurses and allied health necessitates the recruitment of expatriates, which is not only expensive, it retards sustainable human resource development in health. The disparity is also exacerbated by the shortage of qualified health care managers and administrators.

The application of domestic Federal health program requirements through this U.S. affiliated Pacific Island jurisdiction sometimes retards the appropriate progress in health care development as it tends to create inappropriate models of health care in the region.

The digital divide even further isolate these islands through the lack of adequate communication capabilities. The Freely Associated States, FSA, Marshall and Palau Islands are adversely affected because they are not considered insular areas by the Federal Communications Commission and therefore, ineligible for the discounted telecommunication rates for health and communication offered by the universal service fund.

The extreme distances and travel time not only among the jurisdiction but also distance to the U.S. complicates this digital divide. For example, Palau is one complete day, 13 time zones away, and 22 flight hours by commercial jet travel from Washington, DC.

Appropriate and timely health information systems continue to play an integral role in failing to describe the full extent of these mentioned disparities. While there have been improvements so that now we are quoted as Pacific Islanders and not others, there continues to be a significant health information disparities in research and information collection analysis and translation.

To this end, the Pacific Island Health Officers Association is grateful to the Department of Health and Human Services through HRSA, CDC and NIH and the Department of Interior Office of Insular Affairs, for all of their direct and indirect support for PIHOA. PIHOA is also grateful for the resources provided through the Department of HHS and its program, which includes the community health centers, National Health Service Corps, Community Action

programs, human resources development programs, such as area health education centers and health career opportunity programs, and the many condition-specific programs, such as HIV/AIDS, STD, diabetes control and collaborating, tuberculosis, immunization, cancer prevention and control, and last, bioterrorism resources that come from CDC and HRSA.

While there remain significant health disparities in the U.S. Pacific Island jurisdictions, there has been some tangible improvement. For example, in some of the jurisdictions, while the infant mortality rate is still high compared to the United States, there has been as much as six to one person reduction of infant mortality rate over the past 13 years.

In conclusion, Mr. Chairman, PIHOA and the many indigenous populations of the Pacific jurisdiction thank you for this opportunity to tell our story. At the end of the day, we request that our quest for self-sufficiency in health be at the cornerstone of your delivery today and in the future.

I thank you specifically for allowing me, a Pacific Islander, from the Pacific, to testify on this occasion. Because that in itself is a benchmark of your efforts to eliminate disparities among the U.S. affiliated Pacific jurisdictions, and the spirit of the Pacific peoples.

Thank you for your attention, and I will submit the prepared statement for the record.

[The prepared statement of Dr. Benjamin follows:]

TESTIMONY
From
The Pacific Island Health Officers Association
To
The US House of Representatives – Committee on Government Reform

"OUR CONCERN"

Introduction:

To understand the Pacific insular areas' special needs, one must comprehend the challenges posed by the area's demographics, geographic setting and socio economic conditions. The US associated Pacific Island Jurisdictions consists of six jurisdictions: American Samoa, Guam, Common wealth of the Northern Mariana Islands (CNMI), Republic of the Marshall Islands (RMI), Federated States of Micronesia (FSM), and the Republic of Palau (ROP). American Samoa and Guam are unincorporated territories, and CNMI, a commonwealth Covenant, are officially part of the United States. The Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau have all signed Compacts of Free Association - meaning they are politically self-governing Jurisdictions and have established specific rights and responsibilities*.

The total population of all six jurisdictions is approximately 500,000. This population is spread across 107 inhabited islands covering an expanse of ocean larger than the continental United States.

The Pacific Disparities:

As shown in the table below, more than 50% of the population of American Samoa, Palau and FS Micronesia lived below the poverty line. According to the Department of the Interior, and US standards, about 25% on Guam were living below the poverty line, and 33% in the CNMI. For other areas, which live partly on subsistence, which is not considered in poverty determinations, the levels were much higher – about 63% of the people in Palau were below poverty, 68% in American Samoa, and more than 91% in the Federated States of Micronesia.

Per Capita Income for 2000†

Name	Per capita income 2000	Per capita income 1995	Percent Below Per capita income 1995
United States	$36,300‡	$16,555	11.6%
CNMI	$9,151	$6,984	33.3%
American Samoa	$4,357	$2,861	67.7%
Guam	$12,722	NA	NA
Palau	$4,093	$3,508	62/8%
Fed States of Micronesia	$3,943	$940	91.0%
Marshall Islands	$2,281	NA	NA

* The FSM and RMI re-negotiated and signed their compacts in 2003, Palau in 1986. Prior to that time, the Unites States had administrative control over these Islands. Each compact provides for developmental assistance and cedes full authority and responsibility of the jurisdiction's defense to the United States.
† http://www.doi.gov/oia/commerce/comstatpage.htm
‡ http://www.cia.gov/cia/publications/factbook/geos/us.html

Given these statistics, it is not surprising that almost all health indicators for islanders are worse than those in the United States, particularly in the freely associated states (FAS). For example, average life expectancy in the jurisdictions is 69.1 years compared with 76.0 years in the U.S. Infant mortality (deaths per 1,000 births) is very high in the FAS, ranging from 37.0 in the Republic of the Marshall Islands to 16.7 in Palau compared with 6.8 in the U.S. (Attachment 1). Diabetes, cancer, tuberculosis, tobacco use, alcohol abuse, vitamin deficiencies and suicide are serious health problems in many of the jurisdictions. The Republic of the Marshall Islands and the Federated States of Micronesia have been designated by UNICEF as areas of Special Need in the Pacific because of malnutrition and the high infant mortality rate. In addition, the RMI and the FSM are among the highest scoring, i.e., 25, Health Professional Shortage Areas (HPSA) within the United States.

Contributing to these poor health outcomes are unique challenges in the jurisdictions' health care delivery system. Because the population is scattered over such a wide area, in most jurisdictions, over 20% of residents must travel over one hour to a health facility. Since most of the jurisdictions do not have many paved roads, land travel can be slow. In addition, except for Guam, each jurisdiction consists of multiple islands, thus necessitating travel by boat or plane, which adds to the cost and time

There are no tertiary hospitals with specialty care located in the jurisdictions. There are Hospitals in Guam, American Samoa and CNMI that are certified by the Centers for Medicaid and Medicare Services (CMS) to receive Medicare and Medicaid payments, however, maintaining CMS standards has been difficult, and there are no hospitals in the jurisdictions accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO).

In American Samoa, the Marshall Islands, and the Federated States of Micronesia, the hospitals are wood construction or coated ply board, and therefore precipitating major safety problems. Equipment and supplies for radiology, laboratory, and surgery remain unavailable in most of the Jurisdictions.

Although the Flag and the Freely Associated Jurisdictions have distinct health and economic disparities between them, they all share vulnerable borders. However, through HRSA and CDC assistance, these vulnerable borders are protected from emerging infectious diseases (SARS and Avian Flu) and the threat of bioterrorism.

One significant obstacle for the Pacific Jurisdictions – with this Federal assistance, has been the Federal Domestic Grant requirements, and in particular, for the Section 330 Community Health Center Grants. These requirements are based on a US Mainland standard, and inappropriate for the socio-economic conditions Pacific.

Manpower:

None of the jurisdictions have enough health professionals to adequately serve their populations. American Samoa, Palau, and the Federated States of Micronesia are designated Health Professional Shortage Areas (HPSA) in primary care, dental care, and mental health care, according to the U.S. Department of Health and Human Services. The Marshall Islands have shortage areas in primary care and dental care. The remaining jurisdictions (Guam and the Mariana Islands) are a combination of whole and partial shortage areas in these categories. All Jurisdictions except for Guam, have HPSA scores more than 20, with the Marshall Islands and the Federated States of Micronesia at the highest HPSA score of 25.

American Samoa, the Marshall Islands, and the Federated States of Micronesia have significantly higher ratios of population to primary care physicians than the United States average. Likewise, there has been a tremendous shortage of nurses, particularly from the Public Health/Community Health/Primary Care settings.

There are no medical schools located in the U.S. Associated Pacific Basin jurisdictions. Moreover, the Pacific Basin Medical Officers Training Program, a regional Medical Officers training program based in Pohnpei and instituted in 1986 to address an imminent physician shortage, was closed after 10 years. It trained indigenous individuals who function as Medical Officers (M.O.s) throughout the Freely Associated States, American Samoa, and FIJI. Seventy students graduated and are now practicing throughout the region. However, to maintain and improve skills, these M.O.s need access to continuing education and training.

