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H.R. 3014, HEALTH EQUITY AND ACCOUNTABILITY ACT OF 2007

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

TUESDAY, JUNE 24, 2008

Serial No. 110–132

Printed for the use of the Committee on Energy and Commerce

energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE

57–416 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
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H.R. 3014, HEALTH EQUITY AND ACCOUNTABILITY ACT OF 2007

TUESDAY, JUNE 24, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:08 a.m., in room 2322 of the Rayburn House Office Building, Hon. Frank Pallone, Jr. (chairman) presiding.

Members present: Representatives Pallone, Towns, Green, Capps, Baldwin, Schakowsky, Solis, Dingell (ex officio), Deal, Blackburn, and Barton (ex officio).

Staff present: Melissa Sidman, Virgil Miller, Brandon Clark, Brin Frazier, Lauren Bloomberg, Chad Grant, Ryan Long, and Jeanne Ireland.

OPENING STATEMENT OF HON. LOIS CAPPS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Ms. CAPPS [presiding]. This hearing will come to order.

This is the Health Subcommittee hearing on House Resolution 3014, the Health Equity and Accountability Act. My name is Lois Capps. I am Vice Chair of the Health Subcommittee, acting in the absence of Mr. Pallone, who is on the floor discussing Medicare, and I am very honored indeed to welcome our honorable first panel of witnesses, two colleagues in Congress, who will be giving their testimony shortly: the Honorable Mr. Clyburn and the Honorable Mr. Moran.

I want to acknowledge, we also have been joined by the Delegate from the Virgin Islands, Donna Christensen, who is Chair of the Health Task Force for the Congressional Black Caucus.

So, without further ado, welcome everyone. As I mentioned, today's hearing is on Health Equity and Accountability Act introduced by my good friend Hilda Solis. H.R. 3014 has tremendous support from the Tri-caucus, as well as several members of this committee, including myself. The legislation seeks to address the glaring health disparities that exist in our Nation among different racial and ethnic communities and also amongst different geographical groups. I think that we need this bill more than ever. I am constantly dismayed, actually horrified to learn how far the United States lags behind other industrialized countries in terms of maternal and infant mortality rates, as well as other quality of life measures. And upon investigating these statistics, we learn

that they are often caused by the disparities that exist here, right here in our own country.

Why is it that the maternal mortality rate among black women in America is four times that of non-Hispanic white women? Why is it that Hispanics are nearly twice as likely to die from diabetes as non-Hispanic white people? The Institute of Medicine found that these disparities persist even when controlled for socioeconomic factors, and H.R. 3014 does an excellent job of addressing the reasons why these disparities persist and how we should go about fixing them.

For too many, the lack of access to healthcare, specifically culturally competent healthcare, is what is driving these disparities. So H.R. 3014 addresses them by doing at least three things, which I will mention: improving access to healthcare services; second, improving health work force disparities, diversity, that is to have the culturally and significant competencies among staff who are caring for those with different cultural backgrounds; and third, bolstering efforts to ensure culturally and linguistically appropriate healthcare.

Furthermore, H.R. 3014 addresses gaps in our understanding of disparities by strengthening and coordinating data collection. It is, frankly, embarrassing that the United States, with all of our cutting edge science and bio-medical research cannot extend access to quality healthcare services to all of its citizens. Passing the Health Equity and Accountability Act and implementing the provisions within the bill would bring us much closer to where this country needs to be in healthcare services.

As we proceed with this hearing, I would like to briefly note that the Committee is aware of confusion over a drafting error in the language regarding services for immigrants. Chairmen Pallone and Dingell are well aware of this and are prepared to address it as the bill moves forward. And in the meantime, though, I will encourage all of our members and witnesses to stay on message with the underlying bill, which seeks to reduce health disparities like maternal mortality and access to cancer screenings.

Ms. CAPPS. With that, I conclude my opening statement and yield to Mr. Deal, the ranking chair.

Mr. DEAL. Thank you, Madam Chairman. In the essence of time, since we have three panels and the first is our distinguished colleagues, I will submit my statement for the record and look forward to the testimony of the three panels. I yield back.

[Mr. Deal did not submit a prepared statement for the record.]

Ms. CAPPS. And now I will turn to the author of the bill, Ms. Solis, from California.

OPENING STATEMENT OF HON. HILDA L. SOLIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. SOLIS. Thank you, Madam Chair. And I want to personally thank Chairman Pallone for calling this historic hearing today. It has been more than 8 years since we have had a discussion on healthcare disparities in this committee, so I think that this is a wonderful opportunity for us to hear from our witnesses and to

hear firsthand what the challenges and solutions are that are being offered in H.R. 3014.

I want to note that the legislation that was crafted was the work of the Black Caucus, the Hispanic Caucus and the Asian-American Caucus, as well as many other members of the healthcare community. I think that this is one of our best efforts to try to collaborate on bringing together our best ideas and best practices across the country. Well over 100 Members of Congress are on record in support of this piece of legislation, and I am very pleased to have the Honorable Mr. Clyburn here this morning. He will speak on this very important bill, and I want to thank him personally for his leadership in helping us to bridge the gap in healthcare disparities among communities of color. I also want to note that I am very proud to have, as our panelists, a representative from the National Council of La Raza and also the APIA Health Forum. They will shed light on some of the disparities that exist in communities of color.

As you know, I represent a district in East Los Angeles in Southern California, where we see these kinds of issues continuing to grow. And as our economy is not on an upswing, we see that there are more and more of our youngsters that don't have good healthcare and good healthcare outcomes. Many of them are also affected by the fact that they have language barriers. Many communities do not have a command of the English language, so providing multi-cultural services to all these under-represented communities is of utmost importance.

I would like to say also that about a third of the population in my district is under the age of 6 and has no form of healthcare insurance. Clearly this is a crisis that we face in our communities. Language barriers, cultural barriers, and geographic barriers in rural America impact underserved communities. Poor whites, Latinos, and other minorities are disproportionately impacted by asthma, diabetes, HIV, and AIDS. In addition, 25 percent of Latino children are obese, compared to 16 percent of African American children and 14 percent of white children.

Legal barriers also present a great challenge to our community, especially when we are talking about legal, permanent resident children. Over the past decade, legal immigrant non-citizens have faced increasing restrictions on care to federally funded healthcare programs, such as the 5 year waiting period for programs as Medicaid and SCHIP. H.R. 3014 is necessary to reduce the health inequities that Latinos and other communities of color and poor whites face.

Even though minority healthcare providers work in underserved communities, only 4 percent of doctors, 6 percent of dentists, 4 percent of registered nurses in California are Latino. Clearly, access is a great systemic problem that we are seeing with the lack of this representation.

This legislation will increase access to services for the 15 million uninsured people of color, increase the representation of healthcare professionals in the various underserved communities, and will provide States with the option to cover legal, permanent resident women and their children. It also strengthens our educational institutions like historically black colleges and Hispanic-serving insti-

tutions to help provide incentives for more of those individuals seeking careers in the healthcare arena.

This legislation strengthens and coordinates data collection. How are we able to define the problem if we can't collect the data? By investing in prevention efforts and in our healthcare system, I believe that H.R. 3014 will reduce costly emergency room visits and expensive medical errors. Therefore, I look forward, today, to hearing the testimony from our witnesses and thank the members for being here. I would also like to thank our first panelists, and those that have been working behind the scenes for many, many years on this particular bill. Thank you, Madam Chair.

Ms. CAPPS. Thank you. I now recognize Representative Blackburn for 3 minutes for an opening statement.

OPENING STATEMENT OF HON. MARSHA BLACKBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TENNESSEE

Ms. BLACKBURN. Thank you, Madam Chairman. I do want to welcome all of our witnesses that are with us today and I think that we all agree that preserving and improving access to quality healthcare is a critical issue and one that does need our attention. However, this hearing coincides with a critical issue being addressed on the House floor today, and that is the Medicare physician payment cuts. While I appreciate the focus of the hearing, I believe this committee could have used this time more constructively to address critical and time sensitive issues such as reform of the Medicare Physician Payment Formula. Instead, the other side of the aisle dropped a 277-page bill on Friday, 3 days ago, when there have been no hearings or mark-ups in this Committee to address Medicare physician payment.

In fact, this subcommittee, this very subcommittee, has not held a single Medicare related hearing all year long. I have met with doctors from all over Tennessee regarding their concerns about the impending 10 percent payment cut for physicians under Medicare. This is scheduled to go into effect July 1, 2008. That is 1 week away and this committee has not taken one little teeny dab of action to address this and I, Madam Chairman, think that that is a representation of misplaced priorities on our issues that are before us.

I have repeatedly supported congressional efforts to provide physicians with Medicare payment relief through Medicare reform. As healthcare providers in my district have stated time and time again, many Tennessee physicians have already stopped taking Medicare patients. With this cut, a critical number of doctors will cease to serve Medicare beneficiaries completely if a solution is not implemented to fix the physician payment reduction. It is imperative that this committee and Congress act on this crucial issue now. The alternative could be disastrous for this Nation's seniors. They deserve better attention from this very committee. I want to thank the Chairman and I yield the balance of my time.

Ms. CAPPS. I now recognize Congressman Green from Texas for 3 minutes for an opening statement.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Ms. Chairman. And following my colleague from Tennessee, our committee worked last year and passed the CHAMP bill that corrected the Medicare disparity issue. And coming from an underserved district and the reason we are here today is the Health Equity and Accountability Act. If my doctors didn't take Medicare, they wouldn't be in my district because typically 40 percent of their medical care is—50 percent is Medicare/Medicaid and that is what this bill today, that my colleague Ms. Solis has worked on.

I thank the Chair for holding the hearing on the Health Equity and Accountability Act. Houston has the third largest Hispanic population in the country and I represent a district that I grew up in. It is over 65 percent Hispanic. And I know firsthand the disparity issue. However, that distinction is accompanied by a higher rate of diseases like diabetes, cervical cancer, HIV/AIDS, and the heart disease in our community. In fact, Mexican-Americans are twice as likely as Anglos to be diagnosed with diabetes. Hispanic males have three times the rate of HIV/AIDS, and Hispanic women have five times the HIV/AIDS rate as their Anglo counterparts.

According to National Center on Minority Health, Mexican-American mothers are far less likely to receive necessary prenatal care. To be exact, they are twice as likely to start prenatal care only in the third trimester or not receive the care at all. Despite the gloomy picture of Hispanic health these statistics paint, there is one common theme that these diseases are for the most part preventable. However, lack of access to care is still a barrier to minority communities and part of the cause of many health problems for the Hispanic community.

In 2006 nearly half of the 47 million uninsured in the United States were minorities. As we all know, at this committee, access to quality, primary, and preventative care leads to better quality of life and fewer health problems down the road. Yet, minorities still experience access-to-care issues, language barriers, disparities in the quality of care for them. That is why I am an original cosponsor of Representative Solis' bill and I am proud to be one. It is also shameful that the minority population still don't have access to proper healthcare they need and deserve and I want to thank our witnesses for appearing today, particularly our two colleagues on our first panel, and I yield back to my time.

Ms. CAPPS. Thank you, I now recognize the Ranking Minority member of the full committee for his opening statements, Mr. Barton from Texas.

Mr. BARTON. Thank you, Madam Chairwoman, I will submit my formal statement for the record. I want to commend our two lead witnesses, the two distinguished Congressmen, for being here. I cannot support the bill in its current form. I do think there are issues that need to be addressed and perhaps we can address them in this Congress, but for a number of reasons there seems to be duplicity of requirements in this bill. There is a huge issue in terms of how you pay for it. There are just numerous issues with the bill in its current form, but I do think it is an issue that needs to be addressed and I am glad we have the two Congressmen here to dis-

cuss it. And, if possible, I will be here to participate in the hearing. I think that you all know that there is a medical bill on the floor. We are about to take up a physician reimbursement issue and durable medical equipment and I will be on the floor on that issue, so I will be coming and going. But, again, I appreciate the hearing and hopefully we can work something out, but in its current form, H.R. 3014, I would not be able to support it. With that I yield back, Madam Chairwoman.

[Mr. Barton did not submit a prepared statement for the record.]

Ms. CAPPS. It is now an honor to recognize the Chairman of the Full Committee, Mr. Dingell of Michigan, for his opening statement.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. DINGELL. Madam Chairman, thank you and congratulations to you, Madam Chairman, on your position as Vice Chair. We look forward to great things from you. Madam Chairman, I want to thank you for holding this hearing on a critical health issue, health disparities, and more specifically, on H.R. 3014, the Health Equity and Accountability Act of 2007. Before I go into my statement, I want to welcome and recognize our good friend Mr. Clyburn from South Carolina, the distinguished Majority Whip. Mr. Clyburn, welcome. And I want to thank and welcome our friend and colleague Mr. Moran from Kansas. Welcome. Thank you for your presence and for your participation in our business today. Thank you.

Madam Chairman, the existence of racial and ethnic health disparities in every aspect of healthcare is well documented. According to the National Institutes of Health, African-Americans, Hispanics, Native Americans, Asian-Pacific Islanders, who represent some 25 percent of the U.S. population, continue to face dramatic differences in health outcomes compared with white Americans, including shorter life expectancy, higher rates of diabetes, cancer, health disease, and stroke. The statistics represent loved ones lost prematurely and unnecessary suffering and a real unfilled potential for these people and for this Nation. In a country as great as ours, the idea that ones ethnic or racial background factors into your chances of living a healthy and productive life is totally unacceptable.

It is important to note that one of the key tools in reducing health disparities is having health insurance. While having insurance doesn't eliminate disparities, studies show that the disparities are reduced significantly for those who have insurance. The CHAMP Act, which I introduced last year, would make significant headway in reducing the number of uninsured. The CHAMP Act includes provisions targeted specifically at reducing racial and ethnic disparities. Some of the provisions from the CHAMP Act are included in H.R. 3014. While disparities in health insurance coverage are a major contributor, there is no single factor responsible for health disparities that exist. The solution is going to have to be multifaceted.

The subject of today's hearings, H.R. 3014, provides a comprehensive solution that will take us a long way toward addressing

the problem of health disparities among our people. H.R. 3014 includes provisions to expand cultural and linguistically appropriate care, work force diversity, data collection, accountability, improvement of health services, and rural health.