In combination with the lack of these educational resources, the Pacific Jurisdictions have a tremendous difficulty in recruiting and retaining health care providers in such isolated areas. With the exception of Palau, 60% to 100% of the medical doctors with MD or MBBS degrees in the jurisdictions are expatriate physicians, and are often hired on two-year contracts. Thus, there is great turnover with these types of physicians.

There is an extreme shortage and uneven distribution of dentists in the jurisdictions. Half of the region's dentists are on Guam, with the other half scattered throughout the entire region. Excluding Guam, ratios of dentists to people range from 1 per 4,306 in Palau to 1 per 14,811 in the Marshall Islands. In the US, the ratio is 1 dentist per 1,785 people.

Institutions of higher learning in the Pacific remain extremely rare. The only four-year college level educational institution in the Pacific is the University of Guam. Although it does have a Baccalaureate of Science in Nursing; it offers nothing for the remaining allied work force. Adding to this disparity, many of the existing educational institutions/programs have had difficulty recruiting and retaining faculty, directly affecting the quality of the programs. This is compounded by the prevailing low salaries and fringe benefits packages.

One technological breakthrough that could assist the Jurisdictions in training and education of the health care workforce is reliable telecommunications for telehealth, and distance learning. Unfortunately, the Freely Associated States (the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) are adversely affected because they are not considered Insular Areas by the Federal Communications Commission, and eligible for the health and education Universal Service Fund. This results in increased costs, limits development, and impedes low cost communication for education and health. Long-distance phone rates can be from $.99 in Palau to $1.69 in the Federated States of Micronesia, and phone or Internet service is often unavailable, unreliable, or low quality due to bandwidth limitations.

Many outer islands do not have access to phones, but are forced to use single band radios to the main islands. For example, the inhabited outer islands of Palau, North of Papua New Guinea, communicate with the main island of Korror through these single side band radiophones for regular and emergency communication with the Palau Hospital.

Complicating the digital divide problem is the problem of extreme distances and travel among these 107 inhabited Pacific Islands. Palau is one complete day, 13 times zones away, and 22 hours flight time from Washington, DC by jet. Nevertheless, in some Jurisdictions, there are only 2 airline flights a week.

Burden of Health Care

All Pacific Island Jurisdiction tertiary care patients must be referred out of the region for treatment. This creates a serious drain on the jurisdictions' health budgets. In some years, American Samoa, the Marshall Islands, and the Federated States of Micronesia have spent between 20% and 30% of their health care budgets on off-island referrals. (Attachment 1) Round-trip plane fares for stretcher cases are rated at 6 seats cost from $4,700 to $9,200 depending on whether the patient is coming from American Samoa or Palau.

Less than 1% of the Pacific population uses tertiary care, and yet consumes from 10 to 30 % of that Country's total health budget for tertiary care, and associated costs. This tertiary care expenditure undeniably shrinks the dollar amount remaining for basic public health and social services for these Pacific Island communities.

The IOM Report

All of the above testimony is evident in the Institute of Medicine's 1998 Report "Pacific Partnerships of Health: Charting a New Course." However, health care delivery in the Pacific has gotten worse, particularly with the increased incidence of natural disasters and the increased risk of global public health threats, i.e., SARS, Avian Flu, etc.

In this IOM report, there were four recommendations: (1) Adopt and supports viable system of community-based primary care and preventive services. (2) Improve coordination within and between the Jurisdictions and the United States. (3) Increase community involvement and investment in health care. (4) Promote the education and training of the health care workforce. To this end, PIHOA is grateful to the Department of Health and Human Services through its Health Resources and Services Administration (HRSA) and the Centers of Disease Control and Prevention (CDC), the National Institutes of Health (NIH), and the Department of Interior/Office of Insular Affairs (DOI/OIA) for all their support either directly or indirectly in helping PIHOA to serve our US Pacific Island Jurisdictions.

PIHOA is also very grateful for the resources provided through the Department of Health and Human Services and its programs, i.e., the Hawaii and Pacific Basin Area Health Education Centers, Health Careers Opportunity Programs, Maternal and Child Health Bureau block grants, and HRSA's Primary Care and Community Health Center support. All of the above services are in combination with all the needed programs and services the Centers for Disease Control and Prevention (CDC) provides, i.e., Tuberculosis, Diabetes, Immunization, HIV/AIDs, Cancer Control, and BioTerrorism.

The following reduction in the Infant Mortality Rate in the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is directly attributable to this continued DHHS support and assistance.

Jurisdiction	1990	2000	% Reduction
Federated States of Micronesia	52	20	61%
Marshall Islands	63	37	47%
Palau	26	10	61%

Conclusion:

The Pacific Island Health Officers Association want to take this opportunity to thank the Committee on Government Reform, House of Representatives for the privilege of testifying on the health disparities experienced by American citizens living in the Pacific Islands.

(Attachment 1)

Pacific Island Jurisdiction Data

(18 Feb 04)

Freely Associated Jurisdictions:

Jurisdiction	Per Capita Income	Population	IMR/1000	Health budget/capita	% Referral Costs to Total Health Budget	5 - Leading Causes of Death
United States[§]	$34,280	290,342,554	6.8	$4,672[**]	**NOT APPLICABLE**	1 Heart Disease 2 Malignant Neoplasms 3 Cerebral Vascular 4 Chronic Low. Respiratory Disease 5 Unintentional Injury
Federated States of Micronesia[††]	$2,055	107,008	22.2	$86	$11,000,000 **(14%)** of Total Health Budget $1,400,000	1 Diseases of the Circulatory System 2 Endocrine/metabolic 3 Diseases of the Digestive system. 4 Diseases of the Respiratory system 5 Malignant neoplasms
Marshall Islands[6]	$2,281	50,840	37.0	$275	$4,000,000 **(32%)** of Total Health Budget $12,600,000	1 Sepsis/Septicemia 2 End Stage Renal Disease 3 Diseases of the Heart 4 Malignant Neoplasms 5 Pre-maturity
Palau[6]	$6,039	19,626	16.7	$434	$930,000 **(11%)** of Total Health Budget $8,521,362	1 Diseases of the circulatory system 2 Signs, Symptoms & ill defined conditions. 3 Diseases of the respiratory system 4 Accidents 5 Malignant neoplasms

[§] NCHS 2001
[**] Org. for Economic Cooperation and Development (2002) Health, United States
[††] PIHOA (2002). Health Data Matrix of the US Pacific Basin Jurisdictions

Flag Jurisdictions:

Jurisdiction	Per Capita Income	Population	IMR/1000	Health budget/capita	% Referral Costs to Total Health Budget	5 - Leading Causes of Death
United States[4]	$34,280	290,342,554	6.8	$4,672[5]	**NOT APPLICABLE**	1 Heart Disease 2 Malignant Neoplasms 3 Cerebral Vascular 4 Chronic Low. Respiratory Disease 5 Unintentional Injury
American Samoa[6]	$4,357	59,400	10.9	$500	$2,800,000 **(9%)** of Total Health Budget $30,000,000	1 Diseases of the heart 2 Malignant neoplasms 3 Accidents 4 Infectious & Parasitic Dis. 5 Signs, Symptom, & ill defined conditions.
CNMI[6]	$9,151	69,221	7.6	$487	$3,700,000 **(11%)** of Total Health Budget $33,700,000	1 Diseases of the heart 2 Accidents 3 Malignant Neoplasms 4 Symptoms, signs, & ill-defined conditions 5 Infectious and parasitic diseases
Guam[6]	$12,722	157,554	9.8	$162	% Referral Costs **Not Available** of Total Health budget $25,523,097	1 Disease of the heart 2 Malignant neoplasms 3 Cerebral Vascular Disease 4 Suicide 5 Accidents

TESTIMONY
From
The Pacific Island Health Officers Association
To
The US House of Representatives – Committee on Government Reform

"OUR CONCERN – IS OUR PEOPLE"

Digital Divide / Telehealth

Access to telehealth (telemedicine and health professions distance education) technologies and affordable telecommunication rates could help the Pacific Jurisdictions improve health care throughout the region. However, in some of the jurisdictions, in particular the Freely Associated States, phone or Internet services are often unavailable, unreliable, of low quality due to bandwidth limitations and very expensive (long-distance phone rates range from $.99/minute in Palau to $1.69 in the Federated States of Micronesia).[1] Even in the Flag Territories (Insular Areas) where sufficient bandwidth and technology exists for telemedicine and distance education, the high cost of telecommunication rates to access sources of specialty care and distance education are too expensive to be frequently utilized. This is particularly disturbing because the Flag Territories pay into the Universal Service Subsidy fund, yet are unable to benefit from the Fund's Rural Health Provider Program. The Rural Health Provider program is a program established under the Telecommunications Act of 1996 that was created specifically to enable rural communities to access telehealth services at affordable telecommunications rates.