I want to commend our good friends Representatives Solis and Towns for their leadership on this issue. I also want to thank and recognize members of the Tri-caucus for their efforts on this legislation and their persistence of bringing the issue of health disparities to the forefront. Madam Chairman, I look forward to the comments of my colleagues and the testimony of our witnesses today about addressing this serious problem. Again, I welcome our good friend, Mr. Clyburn and Mr. Moran for their presence here and for their leadership and help to the Committee. I look forward to their testimony and thank them for their leadership on this issue, and so many others. Thank you Ms. Chairman.

Ms. CAPPS. I, now, recognize our colleague, Ms. Baldwin from Wisconsin, for 3 minutes for an opening statement.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Madam Chair. I am proud to be a cosponsor of the legislation before us, H.R. 3014, and I am really delighted that our committee is holding hearings on this legislation. I want to thank my colleague and friend Congresswoman Solis for her tremendous leadership on this issue, and many thanks to you also Majority Whip Clyburn and Congressman Moran for being with us today. I look forward to hearing your testimony, along with the testimony of all our other expert witnesses.

Evidence clearly indicates a persistent disparity in health status of racially and culturally diverse populations as compared with the overall health status of the country. We know that over the next decade, our demographic composition of the United States will become more racially and ethnically diverse and will only increase the need for effective prevention programs tailored to specific community needs. The fact that racial and ethnic minorities continue to receive a lower quality of healthcare than non-minorities is unacceptable and, frankly, un-American. And I believe that all Americans deserve access to affordable, comprehensive healthcare.

I do want to make a record of my interest, also, in having this committee and this Congress address the healthcare disparities faced by another community, the LGBT, lesbian gay bi-sexual and trans-gender community, as we move forward with legislation addressing healthcare disparities. For example, although much has been done to educate the public on how HIV and AIDS continues to devastate LGBT populations, many Americans, perhaps some in this room, do not know that gay men and lesbians are at heightened risk for certain cancers. Many do not know that LGBT youth are two to three more times likely than heterosexual youth to attempt suicide, or that LGBT populations have a combined smoking rate almost double that of the general population. In fact, also, few healthcare providers are trained in how best to serve LGBT patients with culturally competent care. And we know that the community suffers from an alarming lack of data. For example, no na-

tional cancer registries collect data based on sexual orientation or gender identity. Just this basic inclusion in registries and large national surveys could answer many simple questions and even point towards new research opportunities.

Now, back to the legislation before us, I wholeheartedly support our committee's effort to quickly and effectively address cultural and linguistically appropriate care, workforce diversity, data collection, increased accountability, and overall improvement of health services for underserved minority population and it is my hope in doing so that we also keep in mind significant barriers to good healthcare faced by those who are in the LGBT community. Again, thank you for holding this hearing and to our panel of witnesses for their time.

Ms. CAPPS. Thank you, I now recognize our colleague from Illinois, Representative Schakowsky, for 3 minutes for an opening statement.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Madam Chairman, I will keep my comments short, but I do want to commend Congresswoman Hilda Solis, the sponsor of H.R. 3014, which you are considering today and a bill which I am proud to be a co-sponsor of. As the Chair of the Hispanic caucuses' task force on health and a member of the Asian Pacific American caucus, Congresswoman Solis has long fought for eliminating the racial and ethnic health disparities that persist across this country. I want to associate myself, also, with Congresswoman Baldwin's remarks about a long overlooked constituency, as well.

I commend that hard work and as a co-sponsor I am very pleased to be discussing this absolutely critical bill in our subcommittee today. In general, our country has seen some significant improvements in health and well being over the past several decades, but certainly this progress has not touched every population. The differences in health outcomes across racial and ethnic populations such as life expectancy, rate of diabetes, cancer, heart disease, and stroke that exist within each and every one of our districts must not be tolerated any longer. While it is my sincerest wish that the near future hold a system of healthcare for all in this country, we must take on the fight of eliminating health disparities today. Otherwise, we run the risk of permitting these gross inequities to continue into that system and surely allow this unequal system to rob the futures of more and more Americans.

This bill will make strides toward a more equitable system for all by improving data collection, accountability and access to care and working to increase workforce diversity and culturally and linguistically appropriate care. I am proud that in Chicago, Asian Human Services has created a community health center focused on providing culturally sensitive care to the Asian American community. More proactive steps like that are needed and this bill will help us to do that. I am so anxious to hear from our witnesses today and I thank Congresswoman Solis again for her tireless leadership on these issues and I yield back.

Ms. CAPPS. Thank you. I, now, recognize the co-author of the bill under consideration today, Mr. Towns from New York, for 3 minutes for his opening statement.

Mr. TOWNS. Madam Chair, I would like to waive my opening statement. I hear the bells are sounding and of course I would like to.

[The prepared statement of Mr. Towns follows:]

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS

Thank you Chairman Pallone and Ranking Member Deal for scheduling this hearing regarding H.R. 3014, "Health Equity and Accountability Act of 2007". This bill can be greatly instrumental in helping our Nation eliminate the health and health care access disparity divide.

I especially would like to thank Representatives Hilda Solis (CA), Donna Christensen (VI) and Doris Matsui (CA), and others for their exhausting and enlightened leadership on this bill that has a total of 110 co-sponsors of which I am proud to be a co-sponsor. I appreciate the collective input and wisdom of the Congressional Black Caucus, the Hispanic Caucus, and the Asian Pacific American Caucus. I think it is also befitting to establish the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care after the late representative. I welcome our witnesses, especially my esteemed congressional colleagues, Representatives James Clyburn (SC) and Jerry Moran (KS).

I also respectfully ask for unanimous consent to admit certain documents into the record.

With that, I yield back and thank you, Mr. Chairman.

Ms. CAPPS. Thank you. Now we turn to panel one and we will ask each of our colleagues to present 5 minutes of their oral testimony. There will be no questions from the members for the first panel. Mr. Clyburn, you may begin.

STATEMENT OF HON. JAMES E. CLYBURN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF SOUTH CAROLINA

Mr. CLYBURN. Thank you very much, Madam Chair. I too hear those bells and I apologize, but let me begin by thanking you, Madam Chair, the other members of the Committee, especially Chairman Pallone and Ranking Member Nathan Deal for allowing me to testify in support of H.R. 3014, the Health Equity and Accountability Act of 2007. I also want to acknowledge the tireless work of our Congressional Tri-caucus, in particular the health chairs, representatives Donna Christensen, Hilda Solis and Madeleine Bordallo.

Now, Madam Vice Chair, we know that prevention and control of the diseases and the protection and promotion of people's health are the primary mandates of public health. The fulfillment of this goal does not solely rely on the government, but needs support of the private sector, communities, families and individuals.

We also know that socioeconomic conditions are known to be major determinates of health at all stages of life from pregnancy through childhood and on into adulthood. These social determinants of health and their association with adult morbidity and mortality, and adult health related behaviors are well documented. Yet we know that episodic intervening in the health system is insufficient to influence health early in the life course. Community-level approaches to impact key determinants of health are also important.

Now, Madam Vice Chair, in 2005 a United Nations Development Program report entitled, Inequality in the United States Healthcare System stated the following: "Although the United States has been rated highly in the United Nations Human Development Index, the shining health indicators of the general population do not reflect the great disparity in the health of certain subpopulations. Absolute health indicators often make the suffering of the vulnerable, especially those living in the wealthiest nation, invisible to the world." The report continued stating that the United States private-public healthcare system should not be used as a model for other countries as it exacerbates the inequality in access to care and health status between the haves and the have-nots.

Now, Madam Chair, I have other things that have been prepared for me to say, but in the interest of time I am not going to. I am going to ask that you allow me to enter my full statement into the record, but I thought it was important for me to get that statement in.

Now, I want to close my comments, Madam Vice Chair, by saying I am no healthcare expert, but I have seen enough of my friends, family, and most recently a beloved employee die from diseases that this bill seeks to address. And I cannot think of a better way—my wife suffered from a heart attack and had a five vessel bypass surgery and on the day that I stood with her, as they were about to discharge her from the hospital, the doctor said something to the effect, I think we caught whatever it was in time. And then asked her, how does she feel. She said something is wrong. Now, this was the fourth day in the hospital, but she came, really, from a part of town that people just didn't think she would be having a heart attack. Yet, they finally decide to put the dye in, and when they did they found three 100 percent blockages and two 50s.

Now, I point this out to say to you, Madam Chair, that I came here today to testify on behalf of people who do not have good healthcare. I would not be celebrating with her our 47th anniversary today were it not for the fact that they took a second look. Not because of what her disease was, but because of who she was, and that is why we are here today. Thank you, Madam Chair, and I yield back the rest of my time.

[The prepared statement of Mr. Clyburn follows:]

STATEMENT OF HON. JAMES E. CLYBURN

Good morning,

I want to offer my sincere thanks to Chairman Pallone and Ranking member Nathan Deal for allowing me to testify in strong support of H.R. 3014 the Health Equity And Accountability Act of 2007. I also want to acknowledge the tireless work of our Congressional Tri-caucus, in particular, the Health Chairs Representatives Donna Christensen, Hilda Solis, and Madeleine Bordallo.

Mr. Chairman, we know that prevention and control of diseases, protection, and promotion of the health of the people are the primary mandate of public health. The fulfillment of this goal does not solely rely on the government, but needs support of the private sector, communities, families, and individuals.

We also know that socioeconomic conditions are known to be major determinants of health at all stages of the life course from pregnancy, childhood, and adulthood. These social determinants of health and their association with adult morbidity and mortality, and adult health related behaviors are well documented. Yet we know that episodic intervening in the health system is insufficient to influence health early in the life course; community-level approaches to impact key determinants of health are also critical.

Mr. Chairman, in 2005, a United Nation Development Program (UNDP) report entitled, Inequality in the United States Healthcare System stated the following: "Although the United States (US) has been rated highly in the United Nations Human Development Index, the shining health indicators of the general population do not reflect the great disparity in the health of certain subpopulations. Absolute health indicators often make the suffering of the vulnerable, especially those living in the wealthiest nation, invisible to the world." The report continued stating that, the US private-public healthcare system should not be used as a model for other countries as it exacerbates the inequality in access to care and health status between the haves and the have-nots."

Consider these statistics:

• Infant mortality rates are higher among African Americans and American Indian/Alaska Natives than among other racial/ethnic groups, even when comparing women of similar socioeconomic conditions.

• On average, Latinos, African Americans, American Indians, and whites have higher mortality rates than Asian/Pacific Islanders at each stage of the lifespan.

• These differences could be attributed to delaying care: 32% of Latinas and 32% of African American women report delaying or foregoing care in the past year, as did 15% of white women. Women report several reasons for delaying care, including cost, lack of insurance, and competing family or work responsibilities.

But these statistics are not surprising or new information, for in 1985 former Health and Human Services Secretary Margaret Heckler published a report from her Task Force on Black and Minority Health which stated that because of these "stubborn disparities" America was on course to creating a "permanent health and healthcare underclass."

Those words came true and became the core argument presented in the landmark Institute of Medicine report published in 2002 on disparities entitled Unequal Treatment: Confronting Racial and Ethnic Health Disparities. This report laid bare the fact that there is healthcare underclass and it is US private-public patchwork healthcare system is to blame.

Although the US healthcare system emphasizes competition, a trademark of privatization, competition occurs at the wrong level. The relevant arena to have competition is in diagnosing and treating particular diseases or conditions, thus creating an atmosphere that rewards value and quality. However, in the US, competition exists among provider networks, whether they consist of hospitals or doctors or both, to assemble bargaining power so that they can strike a better deal for themselves; healthcare is treated as a commodity. However, this kind of cost-shifting or bargaining-power competition does not reward quality or create health care value. It actually does the opposite through adding massive administrative costs, inequities, and complexity into the system.

This is why I am so happy to see this Congress go on record and commit themselves to the elimination of racial and ethnic disparities in health care access, health care quality, health outcomes and the health care workforce because all Americans deserve equal treatment in health care. A proper investment in health care will improve both the health and economic well-being of our country. The legislation before us today seeks to address racial and ethnic health disparities by doing the following:

• Setting the elimination of racial and ethnic health disparities as a goal. The elimination of racial and ethnic health disparities can and should be a goal for all Americans. The health of all communities is enhanced when we work to close the health care divide.

• Expanding the health care safety net. The lack of health insurance and access to health services results in significant declines in health status within racial and ethnic minority communities. The availability, quality, and affordability of health coverage options that provide meaningful access to health services must be expanded in cooperation with health care providers and employers in order to successfully address racial and ethnic health disparities.

• Diversifying the health care workforce. Develop a diverse public health workforce that reflects and understands the backgrounds, experiences, and perspectives of the population it serves. Efforts should be made to recruit and train health care professionals from underrepresented groups. In addition, the training of health professionals should be expanded in order to produce a culturally and linguistically proficient health care workforce.

• Ensuring Health Care Access in Compliance with civil rights laws. Title VI of the 1964 Civil Rights Act and its subsequent amendments provide crucial rights to individuals with limited English proficiency (LEP) to access federally conducted and supported programs and activities. LEP persons should not be inhibited from accessing vital health care services paid for by their and their families' tax dollars.

• Promoting the Collection and Dissemination of Data. In order to fully understand the scope of health care disparities, it is necessary to have data on individuals' health care access and utilization that includes race, ethnicity, primary language, immigration status and socio-economic status. Data is necessary in order to measure the existence, effects, and causes of health care disparities. Ideally, good data collection can lead to a model of appropriate intervention.

• Combating diseases that disproportionately affect racial and ethnic minorities. Existing research has illustrated that diseases such as diabetes, obesity, heart disease, asthma, and HIV/AIDS disproportionately impact racial and ethnic minorities. Federal initiatives should focus on preventing and treating these diseases, educating all communities about their impact, and identifying the behavioral, emotional, and environmental factors that contribute to these diseases.

• Enhancing medical research that benefits all communities. It is important that federal medical research be conducted by, and on behalf of, racial and ethnic minorities. There is a need to recruit medical researchers who are culturally and linguistically proficient and train those who are not. In addition, additional research must be done to analyze the impact, cause, and effect of disease on racial and ethnic minorities.