Given the issues, Congress could help the Pacific Insular Areas and the Freely Associated States in several ways.

An immediate action that would help the health care providers in the Pacific Insular Areas -- American Samoa, Guam and the Commonwealth of the Northern Marianas Islands -- is to pass H.R. 3750 - Pacific Insular Areas Rural Telemedicine. This bill, introduced by Congresswoman Madeline Bordallo and four co-sponsors (Mr. Faleomavaega, Mr. Abercrombie, Mr. Acevedo-Fila, and Mrs. Christensen), would provide for the correct and proper treatment of the Pacific Insular Areas. HR 3750 would enable the health care providers in these jurisdictions to interconnect to Honolulu, Hawaii (the nearest urban area with specialists, sub specialists, and health professions schools including a medical school) under the Universal Service Rural Health Provider program. Specifically, the program would subsidize the difference in telecommunication rates between a jurisdiction and Honolulu, thus providing an affordable mechanism for the Insular areas to access telehealth services.

[1] Many outer islands do not have access to phone and therefore must use single band radiophones to the main islands. For example, the inhabited outer islands of Palau, north of Papua New Guinea, communicate with the main island of Korror through these single side band radiophones for regular and emergency communication with the Palau Hospital.

Under the current law and rules of the Federal Communications Commission, the telecommunication link between the Insular jurisdictions and an urban area with specialty care (i.e., Honolulu) is not eligible for the subsidy because the current law and rules only subsidizes the cost of the communications connections between urban and rural areas within a state, and the FCC is treating the Flag Territories as states for the purposes of the law. HB 3750 would correct the problem by amending the Communications Act of 1934 as follows:

"Section 254 (h) (1) (A) of the Communications Act of 1934 – 47 U.S.C. 254 (h) (1) (A)) is amended by adding at the end the following new sentence: "For the purposes of this subparagraph for American Samoa, the Commonwealth of the Northern Mariana Islands, and Guam, the Commission shall by regulation (i) designate Honolulu, Hawaii, as the urban area that shall be treated as if such urban area were in the same State as the rural areas of Guam, American Samoa, or the Commonwealth of the Northern Mariana Islands, respectively; (ii) specify that the maximum allowable distance shall be the distance between the capital cities of these Pacific insular areas and Hawaii; and (iii) specify that the urban rate shall be based on the urban rate for Hawaii."

There are several compelling reasons why this bill should be supported.

1. First, the Pacific island jurisdictions are all rural as defined by the Universal Service Administrative Company (USAC)[2] and the U.S. Department of Health and Human Services.[3] In fact, no Insular Areas has a metropolitan statistical area (i.e., an area with a population of 50,000 or more), nor even have a metropolitan area (a new OMB designation for an area with an urban cluster of 10,000 individuals).[4] Although the FCC has chosen to label the largest population center of each jurisdiction as "urban" for the purposes of the Rural Health Provider Program, labeling it as such does not change that fact that there is an absence of tertiary and specialty care in each of the jurisdictions.

   Given the lack of a population base to support specialty and subspecialty care, as well as a variety of health professions training programs, each jurisdiction has a great need to connect to health care providers and health professions training programs in an urban area that can provide a range of telemedicine and health professions education services. Hawaii is the closest state with a range of health professions training programs including a well-established medical school, advanced medical facilities, and a statewide telehealth and telemedicine network. Enabling interconnections to the health care providers and education programs would significantly improve health care services for the rural Insular Areas. Being eligible for subsidized telecommunication connections, would enable hospitals and clinics in the Insular Areas to transmit medical imagery, obtain consultations, and share clinical education and Grand Rounds that are routinely offered by the State of Hawaii Telehealth Access Network (STAN). It should be noted that 40 hospitals and clinics are interconnected to the STAN network, including those of the VA Medical and Regional Office Center in Hawaii, and the majority of these do receive benefits under the Rural Health Provider program.

[2] http://www.rhc.universalservice.org/eligibility/rurallist.asp
[3] http://www.whitehouse.gov/omb/inforeg/msa99.pdf
[4] U.S. Census Bureau - About Metropolitan and Micropolitan Statistical Areas, http://www.census.gov/population/www/estimates/aboutmetro.html

2. Second, the telephone subscribers of these Insular Areas pay into the universal service trust fund through surcharges passed on by the carriers. Yet, the rural health care providers in these jurisdictions are unable to apply for discount services to be connected to telehealth providers in an urban area despite paying into the fund. Congressional action is needed to rectify this problem. In fairness, it should be stated that the Federal Communications Commission did solicit comments on this specific problem through both an Insular Area and Universal Service docket. Unfortunately, the FCC has found that it is constrained by the current restrictions in the law.

The FCC has stated in its REPORT AND ORDER, ORDER ON RECONSIDERATION, AND FURTHER NOTICE OF PROPOSED RULEMAKING, released on November 17, 2003 that:[5]

(45) Background. Section 254(h)(1)(A) provides that telecommunications carriers must offer telecommunications services to rural health care providers "at rates that are reasonably comparable to rates charged for similar services in urban areas in that State." Consistent with this statutory language, for purposes of calculating the "urban rate" to determine the amount of universal service support received by rural health providers in insular areas, the Commission looks at the rates charged customers for a similar service in the largest population center in the State. The Commission, however, has recognized that use of this calculation may be ill-suited for insular areas because many rural health care providers are located in the largest population center in the territory, which results in no recognizable urban/rural rate comparison. Accordingly, in the NPRM, the Commission sought comment on whether section 254(h)(2)(A) gives us the authority to allow rural health care providers to receive discounts by comparing the rural rate to the nearest large city outside of their "State." The Commission also sought comment on alternative means for addressing the problems of insular areas, consistent with section 254.

(46) Discussion. Although we continue to recognize that using urban rates within a State as the benchmark for reasonable rates may be ill-suited to certain insular areas, we believe that the proposal made – to permit the comparison of insular rural rates to the Reconsideration, Congress could have provided discounts for tele-communications services that connect rural health care providers to the nearest major hospital within or outside the State. Congress, however, explicitly provided that rates should be compared to the urban rate in that State. We continue to believe section 254 (h) (1) (A) precludes us from designating an urban area outside of the State as the benchmark for comparison for remote, insular areas.

(47) We also disagree with American Samoa Telecommunications Authority that section 254(h)(2)(A) authorizes the Commission to provide support for telecommunication links between American Samoa to an urban center outside the territory, such as

[5] Federal Communications Commission, REPORT AND ORDER, ORDER ON RECONSIDERATION, AND FURTHER NOTICE OF PROPOSED RULEMAKING, November 17, 2003 pgs 45-47.

Honolulu, Hawaii, without regard to the urban-rural rate difference. Section 254(h)(2)(A) authorizes the Commission to take action to increase access to advanced telecommunications and information services. Support for telecommunications services, however, is provided subject to section 254(h)(2)(A) and as discussed herein, requires an urban to rural comparison within the State.

The FCC has recognized the problem, but has found that Congressional action is needed since the Insular Areas are treated as "states" under the law. As a result, there is a gross inequity for the rural and insular areas that are not able to receive benefits from the rural health care fund even though the fund was intended to help such rural, insular health care providers. No health care provider in American Samoa, Guam, or the Commonwealth of the Northern Marianas Islands has received any discount funding for telecommunication services, despite paying into the fund. HR 3750 would correct the problem for the Pacific Insular areas.

3. Third, a recent rule change by the FCC addressing Internet access will provide little benefit in the Insular areas. The FCC, in the Report and Order, Order on Reconsideration and Further Notice of Proposed Rulemakings released November 17, 2003, revised its Internet access rule in a manner that it believes will assist the Insular Areas. Regarding the revised rule, which extends the Rural Health Care Provider subsidy to include covering 25% of the cost of a rural health care provider's Internet access, the FCC states at [47]: "...we believe (this) will functionally provide significant support to health care providers in insular areas". However, this is not a viable solution for the Insular Areas for the following reasons:
   a. An Internet connection would not provide the "Quality of Service" (QoS) needed to support many telehealth and telemedicine applications. An Internet connection is not the functional equivalent of a T1, Fractional T1, DS-3, or other telecommunication connections authorized by the Rural Health Care Program.
   b. If QoS were to be a part of the bid specifications for Internet access, then, it is unlikely that the Internet access providers would be able to meet this requirement with the current capacity. The Internet Access provider would need to augment the underlying telecommunications transmission capacity. This would then become cost prohibitive to the health care provider given that only 25% of the cost would be subsidized.
   c. Although Internet access is available in these locations, the network capacity is not very robust to support video teleconferencing for consultations and telehealth education, or other higher bandwidth applications with locations outside of these rural jurisdictions.
   d. Although for many parts of the United States that have broadband DSL or cable Internet services, the Internet can, as the Commission states, "serve as an invaluable resource, by providing online courses in health education, medical research, follow-up care, regulatory information, video conferencing, web based electronic benefits claims systems, including online billing and other crucial business functions", this is not true for the Pacific Insular Areas because of the limited off-island and on-island connections. Even many distance learning health care education and training

program cannot be delivered via the Internet in the Pacific insular areas because they require large files and other course objects to be transferred.