• Emphasizing a holistic prevention and behavioral health approaches. Estimates suggest that as much as fifty percent of health care costs are caused by behaviorally related illnesses, including heart disease, high blood pressure, obesity, and substance abuse. Cultural and social factors can contribute to the behavioral patterns underlying these illnesses. Behavioral interventions have the potential to prevent such illnesses and save billions of dollars in health care costs.

• Recognizing the complexity of racial and ethnic communities. The diverse communities within our nation present unique health concerns. Acknowledgement must be given to the impact of a person's race, ethnicity, national origin, generation of immigration, educational and socio-economic level, geographic location, cultural beliefs, immigration status and linguistic preference on health status.

Mr. Chairman, last year during the floor debate on reauthorizing the Child Health Insurance Program, I invoked an old judicial axiom that says "Justice delayed is justice denied." My colleagues the same is true for health care. Whether it is the story of thirteen-year-old Devante Johnson from Houston, Texas who had advanced kidney cancer and spent 4 desperate months uninsured while his mother tried to renew his SCHIP coverage only to die in the process.

Or 43-year-old Edith Isabel Rodriguez who laid in pain for 45 minutes on the emergency room lobby floor of Martin Luther King Jr.-Harbor Hospital and later died of a perforated bowel, as janitors sweep around her and hospital staff ignored her.

To the Members of the Committee, I am no healthcare expert but I have seen enough of my friends, family, and most recently a beloved employee of mine (Mr. Ike Williams) die from the diseases that this bill seeks to address and I cannot think of a better way to acknowledge these deaths and bring justice to those who have died prematurely because of disparities in healthcare then to pass this bill.

We need this bill, the American public wants this bill, and it should be noted that the entire leadership of the House will see to it that this bill becomes law.

Thank you Mr. Chairman for allowing me to offer my thoughts on this important piece of legislation. I apologize for having to leave after this testimony but if you have any questions please follow up with my policy director Aranthan S. Jones, II or "AJ" in my office.

As you many of know, AJ is the coauthor of the bill before us and is known on Capitol Hill as the preeminent expert on health disparity elimination policy. It is my sincere hope that as you move this legislation and legislation akin to its substance, that you use him as a resource. Thank you Mr. Chairman.

Ms. CAPPS. Thank you Mr. Clyburn for your oral testimony and your written testimony. Without objection, we will allow Mr. Clyburn's full statement to be entered into the record. Thank you very much, and I know that we have just 10 minutes left on our vote, but we will now turn to the Honorable Jerry Moran from Kansas for his testimony.

STATEMENT OF HON. JERRY MORAN

Mr. MORAN. Madam Chairperson, thank you very much for allowing me the opportunity to join you today, and it is particularly

an honor to be here with the distinguished gentleman from South Carolina, and I wish him a happy anniversary on this special occasion.

Mr. CLYBURN. Thank you.

Mr. MORAN. I am—my guess is focused on the portion of the title of your hearing that says, "and other health disparities." Although the distinguished woman from California, Ms. Solis and the distinguished doctor from the delegate from the Virgin Islands, Dr. Christensen and I participated in a hearing earlier this month with the Ways and Means Committee, and I am certainly interested in learning and hearing more about disparities in a population that needs attention.

But I come today to talk about disparities that exist in rural America and in many instances I believe they overlap with the things that I have heard from Ms. Solis and others. I represent a congressional district that is nearly 60,000 square miles. There are 69 counties. My largest community, largest city is 45,000 people. It would be considered by any standard a rural district and healthcare is one of those factors that is so important in the future of those communities. It is about saving lives today, but it is about whether there is an opportunity for children and grandchildren to raise their families in the places that parents call home.

I have concluded that healthcare, its access and its affordability is, perhaps the number one issue that we face domestically in this country. If you take a look at rural America, you would see a population that is aging. The demographics are much older than the rest of the country and it is challenging for people to access healthcare because of age and disability but also because in rural America there is virtually no public transportation system. And so, because of the distances and yet because of the age, those two factors come together to make access extremely difficult. Rural elderly are more likely to have chronic diseases and yet 10 to 20 percent, statistics show, less likely to have access to any pre-screenings, preventative care and checkups. And so, once again, the paradox is that we have an older population with less ability to access healthcare and therefore less ability to prevent the deterioration of their health.

We are also poor. Rural America is poorer than urban America with an average per capita income of about $7,000 less compared to urban areas. Nearly 24 percent of children who live in rural America grow up in poverty. I have, for much of the time I have been in Congress, in fact the entire time I have been in Congress, been an acting member of the Rural Healthcare Coalition and for much of the time have co-chaired the Rural Healthcare Coalition, and one of the appealing and satisfying aspects of that is that so much of what we pursue and so many members of that coalition are urban members of Congress. We share in rural America many aspects of the delivery of healthcare that core centers of cities, urban core centers share, and so it is an opportunity for us to come together to battle a problem that is common among two different areas of the country.

Uninsurance is certainly an issue in this country, but it is especially an issue in rural America. In my congressional district, particularly in the southwest part of that district, which is the most

geographically isolated and the most ethnically diverse, 16.8 percent of my citizens lack healthcare coverage, and yet in the more urban, northeast corner of Kansas, that number is 7.5. So, even within a rural State like Kansas there are significant disparities between rural and urban areas.

It is difficult for us to keep our healthcare delivery system in place. Hospitals are struggling to keep their doors open. The critical access healthcare program has been something that has allowed that to be an opportunity, but we have a tremendous physician shortage, nursing shortage, dentist shortage. Of the healthcare professional shortage areas in the country, 2,157 of them are in rural areas. Nine-hundred and ten of them are in urban areas. Twenty-five percent of Americans live in rural America and yet 10 percent of physicians practice in rural America. So access to hospitals and doctors is a significant challenge.

Most recently I am pleased that the legislation we are considering today deals with some aspects of pharmacy. I represent seven counties in Kansas that have no pharmacist in the county. 32 only have one pharmacist in the county, and what we have done in regard to the prescription drug benefit as well as other policy decisions we have made in many instances has exacerbated the problem.

Medicare and Medicaid have a significant component in the payment for healthcare. Many of my hospitals and physicians—60, 70, 80, and sometimes 90 percent of the patients that are admitted to a hospital in Kansas or seen by a physician, their bills are paid by Medicare.

And finally I would say that emergency medical services is a significant issue for us in rural America. The time to respond is a significant challenge, but also Madam Chairperson, in most instances, our EMS professionals are volunteers and as the population increases in age, the number of younger volunteers becomes a significant challenge. So, I recognize that the time has expired and I am delighted to be with you. I am happy to highlight these disparities and work with my colleagues, from across the country, as we try to make certain, as Mr. Clyburn said, that there are no differences between the haves and the have-nots. Thank you Madam Chairperson.

[The prepared statement of Mr. Moran follows:]

STATEMENT OF HON. JERRY MORAN

Thank you for the opportunity to testify about disparities in rural healthcare. I represent a congressional district that is nearly 60,000 square miles and has 69 counties. The largest community has a population of about 45,000 people and so I have what most people would consider a very rural district. There are a number of factors regarding rural districts across the country that come together to create significant disparities in the availability and affordability of healthcare.

If you took a snapshot of rural America you'd see a population that is aging faster than in other places in the country. Because many rural residents are elderly, they use more healthcare services. It can be challenging for these rural residents and their families to get to the doctor. Residents in rural Kansas have virtually no access to public transportation and must drive long distances to access health care and because of that, preventive care can be very limited. The rural elderly in Kansas are more likely to have chronic diseases and yet are 10 0920% less likely to receive the recommended pre-screenings, preventive screenings, and checkups.

Compounding the problem of access, rural residents also tend to be poorer and make less than their urban counterparts, a per capita average income $7,000 less

compared to urban areas. Nearly 24% of children who live in rural America are in poverty.

Higher rates of uninsurance are also found in rural communities. For example, in the southwest part of my congressional district, which is the most ethnically diverse and geographically isolated, 16.8% of the citizens lack healthcare coverage, compared with 7.5% of their fellow Kansans in the northeast, urban part of the state.

It is also extremely difficult to keep the proper healthcare infrastructure in place in rural America. It is extremely challenging to recruit and retain healthcare personnel to practice in rural areas when they can make more money serving patients who are younger and wealthier in more urban environments. There are 2,157 Health Professional Shortage Areas (HPSAs) in rural and frontier areas of all states and U.S. territories compared to 910 in urban areas. 25% of all Kansas counties have federal physician shortage area designation for primary medical and all of them are rural counties.

Having access to local hospitals, emergency services, and pharmacies is something that rural residents do not take for granted. It is difficult to keep the doors open for many rural hospitals. In fact, 470 have ceased operations in the last 25 years because there are fewer patients in rural areas and Medicare payments to rural hospitals and physicians are dramatically less than those paid to their urban counterparts for the same services. Medicare use is extremely high in rural districts. In fact, at Smith County Hospital, which is along the Kansas-Nebraska border, 8 out of 10 patients admitted to the hospital are Medicare beneficiaries.

In some of my rural counties, the only access to healthcare services is Emergency Medical Services. It should be noted that there are higher rates of death and serious injury accidents in rural versus urban areas. One reason for this is that in rural areas prolonged delays can occur between a crash, the call for EMS, and the arrival of an EMS provider. Many of these delays are related to increased travel distances in rural areas and personnel distribution across the response area. Statistics show that the average response time in rural areas is 8 minutes more than the typical response time in an urban area. Finally, in most rural areas, the emergency service providers are volunteers. As the rural population continues to age, the lack of young people to fill these critical volunteer positions will continue to compromise the rural healthcare system.

Finally, community pharmacy is something that I hope this committee will consider. Many consequences fell from the Part D prescription drug benefit that was provided by Congress. Community pharmacies are an important component in providing healthcare in rural communities. Seven Kansas communities have no pharmacy and 32 counties only have one pharmacist. Adequate and timely reimbursement for our pharmacies who are serving the Medicaid population and some of our most vulnerable citizens is a necessity in order to ensure access for these populations.

So, as we look at ways to try and eliminate disparities in our health care system, I welcome the opportunity to shed light on the realities that rural communities and their residents across the country are facing. I thank the chairman and ranking member for inviting me to testify, and I would be happy to respond to any questions.

Ms. CAPPS. Thank you Mr. Moran. We now have one vote on the floor so the subcommittee will recess until 15 minutes after the vote. And as we do, we want to wish Mr. and Mrs. Clyburn a very happy wedding anniversary.

Mr. CLYBURN. Thank you.

[Recess.]

Ms. SOLIS. I would like to reconvene the committee hearing. We will ask our second panel to please join us and we will hear 5-minute opening statements from our panel's witnesses. And each part of their statements will be made part of the record and each witness may, in discretion of the Committee, submit additional brief or pertinent statements in writing for inclusion in the record. I would like to thank our two panelists today. We have Dr. John Ruffin, Director of the National Center for Minority Health and Health Disparities with the National Institute of Health and we

also have Garth Graham, Dr. Graham, who is Deputy Assistant Secretary for Minority Health Office of Public Health and Science, Office of the Assistant Secretary of Health Department of Health and Human Services. Both will have 5 minutes to speak to us and we will begin with Dr. Ruffin. Thank you.

STATEMENT OF JOHN RUFFIN, PH.D., DIRECTOR, NATIONAL CENTER ON MINORITY HEALTH AND HEALTH DISPARITIES, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. RUFFIN. Thank you, Madam Chair, good morning.

I am pleased to have this opportunity to brief you on the NIH and, more specifically, the National Center on Minority Health and Health Disparities efforts in furthering biomedical research to eliminate health disparities. By the year 2030, by all indications, racial ethnic minorities will make up almost 50 percent of the U.S. population. If the health disparities trend continues along the current path without aggressive and transformational interventions we will be faced with a resource-strained health care system with the majority of the population in poor health and a workforce that is not representative of the patient population. Madam Chair, to preempt this prediction of health disparities, keep pace with the changing demographics and evolving health disparities environment, a paradigm shift is needed. New approaches and research capacity building and outreach will be critical to address the complex factors that contribute to health disparities such as biology, culture, socioeconomics discrimination, politics, and environment.

At the NIH, our goal is to advance research to better understand these interacting factors and build a multifaceted enterprise defined in solutions. The National Center on Minority Health and Health Disparities was established by Public Law 106 09525. Its purpose is to improve the health populations experiencing disparities in health, and to eliminate health disparities. By law, the NCMHD has two key responsibilities, one to conduct and support research by funding and administering its own programs, and two, to be the focal point for minority health and health disparities research at the National Institutes of Health.

Our goals focus principally on four areas: one, research, which is to enhance our understanding of the multi-factorial causes of health disparities. The center of excellence program supports the NCMHD premiere research being conducted in 31 States, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. A total of 88 institutions have received funding under this program, but about 50 are still being funded.

Another goal is training. Training is essential because we need a strong diverse and culturally competent workforce to do the research and to serve the rapidly increasing patient population. The loan repayment program has funded more than 1,400 health professionals to engage in health disparities research. The largest representation is among Caucasian, 37 percent, followed by African Americans, 34 percent, and Hispanics, 14 percent, and 4 or less American Indians comprising of only 2 percent, and Asian and Pacific Islanders making up 9 percent. Our training and research activities extend beyond our domestic borders. Health disparities

transcend borders, and we are developing future scientists to tackle health disparities on the domestic and the global front. Our own minority health and health disparities international research training program funds 24 domestic institutions to train students and faculty in research related to minority health and health disparities at almost 50 international sites. These countries include India and Ghana and Jamaica and Chile, France, Poland, and New Zealand, and there are many more.

Capacity building is another goal for us. In order to do cutting edge research, our institutions, community based organizations and researchers need resources to build and maintain an updated infrastructure. Our programs that support capacity building include the endowment program, which has funded approximately 16 institutions. Funding has helped some of the institutions to develop involved chairs, programs in diseases like HIV/AIDS, cardiovascular disease or build, as you heard Congressman Morgan say earlier, build pharmacy schools and public health programs. Similarly, the research infrastructure in minority institution program is assisting about 21 institutions in 16 States and Puerto Rico to develop science and research programs to begin molding young research investigators.