Only the passage of HR 3750 will provide the FCC the authority it needs to correct its treatment of the Insular Areas in a meaningful manner.

4. Fourth, it should be noted that the K-12 schools in these jurisdictions do benefit from the Schools and Libraries Program established by the Telecommunications Act of 1996. We are merely requesting that corrections be made to address the needs of the rural health care providers in these areas.

Another way the U.S. Congress could help the rural health care providers in the Pacific Region is to enable the Freely Associated States (FAS) to be given the right to opt-in and opt-out of being regulated by the Federal Communications Commission. The telecommunication carriers in the Freely Associated States, in contrast to the U.S. territories and the Commonwealth, are all monopoly carriers. Enabling the Freely Associated State to elect participation in the National Exchange Carriers Association and be regulated by the Federal Communications Commission would help the health care providers by requiring that these Insular Areas be subject to open competition should they opt-into NECA and FCC regulation.

The Republic of Palau understands the implications of such participation, is ready to participate in the NECA, and is ready to open up to competitive telecommunications. The Federated States of Micronesia and the Republic of the Marshall Islands are not ready today, but might be tomorrow. Competition, coupled with participation in NECA, would significantly help the health care providers in these areas by providing a means for the rural health provider to have access to advanced telehealth and telemedicine capabilities through participation in the universal service programs. Participation would also provide carriers with an opportunity to directly compete for business in these jurisdictions.

In addition to the two options identified above, the rural health care providers in the Pacific Islands region would also be helped if current health care programs funded by the U.S. Department of Health and Human Services were to be encouraged to support the specific telehealth, telemedicine, and distance learning needs of the islands. We have some special problems in this area and targeted special help in these areas could make dramatic differences. The cost of travel to provide clinical services, distance education, and technical assistance can be made far more effective and efficient if some of it can be provided through technology.

Last, we urge Congress to recognize that until the Pacific Insular Areas and Freely Associated States have access to affordable telecommunications for telehealth, they will remain the weakest link in our Nation's defense against disease outbreaks such as SARS and the Avian flu, which started in Pacific Rim countries, as well as against biological and chemical terrorist attacks. We urge Congress to do all it can to ensure that the Pacific jurisdictions have access to affordable telecommunication rates for telehealth services, both to increase needed health care services and health professions training in the region as well as enhance our Nation's overall security.

TESTIMONY
From
The Pacific Island Health Officers Association

To
The United States House of Representatives-Committee on Government Reform

Ladies and Gentlemen of the Committee on Government Reform, my name is Stevenson Kuartei and I am a Pacific Islander who lives in the Pacific and am here on behalf of the Pacific Island Health Officers Association. PIHOA is the association of the Ministers, Secretaries and Directors of Health for the U.S. Pacific Island Jurisdictions which include Guam, American Samoa, Commonwealth of the Northern Mariana Island, Federated States of Micronesia, Republic of the Marshall Island and the Republic of Palau. I want to thank you for this opportunity to tell the Pacific story.

To comprehend the state of health disparities in the Pacific insular areas, let me take a brief moment to outline some of what makes these U.S. territories and associated areas in the Pacific unique. The challenges posed toward reduction of these health disparities, include the areas of vast and isolated geographical setting, an area of the Pacific the size of the continental United States, demographics, an area that consists of at least 9 distinct ethnic cultures with varied socio-economic and political conditions. The region includes U.S. incorporated territory of Guam and unincorporated territory American Samoa, U.S. Commonwealth of the Northern Mariana Islands and the Freely Associated States of the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau. The total population of these islands is approximately 500,000 living on 107 inhabited islands scattered in 5 different time zones.

Let me share with you other issues posted on the backdrop of the health disparities in these U.S. Pacific Islands jurisdictions. The rate, which people in these areas live below the poverty line, ranges from 25% on Guam to as high as 91% in the Federated States of Micronesia. While the infant mortality rates have improved, it remains high compared to those of the U.S. and some as high as 37% compared to 6.8% in the U.S. The average life expectancy rate in these islands is about 7 years lower than in the U.S. and in some of the

islands the difference is over 10 years or more. The U.S. Pacific Islands also find themselves in the state of transition regarding morbidity and mortality such that while they continue to see the illnesses of antiquity such as leprosy, elephantiasis, tuberculosis and parasitism, they are also experiencing the rise of disease of modernity such as diabetes, heart diseases, stroke and others. And, Ladies and Gentlemen, because of our proximity to the Southeast Asia, the disease of globalization and with "blurring borders" have also threatened our region. Due to globalization our borders do not protect us against SARS and Avian Influenza. This is compounded by the ever-present threat of Bio-terrorism and Global warming. Many of these islands are located around the Pacific Ring of Fire and are vulnerable to earthquakes. Some are located right in the middle of the Pacific Typhoon belt such as Guam, CNMI and FSM. The vulnerabilities lead to the widening the gap of health disparities. Typhoon Chataan, which killed 42 people in Chuuk and went on to hit Guam, is an example.

I am told that the this U.S. Pacific Island jurisdictions score up to the maximum of 25 on the Health Professional Shortage Area score, something we are not proud of. This shortage is significant because lack of access to health is not only dictated by remote geography and limited financial resources, but also lack appropriate service availability such as, basic primary health care. Ladies and Gentlemen, some of these areas have difficulty getting basic penicillin tablets that can prevent rheumatic heart disease, a preventable heart disease in this day and age. Within these jurisdictions, there is no tertiary care center and therefore, whatever limited resources available that can be used for the advancement of primary and preventive care, are used to send people off island to Hawaii or Manila, Philippines. The disparity that exists within the region is not in the secondary care systems such as hospital systems but mainly in the population based health care, primary care and tertiary care systems. To develop population based and primary care services in these jurisdictions will require a realistic evaluation of the level of development and allow for them to attain an even playing field in terms of competing for Federal assistance with those of the U.S. based health care services. Ladies and gentlemen, I am here today to testify that there is no even playing field, and to reduce the

gap of health disparities will require a concerted effort in potentiating the development of primary and preventive services in these U.S. affiliated jurisdictions.

All tertiary care patients are referred out of the region for treatment. This not only drains the jurisdiction's limited health budget but also causes severe socio-cultural dysfunction in the health care delivery for the patients who access such services. In some years, up to 30% of the countries' budget has been spent on tertiary care out of the region to Hawaii or the Philippines. The cost to each family can range from $4,700-$9,200,the equivalent of one year's salary. Less than 1% of the population uses tertiary care and yet this 1% consumes up to 30% of the total health budget, which places a significant burden on primary and population based health care services. It is difficult to promote primary health care when you run out of essential drugs and supplies.

The disparities in health in the U.S. Affiliated Pacific jurisdictions become more intense when it is eclipsed by the stagnated educational systems that are unable to produce students who are able to matriculate in health related fields such as, medical, dental, nursing and allied health schools. Most of these institutions are located outside of these jurisdictions. None of these U.S. Affiliated Pacific Island jurisdictions have enough appropriate health professionals to adequately take care of the populations. The shortage of physicians necessitates the recruitment of expatriates. This is not only expensive but also results in a high rate of turn over which does not support long-term sustainability. This shortage is not isolated to the physicians but dentists, nurses and allied health workers as well. The biggest disparity in health manpower is not on the medical side of health care but on the public and primary care, which manages the population-based indicators. This is also exacerbated by lack of trained health care administrators and health care managers

The application of domestic federal health program requirements to these U.S. Affiliated Pacific Islands jurisdiction sometimes retard the appropriate progress in health care development, as it tends to demand inappropriate models of health care developments in the region. The health care systems are not as developed as those of the mainland U.S.

and the application of domestic requirements places significant burdens that sometimes retards appropriate development in health.