Finally, we emphasize outreach because we must translate our research findings and share the lessons learned. We also have to disseminate the information into the community and provide the public and health professionals with the tools needed to improve the community's quality of health and ultimately eliminate health disparities. The community-based participatory research program is our principle vehicle for community outreach. The uniqueness of this program is that it involves the community and the entire research process from needs assessment, research intervention to information dissemination. We supported 25 awards during the planning phase and now are preparing to fund about 40 for the research phase. These are the types of responsibilities that the originating Law gave the NCMHD and the programs it mandated. We have implemented those mandates and now are starting to develop other initiatives to strengthen our efforts. In addition, we collaborate with other NIH institutes and centers and with other federal agencies on several projects.

Ms. SOLIS. Dr. Ruffin, could you summarize? Your time is up.

Mr. RUFFIN. Yes. We are beginning to establish a good foundation and partnership is at the cornerstone of our effort, but considering the various factors such as cultural, biology, and environment that we believe contribute to health disparities, the infrastructure that we have established has to be strengthened. It has to be expanded and sustained if we are to truly eliminate health disparities.

Ms. SOLIS. Thanks.

Mr. RUFFIN. Again, thank you.

[The prepared statement of Mr. Ruffin follows:]

Testimony
Before the Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

The Role of the NIH/NCMHD in Eliminating Health Disparities

Statement of
John Ruffin, Ph.D.
Director
National Center on Minority Health and Health Disparities
National Institutes of Health
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 a.m.
Tuesday, June 24, 2008

Good morning, Chairman Pallone and other distinguished Members of the Subcommittee. My name is John Ruffin. I am Director of the National Center on Minority Health and Health Disparities, one of the 27 Institutes and Centers within the National Institutes of Health, at the Department of Health and Human Services (HHS).

INTRODUCTION

The National Center on Minority Health and Health Disparities (NCMHD) leads the national biomedical research endeavor to promote minority health and eliminate health disparities experienced by racial and ethnic minority, poor, and medically underserved populations in rural and urban communities. Today, 47 million Americans, primarily Hispanics and African Americans, have no health insurance, while 36 million Americans live in poverty[1]. Hospital emergency rooms have become the primary care facility for these groups. Heart disease, diabetes, stroke, and cancer are among the diseases and conditions that continue to plague health disparity populations --African American, Hispanic, American Indian, Alaska Native, Asian American, and Pacific Islander communities, despite scientific discoveries and medical advances to predict and preempt disease. The Centers for Disease Control and Prevention, reports that chronic diseases account for more than 75 percent of the annual $1.4 trillion for medical care costs in the U.S. The existence of health disparities is a complex economic burden that necessitates urgent, direct, and sustainable intervention.

[1] Income, Poverty, and Health Insurance Coverage in the United States: 2006, U.S. Census Bureau

HEALTH DISPARITIES PARADIGM SHIFT

Recent reports project that racial/ethnic minorities will make up almost 50 percent of the U.S. population in the coming years[2]. If the health disparities trend continues along the current path, without aggressive and transformational interventions, we will be faced with a resource-strained health care system where the majority of the population is in poor health, and a workforce that is not representative of the patient population. To preempt this prediction of health disparities, a paradigm shift is needed to keep pace with the changing demographic, and the evolving health disparities environment. New approaches that encompass preemptive, predictive, personalized, and participatory measures can help us to better understand and accelerate the elimination of health disparities.

The newly established Office of Innovation and Program Coordination (OIPC) within the NCMHD Office of the Director will be the focal point at the NCMHD for identifying and developing novel hypotheses, strategies and initiatives to unravel the complexity of health disparities. The OIPC will emphasize transformational, trans-disciplinary, and translational interventions. The OIPC will build on the progress that the NCMHD programs such as the Centers of Excellence, Loan Repayment Program, Research Endowment, and Community-Based Participatory Research Programs have already made.

[2] U.S. Census Bureau

The extent to which socio-economics, biology, environment, behavior, culture, discrimination, politics, and other emerging factors like access, impact the development or persistence of health disparities remains unclear. Imagine the cost and the outlook of health in America and the global implications, if we do not continue advancing science and medicine to understand these factors, or continue establishing research capacity to nurture a workforce that resembles the population.

The NCMHD and the other NIH Institutes and Centers (ICs) are focusing on all of these determinants and seeing results. From studying gene variations in lupus; identifying a susceptibility gene for Polycystic Ovary Syndrome; establishing an environmental health research partnership among research intensive and minority-serving institutions; identifying effective measures to prevent early childhood caries which present implications for changing health policy and clinical practice; to studying chronic kidney disease. The data on health disparities is emerging.

ADVANCING SCIENTIFIC KNOWLEDGE

The NCMHD, through its emphasis on basic, behavioral, social sciences and clinical research is advancing scientific knowledge on the determinants of health disparities. Gaining enhanced insight into the biological and non-biological pathways of health disparities and the implications for predicting and preempting

negative health outcomes, or participatory involvement in personalizing care, is pivotal to our mission.

NCMHD-funded research at the University of San Diego examined the response of African Americans to different classes of antihypertensive drugs. In one study, the results showed the potential of Angiotensin-converting enzyme (ACE) gene polymorphism to predict the blood pressure response time. Further study may lead to our ability to predict the responsiveness of African Americans with specific genotypes to different classes of antihypertensive drugs, and a decrease in the incidence of end-stage renal disease in African Americans.

A study done at East Tennessee State University, examined the issue of intimate partner violence (IPV) during pregnancy in a rural population involving 104 Caucasian prenatal patients. It found that 81% of the participants reported some type of IPV during the current pregnancy, 28% reported physical IPV, and 20% reported sexual violence. The findings have increased our knowledge about the potential impact of pregnancy IPV on health behaviors.

Researchers at the University of Puerto Rico investigating the relationship between limited English proficiency and quality of primary care among three different groups of Hispanics, have amassed insightful data that will be pertinent in informing culturally appropriate interventions for this population.

Socio-economics is a major determinant of health. A recent study from the University of California Los Angeles and Charles R. Drew University looked at racial/ethnic and economic variation in cost-related medication underuse among insured adults with diabetes. Cost-related medication underuse was highest among African Americans and Hispanics, who were also the least likely to have drug coverage.

Timely translation and transmission of these findings into action or programs with the potential to improve health, is the ultimate measure of the impact of research.

COMMUNITY INTEGRATION

The success in eliminating health disparities will be achieved with community integration into the research enterprise. The community is essential not only in carrying out the translational aspect of research, through health promotion and information dissemination, but for the NCMHD, it is the hallmark of the research process. This is evident with our Community-Based Participatory Research program which embraces the community as an equal partner, and underscores its potential at the forefront of science and medicine in developing and executing predictive, preemptive, and personalized techniques.

At the University of Hawaii, the Partnership for Improving Lifestyle Intervention (PILI) 'Ohana Program, exemplifies the value of the community-academic partnership. It links five community groups with the medical school and state

department of health to focus on obesity health disparities. The community was central in designing a personalized weight loss maintenance intervention that is family plus community-focused with potential to preempt and counter obesity.

BROADENING THE CAPACITY BASE

Having the requisite infrastructure is imperative in meeting today's health disparities challenges and in averting those of the future. We continue to strengthen the biomedical research enterprise through our support of individuals, institutions, and communities, globally. NCMHD has supported a diverse team of 1400 preemptive-focused health disparities ambassadors through its Loan Repayment Program (LRP). Almost 70% of the participants come from a health disparity population. Research activities are varied and include health promotion, prevention, health services, patient-provider communication, and cultural competency. Greater benefit and results can be yielded with more investment of time in following the intervention, and training the next generation of health disparities investigators. Career development for promising investigators will be emphasized through the LRP program. Health disparities capacity-building investments today that promote preemptive measures will yield less strain on the health care system of the future.

INSTITUTIONALIZING HEALTH DISPARITIES

NCMHD has led the way to institutionalize a health disparities agenda at NIH through its tradition of collaboration and the development of an agency-wide

strategic plan. The NIH ICs are undertaking important health disparities research activities. Global health researchers are being trained in low and middle income countries. The Asthma Control Evaluation trial shows potential in reducing asthma symptoms in low-income inner-city children. Genetic analysis of sarcoidosis in African Americans offers promise for preventive and therapeutic interventions. Combination antiplatelet therapy (aspirin and clopidogrel) compared to aspirin alone shows potential for stroke prevention treatment. Collaborations will continue to be strengthened, capacity building emphasized, and research integration approached more directly.

CONCLUSION

The body of research on health disparities emerging from the NCMHD and the other Institutes and Centers is starting to grow. Collecting, analyzing, interpreting, and translating the data and lessons learned is our commitment going forward. Research translation into culturally, socially, linguistically, and generation appropriate tools is a high priority. Research is futile and we will have little or no impact in eliminating health disparities, if our findings cannot be translated into a user-friendly language for the community and health care provider. Health disparities remain a daunting challenge that demands urgent, direct, and sustainable interventions.

Thank you for the opportunity to testify. I will be happy to answer any questions.

Ms. SOLIS. Thank you very much. Our next witness is Dr. Garth Graham. Welcome. Thank you for being here and you have 5 minutes.

Dr. GRAHAM. Thank you.

STATEMENT OF GARTH GRAHAM, M.D., M.P.H., DEPUTY ASSISTANT SECRETARY FOR MINORITY HEALTH, OFFICE OF PUBLIC HEALTH AND SCIENCE OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. GRAHAM. Good morning Madam Chairman and other distinguished members of the subcommittee. I want to take this opportunity to thank you for inviting me to testify today and also to thank you for your ongoing efforts to reduce and hopefully eliminate health disparities. It is always a pleasure to talk about issues that are very near and dear to all of us, issues that serve and affect the lives and well being of so many people in our country.

The Office of Minority Health resides within the Office of Public Health and Science in the Office of the Secretary of the U.S. Department of Health and Human Services. Its creation in 1986 by then HHS secretary Margaret Heckler was one of the most significant outcomes of the 1985 Secretary's Task Force Report on Black and Minority Health. OMH was subsequently established in statute by the Disadvantage Minority Health Improvement Act of 1990 and reauthorized under the Health Professions Education Partnership Act of 1998. Yet in the past 20 years we continue to understand that disparities not only continue to exist, but remain persistent.

The most recent healthcare disparities report has shown that progress is being made, but many of the biggest gaps remain. Over 60 percent of disparities in quality of care have stayed the same or worsened for blacks, Asians and poor populations. Nearly 60 percent of disparities have stayed the same or worsened for Hispanics and for blacks, Asian Hispanics and poor populations. Disparities in about half the core measures of access to care are lessening.

Building on strategies, such as those recommended in the 2002 IOM report and others, the OMH has been working to increase awareness around health disparities, improve cultural competence in healthcare, work on strategies to improve data collection, and promote the consistency of care through the use of evidence-based guidelines. In addition, we look to develop new strategies in looking at health information technology as a tool to reduce disparities as well as dealing with emergency preparedness in minority communities.

A recent example, on June 12 of this year here in Washington, we launched a National Health IT collaborative for the underserved. This is a brand new effort which aims to ensure that underserved populations are included as health information technologies are developed and deployed. We work with three organizations in organizing this collaborative: The Summit Health Institute for Research and Education; The Health Information and Management Systems Society; and Apptis Inc., of Chantilly, Virginia. They will be joined by additional Federal agencies, and private sector and community-based stakeholders. It is an ambitious and energetic

group that expects to recruit leaders and subject matter experts in technology, education, outreach, advocacy, public policy, workforce development training, and funding.

In the area of emergency preparedness we supported Drexel University in developing a National consensus statement that provides broad guidance, identifies priorities for integrating culturally diverse communities into public health preparedness planning and implementation. We worked to create the Nation's first online clearing house and information exchange site, designed to help eliminate disparities for culturally diverse communities across all stages of an emergency.

There are a lot more efforts that I could discuss. We have been working in particular in dealing with the intractable problem of the infant mortality disparities in African American communities compared to the general population. I could talk more about our support for a task force seeking to promote broader immunization coverage for Hepatitis B vaccinations among Asian Americans, Native Hawaiians, and other Pacific Islander populations. I could also talk about our work with the Baylor College of Medicine and Intercultural Cancer Council to publish guidelines and best practices for researchers in organizing culturally competent clinical trials.

Every day brings new opportunities and new beginnings. We have set a course that focuses on ensuring that our work is transparent, our contributions are targeted, and we achieve a return on our investment. We can't do this and work alone. We recognize that we have numerous partners in the field from the National Medical Association, the National Hispanic Medical Association, the Summit Health Institute of Research and Education, National Council of La Raza, and many others in the Asian American and Pacific Islander Health Forum and many others who have joined us in our efforts here today. Efforts around reducing and ultimately eliminating health disparities require strong leadership and OMH is up for the task. Working together we can make an even bigger difference in the lives of people. Thank you for the opportunity to testify, and I will be happy to answer any questions you may have.

[The prepared statement of Dr. Graham follows:]

Testimony
Before the Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

The Role of OMH in Eliminating Health Disparities

Statement of
Garth Graham, M.D., M.P.H.
Deputy Assistant Secretary for Minority Health
Office of Public Health and Science
U.S. Department of Health and Human Services

For Release on Delivery
Expected at 10:00 a.m.
Tuesday, June 24, 2008

Introduction

Good morning, Chairman Pallone and other distinguished Members of the Subcommittee. My name is Garth Graham, and I am the Deputy Assistant Secretary for Minority Health, in the Office of Public Health and Science (OPHS), within the Department of Health and Human Services (HHS). I want to take this opportunity to thank you for inviting me to testify today. It is always a pleasure to talk about issues that are very near and dear to all of us, issues that serve and affect the lives and well being of so many people in our country. The mission at hand is a large one, and I assure you that the Office of Minority Health will continue to share what we have in terms of our network, expertise and resources with state and community partners and other agencies in HHS to help make change possible.

The Office of Minority Health (OMH)

The Office of Minority Health is part of the Office of Public Health and Science (OPHS), in the HHS Office of the Secretary. Its creation in 1986 by then-HHS Secretary Margaret Heckler was one of the most significant outcomes of the 1985 Secretary's Task Force Report on Black and Minority Health. OMH was subsequently established by statute, by the Disadvantaged Minority Health Improvement Act of 1990 (PL 101-527) and reauthorized by the Health Professions Education Partnerships Act of 1998 (PL 105-392).