The digital divide even further isolates these islands through the lack of adequate communication capabilities. The Freely Associated States of the Federated States of Micronesia, Republics of the Marshall Island and Palau are adversely affected because they are not considered Insular Areas by the Federal Communications Commission, and therefore, ineligible for the discounted communication rates for health and education offered by the Universal Service Fund. As a result the phone rates range from $0.99-$1.69 per minute which frustrates communications in health. Most of the outer islands in Micronesia do not have access to telephones and are forced to use single band radios for regular and emergency communication with the central hospitals. Some of these remote islands are just north of Indonesia and Papua New Guinea. The extreme distances and travel time not only among the jurisdictions but also distance to the U.S complicate this digital divide. For example, Palau is one complete day, 13 time zones away and 22 flight hours by commercial jet travel from Washington, DC. Some of these U.S. Pacific Islands, such as American Samoa have but only 2 flights a week to the outside world.

Appropriate and timely Health Information Systems continue to play an inherent role in failing to describe the full extent of these mentioned disparities. While there have been improvements so that now we are coded as "Pacific Islanders" and not "Others", there continue to be a significant health information disparities in appropriate research and information collection, analysis and translation.

The above testimony does not differ from the reports in the 1998 Institute of Medicine Report, "Pacific Partnership of Health: Charting a New Course." This report was supported and endorsed by Human Resource Services Administration (HRSA), which fully documents some of the disparities discussed in this testimony. The report made 4 specific recommendations: 1) Adopt and support viable system of community based primary care and preventive services. 2) Improve coordination within and between the

Jurisdictions and the United States. 3) Increase community involvement and investment in health care. 4) Promote the education and training of health care workforce.

To this end, the Pacific Island Health Officers Association which represents the Ministers, Secretaries and Directors of Health in the U.S. Affiliated Pacific Islands Jurisdictions is grateful to the Department of Health and Human Services through HRSA, CDC, NIH and Department of Interior/Office of Insular Affairs for all of their direct and indirect support to PIHOA. PIHOA is also grateful for the resources provided through the Department of HHS and its programs which includes the Community Health Centers, National Health Service Corp, Community Action Programs, Human Resource Development programs such as Area Health Education Center and Health Career Opportunity Program. And the many conditions specific programs, HIV/AIDS, STD, Diabetes Control and Collaborative, Tuberculosis, Immunization, Cancer Prevention and Control Programs and lastly Bio-terrorism resources that comes from CDC and HRSA.

While there remain significant health disparities in the U.S. Pacific Island Jurisdictions, there has been some tangible improvement. For example, in some of the jurisdiction while the infant mortality rate is still high compared to the U.S., there has been as much as 61% reduction of infant mortality rate over the past 13 years. There is a general community perception of improved health care systems and this is because of the efforts of the various agencies and programs that emanates from the U.S. government. However, the gap of health disparities must continue to be narrowed by innovative efforts to assure that appropriate health care strategies, which at times may vary from the U.S. domestic program requirements, are rendered to the U.S. Affiliated Pacific Island jurisdictions.

To conclude this short testimony, PIHOA and the many indigenous populations of the Pacific jurisdictions thank you for this opportunity to tell our story. At the end of the day we request that our quest for self-sufficiency in health be at the cornerstone of your delivery today and in the future. I thank you specifically for allowing for me, a Pacific Islander from the Pacific to testify on this occasion because that, in itself, is a benchmark

of your efforts to eliminate disparities among the U.S. Affiliated Pacific Jurisdictions and the spirit of the Pacific peoples.

Thank you.

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Mr. BURTON. Thank you very much, Dr. Benjamin.

I guess the only real question I have of you, and it was pretty much the same question we had of the Governors, what are the needs, immediate needs of each one of the territories, and how could we best help you solve that problem. I think what I would like to have you do, if you would, is to give us that in writing, so that we can draft a letter and send it to the organization that the President has appointed where various agencies get together and try to come up with solutions of problems of the territories.

We'll also send a letter to the head of HHS urging them to take positive action on the financial requests that will take care of your needs. That I think should be the focus of our hearing today. My colleagues who have been with us today have legislative proposals which may or may not reach fruition. We may or may not get them passed because as I said before, we have these budgetary constraints that are very severe.

But at the same time, I think that if we collectively write a letter to as well as personally contact the people on this commission that the President has appointed, as well as the Secretary of Health and Human Services, we might be able to shake loose the funds that are necessary to get your various territories over the hump as far as immediate health care needs are concerned. I think that's the first thing that needs to be done. Then we can work on the legislative proposals that they talked about.

And with that, do any of you have any comments you'd like to make to add to what Dr. Benjamin said? Dr. Hofschneider, do you have any comments you'd like to make?

Dr. HOFSCHNEIDER. Thank you, Mr. Chairman, for this opportunity. I'm here to elaborate more on the issues, especially affecting the CNMI and to give you more details about our needs. I also support the statement as a member of the Pacific Islands Health Officers Association, I support the statements and the priorities that have been discussed by Dr. Benjamin.

Mr. BURTON. When I met with you in Saipan, we went through your hospital, I think you pointed out some of the things you felt were necessary. You don't really need to go through them again with us today. What I really need, and what we really need is to have it very succinctly stated in writing what is needed, when it's needed, how much money is needed and why we need to get on with that as quickly as possible. I think that would probably be the best thing we could get. Then I'll try to get other Members of Congress who are not with us today to sign on to this letter and try to use their influence to shake loose the funds that are necessary.

HHS has the money. It's just a matter of getting it allocated in the proper way so you folks are getting what needs to be allocated.

Dr. McMillan.

Mr. MCMILLAN. Mr. Chairman, thanks for the promotion. It's just Mr. McMillan.

There are two things I'd like to bring to your attention, sir. Guam's hospital is a Medicare participating hospital. And in my written testimony, we identify that our Medicare reimbursement is still subject to a TFRA count, because we're not part of the prospective payment system. And a very specific and actual thing to do would be to either re-base our TFRA count, that's the least popular

alternative in my book. Second would be to either just eliminate the TFRA count completely for the hospital, or, and this would require a little bit of legislative work, allow Guam Hospital to be declared a critical access hospital. Those hospitals are reimbursed at 101 percent of the cost based reimbursement.

Prior to coming here, I gave Governor Camacho a list of 107 specific Federal funding vehicles, either grant programs or grants or loan guarantees that we intend to rebuild our hospital with. I'll be happy to supply some specific recommendations for your committee to pass on to the HHS.

Mr. BURTON. What we'll do, when we write and contact the health agencies regarding the requests that are being made today is we'll cite all the various avenues that could be followed to get that money. And so I would like to have, did you say 107?

Mr. MCMILLAN. Yes, sir.

Mr. BURTON. If you give us a list of 107, I'll make sure that it is attached to the letter as an addendum, saying you figure you can't take it out of your general budget over there, here's 107 other ways you can do it.

Mr. MCMILLAN. Sir, there's one other thing I'd like to mention. We're very heavily dependent on foreign health care workers. Wage scales are a little low and we're kind of far from home for not only physicians but also nurses and allied health practitioners. The cap on the H1B visa program severely limits our ability to bring in the nurses, x-ray techs and that sort of thing. There's an H1C visa program that if Guam was written into that specific visa program, we would be allowed to recruit a lot more nurses.

Mr. BURTON. That would probably now be under Homeland Security, I believe.

Mr. MCMILLAN. Yes, sir.

Mr. BURTON. It's either State Department or Homeland Security Act. Can you guys write that down, and let's check on that and see if we can't contact them about maybe changing the visa policies, so they can get more health professionals in there.

Mr. MCMILLAN. I realize that's not your purview, but I'm getting my licks in when I can.

Mr. BURTON. That's fine. It is, if it refers to the health care problems of the area. We certainly would like to help.

[The prepared statement of Mr. McMillan follows:]

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Testimony of William I. McMillan, MBA CHE, Administrator/CEO Guam Memorial Hospital Authority

Guam Memorial Hospital is the sole civilian hospital serving the Territory of Guam, with 160,000 population. As such the people of Guam look to the Hospital to provide for their acute care needs. Unlike other communities, we have no choice in facilities, and unlike other facilities that can develop specialized service lines; Guam Memorial Hospital must cover all the bases as best we can.

The population on Guam, the 190,000 residents of Micronesia that also consider Guam a medical hub of sorts, have some health challenges that the Hospital tries to be sensitive to. Diabetes and End Stage Renal Disease, and Heart Disease are many times more prevalent in the region for reasons genetic and cultural, much the same as many Native American populations. Heart Disease and Cancer are the leading causes of death.

As the focus of this testimony is on the disparity between our local healthcare system and that of mainland communities let me just note the prevalence of our big three disease conditions; Diabetes, Heart Disease and Cancer and simply state that with Diabetes and Heart disease, Guamanians have a disproportionate share that only well planned and delivered preventative healthcare can address and improve. I want to focus my comments on disparity in the actual health care system, and in particular the hospital I manage.

As with most hospitals, uncompensated care is a major challenge. The Hospital's annual revenue is $100,000,000, but our cash budget is only $65,000,000. Nearly 40% of Guam Memorial Hospital's revenue is written off as uncompensated. One third of the island's population has no health insurance, or is covered under our local Medically Indigent Program. The Medically Indigent Program is locally funded by appropriation from Guam's General Fund and with only a $16,000,000 appropriation comes nowhere close to funding the cost of care for both hospital based care, and community based care. Like other Hospitals, we shift some of the cost of the uncompensated care to commercial payors, never a popular practice, and because of the size of the uncompensated care burden we are not able to completely shift the cost. Recent changes in the Compact of Free Association that our Congresswoman, Madeleine Bordallo worked on will help, and as part of our uncompensated care is generated by citizens from the Freely Associated States; Thirty percent (30%) of our births are derived from Chuuk citizens who come to Guam for care.

Guam Memorial Hospital participates in the Medicare program, and it is in Medicare reimbursement that a very specific, and remediable disparity occurs. While we participate in the Medicare program, we are not part of the prospective payment system, nor do we want to be part of the Prospective Payment System. We are cost reimbursed. However there is a TEFRA (Tax Equity and Fiscal Responsibility Act) cap on our reimbursement that causes us to lose between $1,500,000 to $2,000,000 per year in Medicare allowable costs that exceed the TEFRA limit. A practical solution would be to re-base our TEFRA cap. This is provided for in 42 CFR 413.4. A more preferable alternative would be to amend PL 97-248 to remove the TEFRA limit for Guam Memorial Hospital. An even better solution would be to declare Guam Memorial Hospital a Critical Access Facility and allow us the one hundred and one percent (101%) cost reimbursement given to Critical Access Facilities. The thinking behind the Critical Access Facility reimbursement understands that in many remote communities the economic conditions to support a hospital do not exist. CAF designation is targeted at very small hospitals in rural areas. While Guam Memorial Hospital is certainly larger than contemplated for CAF (we have 208 beds), and Guam's population density may suggest that parts of the island are urban, I can truthfully say that the hospital's we use for tertiary care are seven hours flight time away in Honolulu, and even longer for the cardiac referral centers in Los Angeles.

Our financial challenge creates disparity in other areas as well. In January we had to call on the cavalry from the Department of Health and Human Services to help with our Neonatal intensive Care Unit. At the time our unit had a capacity of four neonates, and in the middle of January the census climbed from two, to four, to six, passing though nine and ultimately hit twelve premature infants. Without the staff and equipment provided we literally had nowhere to turn to, and I'd like to extend our thanks to the Department, to Secretary Thompson and his staff, and RADM Ronald Banks. The challenge is this; NICU beds to live birth ratios for the United States are four per 1000 live births. GMHA had one per 1000 births. We now have four per 1000 live births. The acute care bed capacity is similarly strained. GMHA provides 1.1 beds per 1000 population, our peer group; Census District 9 averages 2 beds per 1000 population. Hospital spending in these states averages about $1,100 per capita according to the American Hospital Association. GMHA's spending is $406.

These figures describe our challenge. The island's only radiation oncology service went closed permanently due to damage in the last typhoon, we must send patients to Hawaii or beyond for radiation treatment. While we do have a cardiac catheterization lab in the hospital, its use is limited because there is no cardiac surgeon available and surgery is certainly more than one hour away. We have adequate dialysis services on the island, but a high rate of amputation for want of a wound care program. Island health insurance companies estimate they spend thirty percent (30%) of their premium revenue on off-island referrals. With approximately 100,000 individuals covered by commercial health insurance the exodus of cash exceeds $30,000,000 annually, more than enough for GMH to build an excellent oncology program, secure the services of a cardiac surgeon, implement a wound program, and pay the debt service for the financing needed to increase our bed capacity.

Because of our uncompensated care burden GMHA does not currently generate any retained income to fund capital purchases.

My colleagues from the Commonwealth of the Northern Marianas, and the Republic of Belau and I have spoken of the need for a regional resource for healthcare, for the same flight of cash and patients to tertiary centers in the Philippines, and Hawaii impacts the other Micronesian states, possibly even more than Guam. Were we able to make this a reality quality care, to the same standard as our mainland facilities could be delivered in situ. Our region could take care of its own, save for the most complex cases.

To this end we are searching for a medical school partner or partners to establish residency rotations on Guam for physicians in training in family practice. We are seeking partnerships to establish a fellowship in cardiac surgery. We have a strategic plan that has identified 107 federal funding sources, both grants and loan guarantees, predominantly from Health and Human Services and the Department of Agriculture to assist us in this ambitious, but needed effort. We are building the hospital's managerial infrastructure; for the first time in a decade, every member of the Hospital's senor management are fully qualified in their field, all with graduate educations. We are intensively recruiting nurse and allied health care practitioners for as much of a challenge there is to maintain the facilities for care, there is a challenge in finding qualified staff. The University of Guam offers a four year degree in Nursing, but graduates too few nurses to meet the Hospitals attrition rate. There is no other formal training for X-ray technologists, physical therapists, pharmacists and so on.

We rely heavily on foreign trained professionals, and the annual cap on the H1 visa program restricts us significantly. Were we able to make changes in the H1C visa program specifically for Guam we would be able to secure more of the needed professionals.

In closing I wish to thank the Honorable Dan Burton from Indiana's 5th District, and the members of the House Committee on Government Reform for this opportunity to address you, and I'd like to briefly repeat the key actionable recommendations I presented.

GMHA's Medicare reimbursement needs to be addressed. The most favorable remedy would be to recognize, and reimburse the hospital as a Critical Access Facility. At the very lease the TEFRA imposed cap on reimbursement needs to be rebased, or eliminated.

GMHA would benefit significantly if we were able to recruit foreign health care professionals under the H1B or H1C visa program. A separate quota for Guam under H1B and an exemption for the bed size and Medicare/Medicaid payor mix requirements under the H1C program is needed.

Finally, increased spending is needed to bring the Hospital's bed capacity and programmatic scope in line with the island's and regional needs. We have identified a number of funding sources within HHS, DOA and other agencies. Most of these are

competitive grants; some would rely on a specific appropriation. The current level of Hospital spending, at $406 per capita on Guam is inadequate to address the acute care of the island and the region.

Thank you all/

Mr. BURTON. Dr. Hofschneider, I cut you off. I apologize. Did you have more you wanted to say, sir?

Dr. HOFSCHNEIDER. Thank you, Mr. Chairman.

I just wanted to sort of reiterate that we have submitted testimony, written testimony to your subcommittee outlining the needs, the requests that we have in three specific areas. One is the funding for us to enhance our prevention and treatment of diabetes. As you know, as Governor Babauta noted earlier, our prevalence of kidney failure is five times compared to the national prevalence. We are the third in terms of, worldwide, for prevalence of Type 2 diabetes. Only the Pima Native Americans and Narauns have the higher prevalence that the indigenous people of the CNMI.

So we will be asking for funding for prevention, as well as for treatment, including the treatment of the kidney complications. In addition, because of our aging infrastructure we need to upgrade our water system. Our water system, the water that is fed into the hospital is not suitable for medical uses, and it has to be treated. The system is now almost 20 years old and needs to be upgraded. The demands have increased.

In addition, we have a problem with our air conditioning and ventilation system. And in this age of SARS and anthrax, we need to upgrade that.

Last, a big burden and really, this has been mentioned several times, is the Medicaid cap. Currently we spend $13.5 million, that's the total obligation of the local government, the Federal Government gives us $2.5 million, which is 90 percent, this is Medicaid and SCHIP. And I think this burden is preventing access to proper care. We give the care anyway, we don't deny any services to the poor. But we really need some relief, especially at this time when we have a downturn in our economy.

In my recent statement, I also noted that we have a 21 percent increase in our Medicaid population since last year. This issue of inadequate funding is very important. We have been in a situation where we have to practically beg Hawaii hospitals or California hospitals to take our sick child or a person with multiple medical problems, take them so they can get adequate medical care. So really, we can never bring Hawaii closer to us. What was expressed earlier by our Governor and the Governor of Guam is the idea of having some regionalization as part of the long term strategy.