Our goal is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. Our work is more important than ever. After all, the diversity of the U.S. population is growing so fast that we expect that racial and ethnic minorities will comprise 40 percent of the U.S. population by the year 2030 and 50 percent by the year 2050[1].

Today, I'd like to update you on what has been front and center on our agenda.

Grant Programs

OMH supports a number of Competitive Grant programs. Based on FY 2007 year end activities, OMH grantees conducted the following activities:

- Provided interpretation and translation services to 11,462 clients while at appointments with health care providers, case managers, social service providers; also provided translation of written materials that clients need to understand and complete.
- Implemented health education, prevention and outreach to almost 1.2 million individuals
- Developed and disseminated 353,469 health education materials to minority and underserved populations (concerning health risks, prevention, treatment via outreach, presentations, and providers offices)

[1] See Census Bureau projections, http://www.census.gov/ipc/www/usinterimproj/natprojtab01a.pdf

- Conducted diagnostic screening and referral services to more than 25,000 individuals
- Provided support, role-modeling, and mentoring services to 1,052 students
- Targeted and implemented Technical Assistance and Organizational Capacity Building services to 108,428 organizations.

We have also established cooperative agreements to support the vitally important work of medical schools at Historically Black Colleges and Universities. These include cooperative agreements with the Morehouse School of Medicine and the Meharry School of Medicine.

Data Collection

OMH continues to work on challenges around data collection in racial/ethnic minority communities. Such efforts reflect OMH's crosscutting priority on collection and use of racial/ethnic health data.

- *HHS Data Council & Working Group on Racial/Ethnic Data.*--The HHS Data Council coordinates all health and human services data collection and analysis activities of the Department. OMH leads one of the four working groups of the Data Council, the Working Group on Racial and Ethnic Data. The Working Group recently coordinated the development and launch of a new minority health data portal. The purpose of the HHS Minority Health Data Portal is to create a comprehensive web-based minority health research

and data resource in order to identify data gaps and opportunities for linkages. The portal can be accessed at http://www.hhs-stat.net/omh/.

- *Evaluation of Statistical Methods for Race/Ethnicity Data Collection & Analysis.*–The purpose of this project is to identify unique, cost effective and constructive alternative methods of filling data gaps in national surveys for small racial and ethnic minority and other hard-to-reach populations.

The National Partnership for Action

The National Partnership for Action to End Health Disparities (NPA) is our next step forward. The mission of the National Partnership for Action is to build a renewed sense of teamwork across communities; share success stories and methods; demonstrate how model programs can be replicated or tailored for greater impact; and create methods, tactics, and ideas that support more effective and efficient action.

One of the first products of this work is The *Strategic Framework for Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities.* The Framework, which we released earlier this year, is a leadership tool intended to help guide, organize and coordinate the systematic planning, implementation and evaluation of efforts within OMH, HHS, and across the nation to achieve better results relative to minority health improvements and health disparities reductions.

The Framework reflects current knowledge and understanding of the nature and extent of health disparities, their causes or contributing factors, effective solutions and desired outcomes and impacts. It will be the basis for OMH's future strategic plans and a context for much of our work. You can read the Framework on our website www.omhrc.gov.

Federal Collaboration on Health Disparities Research (FCHDR)

The Federal Collaboration on Health Disparities Research (FCHDR) is a collaboration of Federal partners working to find new or improved solutions to eliminate health disparities through research that can influence practice and policy. The purpose of the FCHDR is to engage a wide range of Federal institutions to identify, support, and coordinate research priorities for cross-agency research collaboration to hasten the elimination of health disparities. The co-leads are the HHS Health Disparities Council and the Department of Education's Interagency Committee on Disabilities Research.

Cultural and Linguistic Competency in Health Care

OMH's Center for Linguistic and Cultural Competence in Health Care (CLCCHC) continues to fulfill its congressional mandate of improving the health of racial and ethnic minority populations through the development of programs that will mitigate health disparities. Under the CLCCHC, OMH has launched several flagship programs that have had widespread success in supporting the mandate and served to promulgate the dissemination and implementation of the Culturally

and Linguistically Appropriate Services (CLAS) standards throughout the healthcare system. The Physician Cultural Competency Curriculum Modules and Culturally Competent Nursing Modules are two of the Center's most important training programs. We also created the Health Care Language Services Implementation Guide and are working on a Cultural Competency Curriculum for Disaster Preparedness and Crisis Response.

Partnerships to Address American Indian and Alaska Native (AI/AN) Health Issues

OMH has also been deliberate in addressing the needs of the American Indian/ Alaskan Native community. The American Indian/Alaska Native Health Disparities Grant Program was established to improve the effectiveness of efforts to eliminate health disparities for AI/AN communities. The focus is to increase access and utilization of data and data-related activities, develop partnerships to improve coordination/alignment of health and human services, and improve access to training in public health and prevention.

In response to tribal leaders' health disparities concerns and input in Department-sponsored research, the HHS Secretary's American Indian and Alaska Native Health Research Advisory Council (HRAC) was formed in the Spring of 2006. HRAC addresses health disparities and ensures appropriate tribal participation in health research processes, priorities and needs. We also launched the Indian Country Methamphetamine Initiative, which represents a collaboration between OMH, the Substance Abuse and Mental Health Services Administration

(SAMHSA), Indian Health Service, National Institutes of Health, and other Federal partners to reduce meth abuse in Indian Country. Another initiative, the Secretary's Tribal Prevention Initiative - Healthy Indian Country Initiative, brings together National Indian Organizations and Indian Tribes/Organizations to focus on the prevention of disease in American Indian/Alaskan Native communities.

Emergency Preparedness in Minority Communities

We have a number of projects related to emergency preparedness in minority communities. The project I'll talk about today is one launched by Drexel University. We supported Drexel in developing a national consensus statement that provides broad guidance, identifying priorities for integrating culturally diverse communities into public health preparedness planning and implementation. It lays out eight guiding principles that provide a general roadmap of actions for incorporating diverse communities in preparedness. Already, 26 national public and private organizations have signed on.
Just as exciting, we worked with Drexel to create the nation's first online clearinghouse and information exchange site designed to help eliminate disparities for culturally diverse communities across all stages of an emergency. Find out more about this at www.diversitypreparedness.org.

New Orleans Violence Project

The Post-Katrina Violence Prevention among New Orleans' Children and Youth Initiative is a public/private/community partnership established under the

leadership of the city of New Orleans Health Department to improve family health and reduce violence. The goal of this project is to strengthen New Orleans' violence prevention capacity through an intervention targeting the city's at-risk youth. The New Orleans Department of Public Health will leverage its existing and new relationships with partners, including law enforcement, schools, the faith community, and various community and governmental organizations to effectively address the root causes of crime as the city redevelops.

Health Information Technology

On June 12th, here in Washington, we were proud to announce the first meeting of the National Health IT Collaborative for the Underserved. This is a brand new effort which aims to ensure that underserved populations are included as health information technologies (Health IT) are developed and deployed. We worked with three other organizations to organize the Collaborative: the Health Information and Management Systems Society; the Summit Health Institute for Research and Education, Inc., and Apptis, Inc., of Chantilly, VA. They will be joined by additional Federal agencies, particularly the HHS Office of the National Coordinator for Health IT, and private sector and community-based stakeholders to mount a year-long Health IT initiative. At the end of this ambitious effort, we hope to have a:

- Compilation of models, strategies, practices and/or activities with proven effectiveness in informing and engaging the underserved in the use of Health IT for health self-management and empowerment;

- Description of academic, in-service and other models, strategies, practices and/or activities resulting in the availability of health professionals and technical personnel in underserved communities who are Health IT-literate and competent;
- Compendium of public and private funding options and written guidance for underserved communities seeking financial support for Health IT operations and sustainability; and.
- Recommendations for a structural framework to maintain an emphasis on Health IT adoption in underserved communities, with such functions as providing for information exchange; conducting pilot programs; providing technical assistance and publication of community guidance documents.

Working with Business

Recently, OMH renewed its long relationship with the National Business Group on Health (NBGH) to help large employers highlight the issue of health disparities.

Business Group members provide health coverage for more than 50 million U.S. workers, retirees and their families. Its members, corporate purchasers of health insurance and medical directors, see health disparities as a quality issue, and they're tired of paying for care that doesn't improve the health of their entire work force.

On February 11th, at the National Press Club, NBGH and OMH announced a new two-year effort to strengthen ongoing partnerships and build new business-community coalitions to reduce racial and ethnic health disparities and improve the quality of health care for minority populations. Helen Darling, president of NBGH, called on employers to seek new strategies for getting maximum value for their health insurance dollars by focusing on providers and strategies that will help reduce health disparities affecting minorities. This effort will identify best practices for the business community in addressing racial and ethnic disparities among their workforces.

A Healthy Baby Begins with You

Infant mortality rates among African American babies are twice as high as those of the general population. Even when the rates decrease, the gap continues. OMH launched a new campaign in 2007, "A Healthy Baby Begins with You." It is a national campaign to raise awareness about infant mortality with an emphasis on the African American community. The campaign features Tonya Lewis Lee, author, attorney, television producer and wife of film maker Spike Lee, as its spokesperson.

We've been working with Healthy Start programs, and we'd like to bring more attention to the issue, and to the local community organizations that are the essential service providers for people of color.

The OMH Resource Center (OMHRC)

One of the first projects established by OMH, the Resource Center was founded in 1987 as a national resource and referral service on minority health and has been mandated by OMH's authorizing legislation since 1990. OMHRC focuses on African American, American Indian and Alaska Native, Asian American, Hispanic/Latino, Native Hawaiian and other Pacific Islander communities.

OMHRC has evolved from a call center and fulfillment house into an organization that, (1) responds to customer queries via telephone, e-mail and person-to-person appointments, (2) develops electronic and print products to educate the public on minority health issues, and (3) provides technical assistance to community-based and faith-based organizations working on HIV/AIDS-related issues. The special focus on HIV was initiated in 1999-2000 at Congressional direction for additional HHS and OPHS efforts to combat the epidemic.

The Resource Center's web page, www.omhrc.gov, links to the full portfolio of cultural competency work funded by OMH, (see also www.thinkculturalhealth.org/), including the CLAS standards, online educational packages, and language services implementation guides, as well as to selected materials produced by other HHS agencies.

The technical assistance and capacity development team works with small and new HIV/AIDS community-based and faith-based organizations throughout the

US to help them achieve technical skill and stability that will allow them to make an impact in their community and become eligible to participate in the projects and programs sponsored by the Health Resources and Services Administration, the Centers for Disease Control and Prevention, SAMHSA and the other large HIV/AIDS programs in the Department.

The Resource Center has used Minority HIV/AIDS Initiative funds to create a Pacific Resource and Training Center on Guam, run by a local community organization, that now actively conducts educational outreach, has built new and close ties with the Guam Department of Health and serves as a resource for all of the US-associated Pacific jurisdictions. For example, it has provided mini-grants, technical assistance and training to community-based organizations and heath departments in the six US-associated jurisdictions. In addition, it is developing a mentoring project involving experienced and younger community leaders of HIV/AIDS service organizations to help cultivate the next generation of leadership. To find out more about these and other OMH and OMHRC programs, call 1-800-444-6472 or visit www.omhrc.gov .

Conclusion

In closing, there is more I could discuss. I could talk about our support for a task force seeking to promote broader immunization coverage for Hepatitis B vaccine among Asian American, Native Hawaiian and other Pacific Islander populations.

We have an effective, preventive vaccine, but coverage rates are far from universal.

I could talk about our work with Baylor School of Medicine and the Intercultural Cancer Council to publish guidelines and best practices for researchers in organizing culturally competent clinical trials. The key to all of these activities is that complex problems require leadership, direction, and coordination – this is one of OMH's unique roles, contributions, and strengths. OMH's approach has been to harness the strengths of all of those who have a stake in positive health outcomes for racial and ethnic minorities and in closing racial and ethnic health gaps.

Every day brings new opportunities and new beginnings. We have set a course that focuses on ensuring that our work is transparent, contributions are targeted, and we achieve a return on our investment. But working together, we can make an even bigger difference in the lives of people.

Thank you for the opportunity to testify. I will be happy to answer any questions.

Mr. PALLONE. Thank you, Dr. Graham. Thank you both. We are now going to have questions from the panel and I will start with myself, and I do apologize. I think maybe Congresswoman Solis or Capps mentioned that we have the Medicare Physician Reimbursement bill on the floor, so there is a lot going on at the same time. But I did have your written testimony so I wanted to start. I ask a question of Dr. Graham. You mention in your testimony that the Office for Minority Health leads a working group as part of the HHS Data Council on Racial and Ethnic Data. Can you talk about what opportunities this particular data collection system has helped you to identify? In addition, have outside groups assessed the same data in ways to help advance other solutions and proposals to address health disparities?

Dr. GRAHAM. Sure. One of the main challenges that we face is a lack of data for specific subpopulations of the American population, Native American populations, Native Hawaiian or Pacific Islander populations, sub segments of the Hispanic populations and others. We have been working on a series of efforts to try and figure a cost effective mechanism to be able to not only collect but also be able to report on the data in those very subpopulations. So one of the things we have done is we have created an online data portal on all of the various data that HHS and other private organizations and other partners, I should say, have on these very subpopulations so that they can be available to researchers and other policy makers across the board.

We have also been looking at unique methodologies in terms of increasing data collection on those subpopulations that I was just describing. I have to tell you that it is a large task and as we look through these strategies and as we try to figure out ways in which to do this, we do find that there are interesting ways in which we can do this and we have been working with RAND Corporation to hopefully identify some further opportunities.

Mr. PALLONE. All right, well thank you. I appreciate you mentioning, particularly, Native Americans because I know that Ms. Solis' bill came from the Tri-caucus but the Native American caucus, which I actually vice chair, was very supportive of the legislation as well and they, of course, have huge disparities, as well. In your testimony, though, you provide impressive numbers about the number of individuals that have been served by programs such as interpretation and translation services, health education, outreach, referral monitoring services. Has your office conducted any research to determine the impact of these types of programs on the populations they serve? For example, for 1,052 people served by the mentoring program, I would be curious to know if their health outcomes are better than they would have otherwise been.