So we ask for your support for this request, and thank you very much again.

Mr. BURTON. Well, like I said, if we have that in writing, and I think the Governor mentioned part of that, we'll certainly—that regionalism you're talking about I think makes a lot of sense. It might help us when we're trying to get resources if we say that they're cooperating in a way to, because you know, for instance, Guam and Saipan are not that far apart. If there was some way you could eliminate some duplication and use funds for other areas, it would be helpful when we're talking to HHS about more money.

Dr. Kuartei, did you have a comment you'd like to make, sir?

Dr. KUARTEI. Thank you very much, Mr. Chairman, for the opportunity to be here. Dr. Benjamin actually spoke on behalf of the PIHOA. I can only say that as a Pacific Islander, sitting over here

today, it's probably a benchmark for a moment that's probably positive. Thank you very much.

Mr. BURTON. Well, we really appreciate your being here and the Governors being here. We will not drop the ball on this. I can't guarantee how much money we're going to be able to shake loose and how much of the problem will be solved, but I promise you that I as the chairman of this subcommittee will push very hard, and I'll try to get other Members besides those who are here today to likewise push hard to get some of these things done.

With that, thank you very much for being here. It's been nice being with all of you.

We stand adjourned.

[Whereupon, at 4:42 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The prepared statement of Hon. Elijah E. Cummings and additional information submitted for the hearing record follow:]

Statement of Congressman Elijah E. Cummings
House Government Reform
Subcommittee on Human Rights and Wellness Hearing
On
"Investigations Into Health Care Disparities in the United States Pacific Island Territories"
February 25, 2004 at 2:00 p.m.

Thank you, Mr. Chairman for holding this hearing to consider the health care system of the United States Pacific Island Territories of Guam, the American Samoa, and the Commonwealth of the Northern Mariana Islands.

It has come to the attention of the committee that in the United States Pacific Island Territories, United States citizens and nationals receive inadequate medical attention, often due to lack of resources such as equipment and trained staff, creating disparate medical treatment. With the increasing incidences of diabetes cases in these territories, the low hospital and physician ratio to patients (1 hospital in Guam serves the 155,000 citizens of the region and there is 1 doctor to every 1,033 patients), and the increasing debt the hospitals are accruing, it is urgent that we identify ways to rectify these healthcare disparities.

Having received less federal funding than the continental United States, in addition to suffering through a down-turned economy due to the decreased tourism since 9/11, these territories need our immediate attention. In fact, the territories receive less than 50% of Medicaid funding versus the 77% the 50 U.S. continental states receive. Similarly, the only civilian hospital in Guam, Guam Memorial Hospital Authority, recently declared bankruptcy and is now 20 million dollars in debt. Unemployment rates are soaring and, needless to say, the territories' need for federal aid is increasing.

Mr. Chairman, I would like to point out that healthcare disparity is not just an issue affecting our Pacific Island Territories. Even here in the continental United States, minorities are subject to unequal treatment in accessing healthcare. In November, I introduced the Healthcare Equality and Accountability Act, H.R. 3459, which was supported by the Congressional Black Caucus, the Congressional Asian Pacific American Caucus, the Hispanic Caucus, and the Native American Caucus. This bill not only aims to improve minority health and healthcare, but it also seeks to eliminate racial and ethnic disparities in health and healthcare. Affordable and accessible health care is a top priority for Congress. We must not hesitate to

address the needs of those who fall outside of the safety net. All United States citizens deserve equitable healthcare.

Lastly, it is imperative that we find a way to eliminate healthcare disparities in minority communities, such as those that exist in the U.S. Pacific Island Territories. Eliminating these injustices will lead to a broader discussion of eliminating healthcare injustices everywhere. Every American should enjoy affordable, quality healthcare.

I know the witnesses we have here today will help us to better understand the healthcare needs of the United States Pacific Island Territories. Congress must insure that measures are taken to correct the health disparities in the United States Pacific Island Territories.

Once again, thank you Mr. Chairman for holding today's hearing. I look forward to hearing from today's witnesses.

STATEMENT OF

THE HONORABLE DONNA M. CHRISTENSEN

GOVERNMENT REFROM COMMITTEE

SUBCOMMITTE ON HEALTH AND WELLNESS

FEBRUARY 25, 2004

Thank you Mr. Chairman, Ranking member and other members of the committee, I appreciate the opportunity to testify on this important panel.

My written testimony which contains the details of the specific funding and language requests. Although I will be speaking specifically to issues in the Asian American and Pacific Islander communities, my remarks are generally applicable to all communities of color and many rural communities as well.

Today almost 45 million Americans are uninsured, of which 50% are minorities.

- 18% of the total elderly population has no coverage at all;
- 1 out of 6 Americans do not have health insurance; and
- more than 100,000 people lose their health insurance every day.

Our health care system in this country is currently in peril. It is falling short on promise and contributing to the disabling illness and premature death of the people it is supposed to serve. The picture is the worst for Asian Americans and Pacific Islanders (AAPIs)who for almost every illness are impacted most severely and disproportionately -- in some cases more than all other minorities combined. Today we know that much of it happens because even when AAPIs have access to care, the medical evaluations and treatments that are made available to everyone else are denied to them -- not only in the private sector but in the public system as well.

What I am here to try to do today is to leave you with one indelible message: that there are gross inequities in healthcare which cause hundreds of preventable deaths in the AAPI community everyday and which tear at families, drain the lifeblood of our communities, and breed an escalating and reverberating cycle of despair which this subcommittee has the power to end this today if it has the will to do so.

As you know, inequalities in income and education underlie many health disparities in the US. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of death and illness, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford

better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors.

The choice if it can be considered that, is either to write off human beings -- our brothers and sisters -- who make up this segment of our population, or to make the requisite investment in fixing an inadequate, discriminating, dysfunctional health care system.

The current strongly held-to "cost-containment" paradigm while it sounds good on the surface, has obviously not worked. We now have double digit increases in premiums in an industry that was to rein in its costs. What it did instead was create a multi – tiered system of care, both within managed care and without. Those at the lowest rungs of the system got sicker, the sicker, ie. more costly, were and still are being dropped, and those who were the sickest were and remain locked out entirely. So not only are health care costs continuing to escalate, the overall health picture in this country is worse than ever.

What we now have is a system, which continues the failed paradigm in which AAPI and other people of color who because they have long been denied access to quality health care, now experience the very worse health status. Not doing what is needed to change this is to threaten the health of not just AAPIs and other people of color but every other person in this country, especially at a time when we live under the cloud of possible bioterrorism.

Controlling the cost of health care, which can only be done in the long term, will never be achieved without a major investment in prevention, and leveling the health care playing field for all Americans through fully funding a health care system that provides equal access to quality, comprehensive health care to everyone legally in this country, regardless of color, ethnicity or language.

As you may know, the available demographic and health data on AAPIs)are usually of limited value because of the attempt to encompass the broad AAPI group, in spite of the enormous diversity among the peoples included. Without disaggregating the data, it is impossible to detect the great variations in income, education, and health status among AAPI populations, hiding serious socioeconomic and health problems both within and between subgroups.

Health indicators for AAPIs overall suggest that this population is one of the healthiest in the US. However, there is great diversity within this group, and marked health disparities exist for specific segments. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis are also higher in AAPIs living in the US than in whites.

In 1985, the Heckler Report considered Asian Americans to be in good health because it failed to include a sufficiently large sample for a meaningful analysis and did not include health conditions (e.g., tuberculosis, hepatitis B) prevalent among Asian-American populations. The limited studies about Asian-American health are often published in non-

peer-reviewed journals because mainstream journals consider them to be of "limited scope and relevance."

As in both white and black populations, the three leading causes of death in AAPIs are coronary artery disease, cancer, and cerebrovascular disease. Other health concerns for AAPI populations are prenatal care and mental health. AAPI girls have the highest suicide rate for females between the ages of 15 and 24, and 30% of Asian-American girls in grades 5 through 12 reported symptoms of depression.

There is a high incidence of TB among AAPI populations is 41.6 per 100,000, compared with 2.8 for white non-Hispanics and 22.4 for black non-Hispanics. Approximately 1.25 million people in the US are chronically infected with the hepatitis B virus (HBV). Annually, 5,000 deaths are caused by HBV-induced liver failure. Although they make up only 4.4% of the US population, AAPIs account for approximately 50% of HBV infections and 50% of deaths caused by HBV-induced liver failure.