Dr. GRAHAM. Sure. We continue to provide—I am sorry, we continue to assess our efforts and evaluate our efforts on an ongoing basis and we have a uniform data management system that we put in place and not only capture what our grants do, but also to be able to make sure that we tie and link those to health outcomes. Now, one of the things, Chairman, that we do know in terms of looking at some of our programs that increase training and increase opportunities for younger individuals, one of the programs that you just mentioned to enter health professions is beyond just

the data that OMH has. We do know from Sullivan Report, the Institute of Medicine Report and many other reports that increasing diversity in the work force needs to be a priority in terms of the elimination of health disparities. Our efforts go along those lines and hopefully serve to strengthen and create opportunities for younger individuals to enter the pipeline and enter pipeline programs, and that is where those efforts are targeted.

Mr. PALLONE. OK. Let me ask Dr. Ruffin, I know that you changed your plans to be here today and you have to catch another plane so thank you for making those arrangements so you could be here. There are some who feel that there should be minimal to no Federal involvement in trying to close health disparities gaps, and I happen to disagree with that and there are a number of things that you mention in your testimony that appear to indicate that you would agree with me on this issue. What role should the Federal Government play with respect to health disparities and how can we, at this level, make a difference?

Mr. RUFFIN. Mr. Chairman, I think that some of the programs that I mention in my testimony, in particular I would like to emphasize the loan repayment program and I would like to use what we have learned just from, say, the AIDS research that we have conducted at the National Institutes of Health. I have been at NIH now 19 years so I remember when the AIDS loan repayment program was put in place, and I can tell you that much of what we have learned about AIDS, that we would not have known about AIDS if we had not put that loan repayment program in place. In fact, what we said to doctors was that if you were to come to the NIH and conduct research, we will pay off your loans. That program has been very successful and much of the data that we have gathered has been proof of that.

I think that if we are going to do anything about health disparities, I really think that it is going to start with a strong workforce. That is what we need, and I think that what we have to do is to put in place a program that goes after the best and the brightest people and say, if you were to go into health disparities and help us to solve some of these problems, we will pay off some of these loans that you have. That is what was mandated to us by Public Law 106 09525 and it is paying off. I don't think that it is just the Federal Government's responsibility. I think that it is going to have to be the responsibility of a broad segment of our society.

Mr. PALLONE. But now you are talking about people going into this disparities issue, or just the need for minority representation in healthcare?

Mr. RUFFIN. I think it cuts across the spectrum because when you look at our loan repayment program now, that program cuts across the entire health spectrum, not just for physicians, physicians, Ph.D.s, dental, nursing.

Mr. PALLONE. Right.

Mr. RUFFIN. Sociology, Psychology, as long as they go into the health profession.

Mr. PALLONE. I am amazed, we had—I don't know if it was this year, whenever we had a hearing on Indian healthcare and the number—I think there was some ridiculous number like 400 Indian American physicians in the whole country, less than 500 for the

whole country. It is just amazing how for some populations and in some of these health care professions, there are so few, there is so little representation. Did you want to comment on this Dr. Graham?

Dr. GRAHAM. Yes and actually that points back to that earlier point when you alluded to some of the training programs that we have been sponsoring and hopefully provide. You touched on a very, very important issue and I want to as well support Dr. Ruffin's statement. This issue of workforce diversity is critical to the reduction elimination of health disparities. The numbers that we have in terms of Native American, Hispanic, African American physicians who are either practicing or even if you look at just medical school faculty, in terms of other kinds of training, even if you look at the nursing profession, we see even more challenging numbers. Those are numbers that we need to tackle head on, and we need to be able to address those pipeline issues looking from not just when kids get into college, but be able to reach out to them even in high school and earlier so that they understand the benefits of entering health professions and create a supportive environment so that they can truly make their way through the pipeline. And I would have to say that institutions that train—historically black colleges and universities, HSIs and other institutions that help to train—these providers are very, very important and we have to continue to support them.

Mr. PALLONE. Well thank you both. Mr. Deal.

Mr. DEAL. Thank you. I want to thank both gentlemen for being here today. And Dr. Ruffin, I agree with you that the workforce is, perhaps, the most critical ingredient in this whole picture and my State, of course, has Morehouse School of Medicine and I think it is one of the institutions that you mentioned in the programs that you help support and I thank you for that. I think they do an excellent job of training primarily minority physicians but they have a broader impact in our State and in our economy as a whole. Dr. Graham, let me ask you this: do you believe that the Office of Minority Health that you are involved in is adequately addressing this issue of health disparities?

Dr. GRAHAM. I think we are. I think we have a dedicated staff and a dedicated team of individuals who historically, through the years have been working very hard to address this issue of health disparities. And I think we have been focusing our efforts now on not just those traditional areas around workforce diversity and some of the things we talked about here, but as I alluded to looking at how we develop new areas around health information technology, emergency preparedness and other emerging problems that we know are at the forefront around health disparities.

Mr. DEAL. Well, one of the concerns that some of us have with this legislation is that since we already have the Office of Minority Health within Health and Human Services is that the legislation would create minority health agencies within each agency of HHS. Some of us have concern that this would just be another example of excessive bureaucracy overlaying what we already have. Do you have any thoughts on that?

Dr. GRAHAM. Well, I can't speak to the specifics of the legislation from the position that I am in, but I can say that we look to work

with partners within HHS and across various State and other agencies, so efforts to strengthen our partnerships, we fully encourage, but I am going to refrain from speaking specific on the legislation.

Mr. DEAL. OK. One of the things that I think both of you have eluded to is this issue of developing a workforce and I am glad to hear you mention that we need to go beyond just the med school level or the nursing school level. We need to get young people interested in going into healthcare careers. One of the encouraging things I have seen in my community is, our education system now is beginning at the high school level to begin to emphasize these career paths, not just for minorities but for everybody. One of the great difficulties in a rural district such as mine, and mine is in some ways very much like Congressman Moran talked about, a rural area, is that we are increasingly depending on foreign educated doctors to service our healthcare needs. And I just think that is something that we ought to correct and we can correct it by improving the basic educational skills of our young people of all races in elementary and secondary and then encouraging them and making the opportunities available for them to go into healthcare related careers. And so I commend both of you and your organizations for what you do and I would be glad for you to elaborate on further as that issue presents itself.

Mr. RUFFIN. Well, I think you are right and I think that in order to do that, what we need to do is to collaborate more. Collaboration and partnership is going to be the key there because many of our agencies all have a specific mission. If you look at training at the National Institutes of Health, for example, if you look at our total training portfolio you will find that at the undergraduate level, the graduate level, moving forward NIH has a very strong portfolio. If you were on the other hand, though, to look at K through 12 education, you are not going to see much in the way of training there, but here is what we need to do and this is what we are doing. We need to collaborate with other agencies whose portfolio is bigger. The National Science Foundation, for example does a lot as it relates to K through 12 education. We have formed partnerships with the National Science Foundation and essentially what we are saying to them is that you, for example, you do the engineering and you do the math, and we will do the life science and we will work together in terms of putting programs together across agencies. So, we can't just work within our individual silos, i.e., we have 27 institutes and centers at the National Institutes of Health and we have learned a lot about partnering within the agency. We have to also learn a little bit about partnering and collaborating across agencies.

Mr. DEAL. I agree with you and I am glad to hear that you are doing that and I thank you, both of you gentlemen, for being with us today. I yield back my time, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal. Next is the gentlewoman from California, who is also the sponsor of this legislation and I have to say has been working on this bill for a long time and really highlighting it to her colleagues, Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman, and I do want to just state that earlier in the hearing we heard from members on the other

side of the aisle mentioning that it was somewhat unnecessary for us to have this debate and this discussion on this particular issue, and I just want to for the record say that I cannot agree with that. I think that this is a very timely issue and it is integrated in all of our healthcare systems. It is an impact that is so profound that I believe that in the upcoming session that this should be a priority for us to look at because it does involve all segments of our society whether you have smaller pockets of low-income whites or if you have an increasing rural population, or you see migration issues occurring across the country, you are going to be impacted one way or another by the disparate treatment in healthcare delivery in our overall healthcare system. So, I wanted to make that clear for the audience because there was a statement made earlier by a member on the other side of the aisle.

But I do want to focus my attention and questioning with Dr. Ruffin regarding some of the loan repayment programs that you talked about. Can you please go over with me, again, the number of slots that exist? You mentioned there were different percentages for different groups. How much of a change have you seen in the last, say, 10 years in this area?

Mr. RUFFIN. The changes have been immense just from the numbers. What we have to do a better job of is making sure that we reflect the diversity of the populations that we want. In fact, I mentioned to you that when you look at our funding portfolio now the vast majority of the individuals are Caucasians. We have about 34 percent African Americans, about 14 percent, only about 2 percent Native Americans in that portfolio, and about 9 percent when we get to the Asian Pacific Islanders populations. We have to increase those numbers. That is recruitment. We have to say to all of our societies and all of the various organizations out there to assist us, but this to me is the best thing since sliced bread because we are saying to folks, if you come in and you do health disparities research, then we fund you. Now, the amount depends upon the loan debt that the individuals have—

Ms. SOLIS. But has the number grown? I mean, the 1,400 that you mentioned, has that grown?

Mr. RUFFIN. We have 1,400 that have just about graduated from the program. We have about 1,200 that are in the program currently.

Ms. SOLIS. One-thousand two-hundred.

Mr. RUFFIN. And then we have about 600 applications that we are now in the process of screening.

Ms. SOLIS. And has that number been consistent over the last 5 years?

Mr. RUFFIN. No, that number is increasing.

Ms. SOLIS. Where was it 5 years ago, as an example?

Mr. RUFFIN. I would say that 5 years ago the numbers would have been somewhere around 600 and now we are talking, now, in terms of the number of applications that we may have received, the numbers may have been higher, but the caliber of applicants that we are looking for, the best and the brightest, that number is increasing as well.

Ms. SOLIS. Would you say that there is a need to increase those slots?

Mr. RUFFIN. I think that we need to do two things. I think that we need to increase the number of slots, but in addition to increasing the number of slots, and we are beginning to do this too, we have to think about the other end of the spectrum, i.e., what are these individuals going to do once they finish the loan repayment program? After all, the program was not created just to pay off the loan.

Ms. SOLIS. Dr. Ruffin, if I could just interrupt you. How many of those slots are actually for research in disparities, I mean?

Mr. RUFFIN. All of them.

Ms. SOLIS. All of these you are talking about?

Mr. RUFFIN. That is a prerequisite for the loan repayment program.

Ms. SOLIS. And under the Title 7 program, we also have the ability to assist young people and create career opportunities there. What proportion of that have been set aside for disparities research?

Mr. RUFFIN. Well the Title 7 program, the main part of that that impacts our office has been the endowment program, because when the endowment program was created it was created in concert with HRSA, and so the prerequisite for an endowment program is that you must have a COE, you must have a Center of Excellence, and so that is a partnership between NIH and HRSA. And right now only about 16 institutions have those programs.

Ms. SOLIS. Sixteen, and does that include Hispanic- and Black-serving institutions?

Mr. RUFFIN. Yes, and not only that but also Native American institutions as well.

Ms. SOLIS. One of the concerns or issues that has presented itself to some of us is the way to do non-traditional outreach, that is for some of the institutions to partner with CBOs or recognized groups that are actually in the business of doing this work and identifying that core population of potential labor force that you are looking at.

Mr. RUFFIN. Right.

Ms. SOLIS. Is that something that might be of interest to your—

Mr. RUFFIN. Not only of interest, but if you go back to part of my statement that dealt with the community based participatory research program, that program incorporates the very element that you are discussing, because the community can drive that particular program activity.

Ms. SOLIS. And have there been grants given?

Mr. RUFFIN. Yes.

Ms. SOLIS. There have?

Mr. RUFFIN. The interesting thing about that program, if I can say it quickly, is that it has three parts to it, three phases to it. It is funded for 3 years so that you get your partners together and you talk, because this is not a program where there is just one size fit all. It depends on the activity in that community. So, the first 3 years is a planning period. After the planning period, you get a 5 year research phase, participatory phase, and then 3 years to get that information into the community. So, if you look at it, that is 5 plus 3, that is 8, 9 10, 11 years of support if one is successful in that particular arena.

Ms. SOLIS. Can you provide the Committee with information about that and exactly where we are?

Mr. RUFFIN. Absolutely.

Ms. SOLIS. That would be very important.

Mr. RUFFIN. Yes,

Ms. SOLIS. Has my time run out? I am sorry, I believe we can go for another round, or we will submit questions to you.

Mr. RUFFIN. Fantastic.

Mr. PALLONE. I was going to move forward to the third panel, unless—OK. This is such a crazy day. We appreciate your testimony and answering our questions and I know, in particular, you had to change your schedule, so thanks a lot. You may get additional questions in writing within the next 10 days that the clerk will submit to you and of course we would appreciate if you would respond to them, but thank you very much.

Mr. RUFFIN. Be my pleasure.

Dr. GRAHAM. Thank you very much.

Mr. PALLONE. And then I would ask the third panel to come forward if you would. I know we have a large group, but if you could come forward and take your seats. Do we have the name tags up there? Have name tags for the others? I know we have a large panel today, but let me introduce everybody from left to right. First of all is, from my own state of New Jersey and from my district, actually, is Dr. Risa Lavizzo-Mourey, who is President and CEO of the Robert Wood Johnson Foundation. It says Princeton, but I will put you in New Brunswick, if that is all right. And then, next to her is Dr.—I am sorry, yes, Dr. James Edwards, who is Adjunct Fellow of the Hudson Institute in Arlington. And then we have Dr. Mohammad Akhter, Executive Director of the National Medical Association. And then we have Dr. Sally Satel, who is with the American Enterprise Institute. And we have Ms. Janet Murguia, who is President and CEO of National Council of La Raza, here in Washington. And then we have Mr. Bruce Lesley, who is President of First Focus, and Dr. Theodore Knatt of the Greater Baton Rouge Musculoskeletal Group, in Baton Rouge, obviously. And last is Deeana Jang, who is a Policy Director for the Asian and Pacific Islander American Health Forum. Thank you all for being here today. You know the drill. We have 5-minute opening statements that become part of the record, and in the discretion of the Committee, we may submit additional questions, in writing, that we would ask you to get back to us about. But I will start with Dr. Lavizzo-Mourey. Thank you for being here. I don't know if that is on, or maybe you need to move it closer to you.

Dr. LAVIZZO-MOUREY. How is that? Better?

Mr. PALLONE. That is better.

STATEMENT OF RISA LAVIZZO-MOUREY, M.D., M.B.A., PRESIDENT AND CEO, ROBERT WOOD JOHNSON FOUNDATION

Dr. LAVIZZO-MOUREY. I want to thank you for the opportunity to submit testimony for this important issue on disparities in health and healthcare and for the opportunity to express my support for the Health Equity and Accountability Act. As you have already noted, I am Dr. Risa Lavizzo-Mourey, President and CEO of the Robert Wood Johnson Foundation, the Nation's largest philan-

thropy devoted exclusively to improving the health and healthcare of all Americans.

As a philanthropy committed to producing measurable impact, the challenges we face in health and healthcare are formidable and are often interrelated. Like you, we have to think about these challenges on a number of levels. For example, we recognize that Americans' health results from different factors, like personal behaviors and factors such as housing and education. We also recognize that getting good care is a matter of both access and the quality of care that is available in a person's local community.

In order to make good on our commitment to improve health and healthcare for all Americans, we cannot ignore the evidence that certain groups persistently suffer worse health and worse healthcare. I had the honor of serving as the Vice Chair of the Institute of Medicine's Committee that produced the 2002 report, Unequal Treatment. We reviewed hundreds of research studies documenting gaps in care between blacks, Hispanics and whites, and it was indeed sobering. We found that racial and ethnic disparities in care persist even when other factors such as health insurance and income levels are equal. We also know that there are marked racial and ethnic disparities in devastating outcomes of care.

The Robert Wood Johnson Foundation recently commissioned a report by the Dartmouth Atlas Project that found considerable variation in care by region and by race. Perhaps, most striking, this research showed that the rate of leg amputation, nationally, is four times greater for black Medicare patients with diabetes than for white Medicare patients with diabetes. When we released this data we got a lot of questions. What is at fault? Who is to blame? Why are the amputation rates higher for one group over another? Is this personal health behaviors or is it the system? Our answer is that there is no single cause behind this devastating outcome. Rather, it comes from a number of things that progress over time, and we as a Nation must focus on comprehensive solutions.

So, how does one begin to think about closing these gaps in health and healthcare? To illustrate the point, I am going to ask a question. How do the amputation rates for Hispanic patients compare to those of non-Hispanic black or non-Hispanic white patients? The answer is, we don't know. The Medicare data don't tell us the answer for Hispanics, for Asians, for Native Americans. The processing of Medicare claims does not yield information of this sort and the data tell us only about differences between blacks and whites in the levels of care that they get. The Health Equity and Accountability Act would change that, ensuring the collection of data on both race and ethnicity, as well as primary language.

At the Robert Wood Johnson Foundation we have taken the approach to data collection in several stages. We have looked at the legal aspect, showing that Medicare can do much more in standardizing data collection on race and ethnicity. However, data collection is only one step. We also have to show that healthcare institutions serving high numbers of minority patients can improve and we have, in fact, seen that. In 2005, our Foundation launched a program called Expecting Success, a program specifically aimed at improving cardiac care for minority patients in hospitals. Now, many hospitals were surprised to see stark gaps in the levels of care they

were providing to different patient groups. For example, one hospital found a big difference in non-Hispanic patients and Hispanic patients when it came to handling critical information at the point of discharge. They took steps to address the gap by looking at what was happening as patients left the hospital and making sure that discharge instructions were given in Spanish. These seemingly straightforward and simple measures—measure the quality by race and ethnicity, implement interventions designed to improve the quality of care, and then measure again—show that we can make a difference. But data collection identifying the disparity is critical to making these improvements.

Another essential step in improving the quality and availability of healthcare is language services for patients with limited English proficiency. Poor communication can lead to devastating and deadly consequences for patients, and with nearly 20 percent of the Nations population speaking a language other than English at home, it is critical that our healthcare system meet their needs.

In short, I want to express my support of the Health Equity and Accountability Act and note that we are committed to moving forward with you as partners and to continuing our efforts to bring other critical partners as we strive to improve health and healthcare for all Americans. Thank you.

[The prepared statement of Dr. Lavizzo-Mourey follows:]

Testimony of Risa Lavizzo-Mourey, M.D., M.B.A.
President and CEO, Robert Wood Johnson Foundation
Before the Subcommittee on Health of the Committee on Energy and Commerce
U.S. House of Representatives
H.R. 3014, Health Equity and Accountability Act of 2007
June 24, 2008

Chairman Pallone, Ranking Member Deal, Representative Solis, and members of the Subcommittee, thank you for this opportunity to testify about the critical importance of addressing disparities in health and health care, and to express my support for the Health Equity and Accountability Act.

I am Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans.

To improve the health and health care of all Americans means that we must tackle multiple issues on a number of fronts. As a philanthropy committed to producing measurable impact, the challenges we face in health and health care—from the epidemic of childhood obesity to the millions of Americans without health insurance coverage—are formidable, and are often interrelated. Like you, we have to think about these challenges on a number of levels, and understand that some solutions are short-term, whereas others will take longer to succeed. For example, we recognize that Americans' health results from different factors, like personal health behaviors and factors in the surrounding environment, such as housing. We recognize that getting good care is a matter of both access and the quality of care in a person's local community.

In order to make good on our commitment to improve the health and health care of all Americans, we cannot ignore the evidence that certain groups persistently suffer worse health and worse health care. Both race and social class, independently and in combination, contribute to health inequalities in the United States. Lower income generally means worse health, and racial and ethnic differences in health status also persist.

To be clear: Racial or ethnic disparities do not simply reflect differences in income. Such disparities are also seen within each income group. I was vice-chair of the Institute of Medicine committee that produced the 2002 *Unequal Treatment* report. We reviewed hundreds of research studies documenting gaps in care between black and Hispanic and white patients, and it was sobering. We found that racial and ethnic disparities in care persisted, even when other factors such as health insurance and income level were equal.

A combination of health and health care disparities—poor living conditions, personal health behaviors, and poor quality care—can lead to marked racial or ethnic disparities in devastating health outcomes. The Foundation recently commissioned research from the Dartmouth Atlas Project that found considerable variation in care by region and by race. In Mississippi, 57 percent of female patients aged 65-69 got mammograms in 2004-2005, compared to the national average of 64 percent. Maine fared best with 74 percent—a 17-point gap between the high and low states. Overall, the study shows 64 percent of the white women got mammograms, compared to 57 percent of African-American women. Perhaps most strikingly, this research shows that the rate of leg amputation nationally is four times greater for black Medicare patients with diabetes than

for whites. Among states, the overall leg amputation rate was highest in Louisiana and lowest in Utah. [1]

When we released the amputation data, we got a lot of questions about that statistic. We were asked, "Well, whose fault is it? What causes the amputation rates for black patients to be so much higher? Is it personal health behaviors, like smoking? Or is it poor care?"

And our answer was, "There IS no single cause behind this devastating outcome for black patients. This is an unacceptable outcome that usually comes from a number of things that progress over a period of time. And we want to focus on the solutions, rather than focus on who's to blame."

To be truly effective, the goal and solutions will need to be tailored to different regions, and doing so requires data.

So how does one begin to think about closing these gaps in health and health care? Well, we all need a starting point. And to illustrate one such starting point, let me ask a question: How does the amputation rate for Hispanic patients compare?

And the answer is, we don't know. The processing of Medicare claims, which leads to the database that supplies the information for the Dartmouth analysis, does not yield this

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[1] See "Disparities in Health and Health Care Among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project," at http://www.rwjf.org/files/research/dartmouthexecutivesummary.pdfhttp://www.rwjf.org/files/research/dartmouthexecutivesummary.pdf

information. The data tells us only about black-white differences in care, not what is happening with the quality of care for Hispanic or Latino Americans, Asian-Americans, or Native Americans.

The Health Equity and Accountability Act would change that, ensuring the collection of data on both race and ethnicity, as well as on primary language.

The Robert Wood Johnson Foundation has long recognized that data collection on race and ethnicity can be a critical first step to reducing disparities and to improving health for all. We have approached the issue in several stages: We first supported efforts to establish that the collection of such data was legal, a matter that organizations such as the National Health Law Program and the George Washington University Health Information Law Project have since clearly resolved. When conducted as part of a program to improve health care quality, identifying patients' race and ethnicity does not violate federal or state law, or increase the risk of race-based malpractice claims.[2]

Next, we demonstrated that educating patients about why their race and ethnicity matters in the health care context is critical, and that patients agree that collecting that data is acceptable when such data are used to improve health care.[3] Finally, we commissioned the National Academy for Social Insurance to create an expert panel that showed that the Medicare program can do much more to help us reduce inequality in care. The panel made 17 recommendations for how Medicare, using its leverage as the largest purchaser and regulator of health care, could play a

[2] See http://www.rwjf.org/pr/product.jsp?id=21878
[3] See "Key Findings Among a National Survey Conducted Among Adults With Health Insurance," http://www.rwjf.org/pr/product.jsp?id=15783http://www.rwjf.org/pr/product.jsp?id=15783

leading role in five different areas, including the standardization of racial and ethnic data collection.[4]

However, data collection is the first step. We also have to show that health care organizations serving high numbers of minority patients can improve care. And we're seeing that they can.

In 2005, the Foundation launched a program called *Expecting Success: Excellence in Cardiac Care*. This program was specifically aimed at improving cardiac care for minority patients in hospitals. Why did we choose cardiac care? Treatment for heart disease represents an area where the evidence of racial and ethnic gaps is strong, both in care and outcomes. Heart disease is a leading killer of African Americans. And cardiac care is an area of medicine where the standards of care are well-established.

There were a range of hospitals participating – ranging from smaller safety-net hospitals to some well-known academic medical centers. Many of the hospitals were surprised to see stark gaps in the level of care they were providing to different patients.

Most physicians think that they're providing great care to all patients, but the data often show a very different picture. For example, one Expecting Success hospital found that 83 percent of non-Hispanic patients were receiving discharge instructions after a cardiac episode, compared to 66 percent of Hispanic patients. To address that disparity, first, they instituted some training

[4] See http://www.nasi.org/usr_doc/Strengthening_Medicare's_Role.pdf

procedures among hospital staff to ensure that the discharge instructions were given out. Second, they made sure that the materials were available in Spanish.

These steps are seemingly so straightforward and simple—measure the quality of care delivered in each group, implement interventions designed to improve the quality of care for each group, and measure again. Through this process, the Expecting Success hospitals made impressive progress: at one hospital, the rate of providing proper discharge instructions soared from 74 percent to 98 percent, and counseling for smoking cessation jumped from 76 percent to 92 percent. But without the data collection that identified the disparity in the first place, this hospital would not have known where to target its efforts to improve.

Much of what we continue to learn about reducing disparities on all fronts will be applied in what is the Foundation's biggest effort to date to improve the quality of health care for all Americans, *Aligning Forces for Quality. Aligning Forces,* which aims to lift the overall quality of care in targeted communities and, at the same time, close racial and ethnic gaps. The initiative aligns the key players and market forces within 14 geographic regions across the U.S., representing about 11 percent of the nation's population. I'm pleased that the legislation before you today would provide grants for similar work in communities with high minority populations.

The 14 *Aligning Forces* community teams have already committed to measuring and publicly reporting on health care by the end of the year 2009, and are now also committing to collecting patient data by race and ethnicity.

This regional approach is critical to reducing disparities because, like any quality problem, disparities do not look the same everywhere. In some areas, as the recent research we commissioned from Dartmouth shows, black Medicare patients received equal to or better care than white patients, but the overall quality of health care was poor for everyone. And in many instances, as the leg amputation data suggest, the quality of care for black patients is still far worse, with tragic consequences.

Collection and reporting of race and ethnicity data are essential to reducing disparities. Another essential step is increasing the quality and availability of health care language services for patients with limited English proficiency.

Poor communication can lead to devastating, even deadly consequences for patients. With nearly 20% of the nation's population speaking a language other than English at home, our health care system needs to do a better job of ensuring that all patients, regardless of the language they speak and understand, receive high-quality, culturally competent care.

The Health Equity and Accountability Act will not only support standards for language services, but also provide additional research on the barriers, cost-effectiveness and best practices for delivering language services.

These are serious and ongoing issues, and we believe that fixing the problems of health and health care disparities by focusing on any one cause just won't work, and that there is no single solution to the persistent problems of disparities. The Health Equity and Accountability Act takes

a broad view and targets a number of approaches for reducing racial and ethnic disparities that together will make tremendous strides toward closing the gap. We look forward to working as partners on the same path to improving health and health care for all Americans.

Thank you for your attention to this issue and for the opportunity to testify today.

Mr. PALLONE. Thank you, Doctor. Dr. Edwards.

STATEMENT OF JAMES R. EDWARDS, JR., ADJUNCT FELLOW, HUDSON INSTITUTE

Mr. EDWARDS. Thank you, Mr. Chairman, and thank you for the opportunity to comment on H.R. 3014. Because of time limitations I will focus my remarks on Section 503. This section lets States provide Medicaid to what could be termed an unartfully described class. It extends eligibility to, quote, "undocumented residents who are lawfully residing in the United States." That description is kind of curious, since the Federal Government issues documents to every legal immigrant and non-immigrant visa holder, or requires them to have a valid visa with an entry stamp. This new category is vague and therefore prone to abuse.

Who would be covered under this description? It seems to describe one-time illegal aliens who have managed to delay their removal. "Undocumented resident" is a term usually referring to illegal aliens. They have no valid document authorizing their presence in the United States. Illegal aliens delay or avoid deportation by requesting formal removal proceedings or by filing an application to adjust their status to lawful permanent resident, a non-immigrant category, or asylum. Since aliens can't be deported until final determination in their formal removal process, adjustment application or asylum claim, it could be argued that these aliens are technically "lawfully residing in the United States."