Healthcare coverage in an older study, stated that 27% of Asians were uninsured, compared with 12% of whites, 19% of blacks, and 27% of Hispanics. The percentage of AAPIs who were uninsured had declined to 19% in 1999-2001 (three-year average), however this maybe relate to data discrepancies. But even with health insurance, culturally accepted medical treatments such as acupuncture and herbal medicines often are not covered, which may limit access to health care by Asian Americans.

An important element contributing to the lack of health care coverage is the fear of deportation and concerns about jeopardizing their chances of obtaining citizenship or permanent residency can discourage AAPIs from seeking health care. Many recent immigrants and refugees are confused about their eligibility for services and reluctant to visit Western physicians.

Studies have also shown that AAPI Immigrants who are unfamiliar with Western health care systems tend to underutilize health care services, avoid public healthcare coverage programs, delay seeking health care, and not adhere to treatment recommendations.

A definitive example of the access to care problem is the complicated telephone systems that are unresponsive to non-English-speaking clients can be problematic for Asian-American immigrants and refugees. Longer waits for services occur when interpreters cannot be found, and child family members are sometimes called on to interpret.

As you may know, the percentage of persons 5 years or older who do not speak English varies by Asian-American group: 61% of Vietnamese, 51% of Chinese, 24% of Filipinos, and 24% of Asian Indians are not fluent in English. A very large proportion of Asian Americans over 65 years of age cannot speak English well. The absence or limited supply of interpreters and bilingual providers impedes access and communication. Even when interpreters are available, the multiple languages and dialects among different Asian ethnic groups make communication difficult.

A nuance to the AAPI community is the incidence of intestinal parasitic infestation among AAPIs entering the US has been shown to be as high as 80%, and multiple parasitic infestations have been found in as many as 55% of the Southeast Asian refugees screened. Hookworm is by far the most common (38%), followed by *Giardia* (9%), *Ascaris* (7%), and *Strongyloides* (6%).The prevalence of parasitic infestation varies significantly among different ethnic groups. Hmong are the most frequently infected (75%), followed by Cambodians (74%) and Vietnamese (47%).The distribution of parasite types also varies among ethnicities: *Ascaris* and *Trichuris* are more common in Vietnamese; *Clonorchis* species are more prevalent in Laotians; and Cambodians show more multiple infestations by *Strongyloides*, hookworm, and *Giardia*.

Youngsters less than 4 years old are least infested, and school-aged children are most heavily infested, by *Trichuris*, *Giardia*, and *Strongyloides*. Adults have a majority of the hookworm and *Clonorchis* infestations. Although malaria is not a significant problem in the US, it may occur among refugees and travelers from endemic regions or military personnel stationed there. Thus, more than 99% of cases are imported; 55% occur in Southeast Asian refugees, more occur in males than in females, and the highest incidence is in the 10 to 29 age group. Vivax malaria is the predominant form (82%) among refugees in the US.

Studies have documented that smoking among AAPIs age 18 and older, 24% of men and 7% of women smoke. (Tucker and Tervalon, 2003). Some social structures may encourage negative health behaviors. For example, smoking rates exceed 50% among immigrant male restaurant workers. Female AAPI nonsmokers are exposed to more secondhand cigarette smoke than are male AAPI nonsmokers. It is believed that the women's exposure to secondhand smoke is due to male smokers in the household.

In, recognizing all of the health problems experienced by AAPIs, I am proud to say the Democratic party lead by the Congressional Minority Caucuses (Congressional Black, Hispanic, Asian Pacific Islanders and Native American Caucus) introduced legislation HR 3459 that seeks to improve AAPIs' health status and healthcare systems.

HR 3459, the Healthcare Equality and Accountability Act expanding health coverage. The bill would give states the option to expand eligibility and streamline enrollment in Medicaid and the State Children's Health Insurance Program. Specifically, the bill would give States the option to cover uninsured parents who have children eligible for Medicaid and CHIP; pregnant women; children through age 20; residents at or below the federal poverty line; and legal immigrants.

The bill expands and guarantees language access by requiring each federal agency that carries out healthcare-related activities shall prepare a plan and receive reimbursement to improve access to the federally conducted healthcare-related programs and activities of the agency by limited English proficient individuals.

We also establish a number of health profession programs to to attrack AAPIs. An example of such programs is the Patsy Mink Health and Gender Research Fellowship Program which directs the Director of CDC, in collaboration with the Director of the Office of Minority Health, the Administrator of the Substance Abuse and Mental Health Services Administration, and the Director of the Indian Health Services, to award research fellowships to post-baccalaureate students to conduct research that will examine gender and health disparities and to pursue a career in the health professions.

The bill provides grants to states, territories or local or tribal units, to promote positive health behaviors for women in target populations, especially racial and ethnic minority women in medically underserved communities. Grants may be used to support community health workers by providing education, guidance, and outreach services to racial and ethnic minority women. In awarding grants, the Secretary must give priority to those applicants who propose to target geographic areas: with a high percentage of residents who are eligible for health insurance but are uninsured or underinsured; with a high percentage of families for whom English is not their primary language.

It directs the Administrator of HRSA and the Director of the Office of Minority Health, and in cooperation with the Director of the Office of Community Services and the Director of the National Center for Minority Health and Health Disparities, must make grants to partnerships of private and public entities to establish health empowerment zone programs in communities that disproportionately experience disparities in health status and healthcare.

Finally the bill includes the following Data and Healthcare Infrastructure provisions:

Data

- Each health-related program operated by or that receives funding or reimbursement from DHHS shall: (1) require the collection of data on the race, ethnicity, and primary language of each applicant for and recipient of health-related assistance under such program; (2) systematically analyze the data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and healthcare and when appropriate, for men and women separately, and report the results of such analysis to the Secretary, the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives; (3) provide the data to the Secretary on at least an annual basis; and (4) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

- The Secretary, in collaboration with the Administrator of HRSA, the Director of AHRQ, and the Administrator of CMS, must award grants to eligible entities for the conduct of demonstration projects to improve the quality of and access to

healthcare. An entity must use amounts received under a grant to support the implementation and evaluation of healthcare quality improvement activities or minority health and healthcare disparity reduction activities. The Secretary must provide financial and other technical assistance to grantees for the development of common data systems.

Healthcare infrastructure

- The Secretary, acting through the Administrator of HRSA, must designate centers of excellence at public hospitals, and other health systems serving large numbers of minority patients, that demonstrate excellence in providing care to minority populations and in reducing disparities in health and healthcare.

- The Secretary must provide direct financial assistance to designated healthcare providers and community health centers in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii for the purposes of reconstructing and improving healthcare facilities and services. Not later than 180 days after the date of enactment of this title and annually thereafter, the Secretary must submit to the Congress and the President a report that includes an assessment of health resources and facilities serving populations in American Samoa, Guam, and the Commonwealth of the Northern Mariana Islands, the United States Virgin Islands, Puerto Rico, and Hawaii.

- The Secretary shall establish a Trust Fund must be allocated $150 million annually for the loan guarantee program in order to create a cumulative reserve in support of loan guarantees. At least 20% of the dollar value of loan guarantees made under this program during any given year must be allocated for eligible rural healthcare facilities, to the extent a sufficient number of applications are made by such healthcare facilities. At least $200 million of the annual dollar value of loan guarantees made under the program must be reserved for loans of under $50 million, if there are a sufficient number of applicants for loans of that size. Not more than 20% of the amount allocated each year to the loan guarantee program established may be allocated to guarantee refinancing loans during the year.

Therefore, given what this bill does for the AAPI community and acknowledging the comments made by others today; passing HR 3459 is the needed step forward to ally AAPIs health problems. So I call on this esteemed and distinguished subcommittee to make a commitment to eliminate the disparities that have existed for centuries and are increasing today for AAPIs, and to finally ensure equality in health care for us and every one in this otherwise great country.

The cost in dollars today will be significant, but the cost in lives and to our economy in the future are risks that we must not take.

There is no question that health disparities are deeply rooted in our medical system and in our culture. Eliminating them is going to take a lot more than one leadership summit or one media campaign. It will take a long-term commitment. It will take a long-term investment.

This subcommittee and the larger committee have the power to eliminate disparities in health care. This is an important part of the stewardship on which we will all be judged.

Dr. Martin Luther King, Jr. once said, "Of all the forms of inequality, injustice in health care is the most shocking and inhumane." We have a moral obligation to end injustice in health care and health disparities among Americans. I urge my colleagues to support this request.

On behalf of the Congressional Black Caucus, and personally, I thank you once again for the opportunity to testify.

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