Welfare reform barred non-immigrants, that is, temporary visa holders, and illegal aliens from means-tested programs, including Medicaid. So, H.R. 3014 loosens the qualifications for people under the definition above of questionable legality. This would seem unfair to lawful immigrants who abided by the law to get here and must rely on their sponsor for their financial well-being. Green card holders are barred from Medicaid for 5 years, as both they and their sponsors agreed in a legally binding affidavit of support. This section also explicitly exempts "any sponsor" of these "undocumented residents" from their liability to repay the medical cost imposed on the public. This financial liability is sworn, legally enforceable debt that was willingly agreed to. So, this section goes backwards on the principle of individual responsibility.

If a legalization bill were to pass, then under this definition in this section, it might multiply greatly the number of beneficiaries. Under every recent amnesty plan illegal aliens would receive some sort of interim status while waiting for longer term documentation. They would now be "lawfully residing in the United States." The consequences and costs and impact on medical resources would be serious.

Also, Section 503 could potentially spur fraud and abuse. The bill's flimsy description of who qualifies adds an incentive to enter or remain in the country illegally, to perpetrate immigration benefit fraud or both. Immigration benefits fraud is already rampant. It costs American taxpayers and it adds to the already lengthy time that law-abiding immigrants must wait for visas. This provision diminishes a principle whose essence is promoting individual responsibility and self sufficiency. It is called public charge doctrine. A public charge is someone who cannot or will not support himself.

Since the 17th century, colonies, then States and Federal Law have excluded foreigners likely to depend on the public's resources. They have required ship's manifests to be given up front. They have required posting bond for potential public charges or even returning passengers at the ship's captain's expense. Immigrants have normally been held to the standard of self sufficiency that we expect of our fellow Americans. The 1996 Immigration and Welfare Reforms were true to that standard.

This bill shouldn't move without coupling it with at least one of a couple of other bills that would help mitigate the potential harm of the bill in question today. Ranking Member Deal's H.R. 1940, the Birthright Citizenship Act, would end automatic U.S. citizenship to the newborns of illegal aliens. The other bill, H.R. 938, is the Nuclear Family Priority Act. It would enact the recommendations of the Barbara Jordan Commission. It would eliminate chain migration visas and place priority on reunifying spouses and minor children. In summary, H.R. 3014 may be well intentioned, most of us would like to see reductions in health disparities and expansion of health information technology, but it needs some work at this point.

[The prepared statement of Mr. Edwards follows:]

STATEMENT OF JAMES R. EDWARDS, JR.

Thank you for the opportunity to comment on H.R. 3014, the Health Equity and Accountability Act. This is wide-reaching legislation and perhaps overly ambitious, given that some of its proposals are likely to reap untold consequences. This bill falls at the intersection of welfare, health care, and immigration policy. Any one of these is difficult to craft prudently and responsibly, so as to minimize adverse effects. Attempting to delve into all three policy areas at once could well prove risky.

I will focus my remarks on Section 503 of this bill, as well as translation provisions. I will place the first section in broader, historical context.

This section would amend both Medicaid and the State Children's Health Insurance Program statutes. States could opt to provide medical care through Medicaid to an unartfully described class. Waiving the 1996 Welfare Reform Act's bar on immigrant eligibility for taxpayer-funded welfare programs, in this case Medicaid, this bill extends this entitlement eligibility to "undocumented residents who are lawfully residing in the United States." For anyone involved in immigration policy, that description is curious, to say the least, since every legal immigrant and nonimmigrant visa holder is either issued documents by the Federal Government or required to possess a valid visa with an entry stamp. This new category is unacceptably vague and, therefore, dangerously abuse-prone.

Who is this curious group? It would seem a description of one-time illegal aliens who have managed to secure an interest in a bureaucratic process, which delays their removal. As you know, "undocumented alien" or "undocumented resident" usually is a euphemism for illegal alien. This could be someone who unlawfully crossed the border or who arrived on a valid, temporary visa and never left when the visa expired. Thus, such people would be "undocumented"—they have no valid immigration or other document authorizing their presence in the United States. Illegal aliens may seek to delay or avoid deportation or prosecution by requesting formal removal proceedings rather than voluntary departure, or by filing an application to adjust their status to some other category, such as lawful permanent residence (a "green card"), one of the many temporary nonimmigrant categories, or asylum. Since aliens may not be deported until their formal removal, adjustment application, or asylum claim is processed and a final determination is made, it could be argued that these aliens are technically "lawfully residing in the United States." Without further clarification, however, this category is open to interpretation.

The Medicaid expansion further specifies that welfare eligibility is to be extended to "pregnant women," during and for 2 months following the term of their pregnancy. It should be noted that HHS regulations on SCHIP issued in 2002 already provide for prenatal care to fetuses of illegal aliens; so, the care is already available to unborn babies and their pregnant mothers, and this provision is unnecessary.

This bill also qualifies "children" under age 21, which would include people old enough to drive, to vote, in many states to drink alcohol, and to enlist in the military.

It is important to note that welfare reform barred nonimmigrants (or holders of temporary visas) and illegal aliens from means-tested programs, including Medicaid. So, H.R. 3014 rolls back welfare reform by loosening up the qualifications for people of highly questionable legality. This seems fundamentally unfair to lawful immigrants, who abided by the law to get here and must rely on their sponsor, not the government or the American taxpayer, for their financial well-being. Green card holders are barred from Medicaid for five years, as both they and their sponsors agreed in a legally binding affidavit of support. The exception written in this section seems to take the guise of "compassion" to mask unfairness—toward working Americans, taxpayers, and lawful immigrants.

The next provision of this section explicitly exempts "any sponsor" of these "undocumented residents" from their liability to repay the medical costs these people will impose on the public treasury. This financial liability is sworn, legally enforceable debt willingly agreed to as a condition of the American people's generosity in allowing sponsored aliens the privilege of residing in our Nation. This bill undermines the clear principles of individual responsibility and balance that welfare reform put into place.

Importantly, if any legalization bill were to pass, it would apparently multiply greatly the number of people who would qualify under this poorly worded eligibility category. Under every major amnesty plan discussed in the past several years, illegal aliens would receive some sort of interim status while waiting for longer term documentation. This would mean these "undocumented" residents were now "lawfully residing in the United States." The consequences, the costs, the impact of added demand on scarce medical resources in every locality would be serious.

Another important concern with regard to Section 503 is the incentive for fraud and abuse that it creates. The flimsy description of who qualifies for Medicaid adds yet another incentive to enter or remain in the country illegally, to perpetrate what is known as "immigration benefits fraud," or both. Immigration benefits fraud is one of the most unsung, but heavily abused areas where our immigration laws are broken. It results in additional costs to American taxpayers, and it adds to the already lengthy times that law-abiding immigrants and nonimmigrants must wait to receive their visas, since it diverts personnel and resources at U.S. Citizenship and Immigration Services (USCIS). This provision compounds that problem and would likely lead to more of this fraud.

Given the uncertainty in and open-ended nature of the description of who would qualify under H.R. 3014 Section 503, it is hazardous to guess how much this provision will cost taxpayers. A provision similar to this section was in the CHAMP Act, H.R. 3162. It extended Medicaid and SCHIP coverage to lawfully permanent resident pregnant women and children up to age 19. The Congressional Budget Office scored that provision, Section 132, at $2.2 billion over 10 years. The state spending that provision would require nearly doubled the cost. Four billion dollars is a significant amount. One would expect costs at least as great, if not greater, than CHAMP. I would urge lawmakers to question the advisability of extending any entitlement program, such as Medicaid. Such is an open-ended commitment. At a time when entitlement programs—Medicare, Medicaid, and Social Security—careen on a course of fiscal unsustainability and overwhelming debt, would it not seem fiscally irresponsible to compound the unfunded liability exposure? Rather, prudence would dictate reducing financial liability and narrowing program eligibility.

Stepping back a bit, this provision, and other parts of the bill, diminishes one of the oldest, central principles of American immigration law—a principle whose essence is promoting individual responsibility and self-sufficiency: public charge doctrine.

A "public charge" is someone who cannot or will not support himself and instead is reliant on society. Massachusetts adopted the earliest American public charge laws, in 1645. The colonies protected themselves against public charges by excluding, or refusing to allow to settle, people who were regarded as likely to become dependent on the public's resources. Colonies required arriving ships to provide the list of passengers or required that ship captains post bonds for potential public charges. Otherwise, the ship had to return the "lame, impotent, or infirm" passengers "incapable of maintaining themselves." These types of colonial laws were incorporated as state laws following American independence. Over time, as Congress became more active in making immigration policy, Congress and states acted concurrently to bar likely public charges or to deport immigrants who became public charges. By the late 19th century, Congress took on the responsibility of setting immigration policy, and promptly enacted in the 1882 Immigration Act the exclusion

of any immigrant "unable to take care of himself or herself without becoming a public charge."

The reason for such a "tough love" standard is compassion, properly understood, toward the native-born and capable immigrants. They must work harder, pay more taxes (or health insurance premiums), etc., to subsidize people who otherwise would not live here; it is the same as Captain John Smith's "tough love" rule in Jamestown, Virginia, that those new arrivals who were not willing to work and pull their weight were excluded from meals.

This section of H.R. 3014 swims against the stream of our history. It weakens public charge doctrine. It diminishes the concept that America is the land of opportunity for those we, the American people, decide to admit. We have traditionally rejected the idea that Americans should have to accept all comers or materially support immigrants. No, immigrants have normally been held to the standard of self-reliance that we expect of our fellow Americans.

The 1996 immigration law (Public Law 104 09208) and welfare reform (Public Law 104 09193) remained true to and strengthened that venerable standard. These laws required: most immigrants, relationally based and employment-based accompanying family members, must secure an affidavit of support from the sponsor. The affidavit of support, which a sponsor signs accepting financial responsibility for an immigration applicant, became legally binding. Sponsor income must be at least 125 percent of the federal poverty line. All sponsor income is "deemed" as available to the immigrant. Government agencies could seek reimbursement of the costs the sponsored alien imposes on the taxpayer, until the sponsored alien naturalizes or has established a 10-year work history. The legislation that is the subject of this hearing substitutes an opposite standard.

Briefly please allow me to touch on the bill's translation provisions. First, Medicaid already covers translator services. So, this appears an unnecessary addition. Second, there could be unintended consequences. Medicaid already provides very low provider reimbursements, less than actual costs. Thus, in certain locations Medicaid has difficulty attracting doctors to see Medicaid patients. Adding translation mandates could force more providers to decline acceptance of new Medicaid patients.

The American Medical Association has voiced this very concern, the reduction of access due to government-mandated translation services:

. . . It is extremely inequitable to require physicians to fund written and oral interpretation services. The cost of hiring an interpreter, which our state survey shows can greatly vary between $30 and $400, is significantly higher than the payment for a Medicaid office visit, which in many states ranges between $30 and $50. Physicians would sustain severe economic losses if forced to cover the cost of interpretation services and thus may no longer be able to provide services to LEP [limited English proficient] patients. Indeed, AMA data shows that two-thirds of physician offices are small business. If a business, especially a small business, continues to lose revenue and begins to operate on a negative balance sheet, the business cannot be maintained.

The AMA noted the cost differential between the costs doctors bear and revenue from Medicaid, the difficulty finding interpreters in many states, and impracticalities such as cancelled appointments where arrangements were made to secure an interpreter (who still expects to be paid for his or her time). The potential for these kinds of factors do not seem to have been fully contemplated in H.R. 3014.

Further, Section 101 translation provisions effectively codify Executive Order 13166. This very controversial order directs every Federal agency to provide "access to federally conducted or federally assisted programs for persons who, as a result of national origin, are limited in their English proficiency." Executive Order 13166 amounts to an unfunded mandate on hospitals, public health clinics, and health care providers who receive federal funds. Also, the government uses a highly suspect definition of "limited English proficient," which can unnecessarily escalate the costs to taxpayers. The definition should generally be fixed so interpreter and multilingual materials mandates apply only in common-sense ways and only assist those who in fact do not speak English "very well." The other impact of these policies is to work against assimilation. They cool the melting pot, whereby people from other lands learn to speak English, adopt American political virtues, and become, in Lincoln's words, "blood of the blood, and flesh of the flesh of the men who wrote that Declaration [of Independence]."

Should the committee choose to move this legislation, in addition to addressing the matters I have raised, the bill should not be enacted without coupling it with at least one of two other bills. Either of these other bills would mitigate the potential harm caused by H.R. 3014. Ranking Member Deal's H.R. 1940, the Birthright Citizenship Act, would eliminate the incentive some illegal aliens have of birthing

their offspring in the United States. The policy of granting automatic U.S. citizenship to the "anchor baby" effectively foils the parent's deportation, qualifies the illegal parent to derive benefits accorded to the newborn based on his or her citizenship, and allows that illegal alien to begin his own chain of relatives once the citizen child turns 21. The child can sponsor the illegal alien mother, as well as extended relatives. Ending automatic citizenship on account of birth here would help alleviate this abuse. The other bill that should accompany this legislation is H.R. 938, the Nuclear Family Priority Act. Congressman Gingrey's bill would enact the recommendations of the Barbara Jordan Commission. It would eliminate extended relative visa categories (chain migration visas), instead placing priority on the nuclear family's reunification: spouses and minor children. Without one or both of these bills as counterbalance, H.R. 3014 should not move at all.

In summary, in 1996, a Democratic President and a Republican Congress came to agreement on landmark immigration and welfare reform legislation. That bipartisan accomplishment was not easy. Sadly, H.R. 3014 seems to fall short of that model. This bill may be well intentioned—most of us would like to see reductions in disparities in the health of minorities and other demographic subgroups, expansion of the reach of health information technology, especially to rural areas, and so forth. But H.R. 3014 goes about it in certain ways that are more divisive than unifying.

# # #

Mr. PALLONE. Thank you Dr. Edwards. Dr. Akhter.

STATEMENT OF MOHAMMAD N. AKHTER, M.D., M.P.H., EXECUTIVE DIRECTOR, NATIONAL MEDICAL ASSOCIATION

Dr. AKHTER. Thank you, Mr. Chairman, members of the Committee. It is an honor to appear before you. My name is Mohammad Akhter. I am Executive Director of the National Medical Association. The National Medical Association is an organization of African American physicians, 30,000 of them strong, in this country, serving the minority communities all over the United States. This issue is very important to us. In addition to myself, the President of the National Medical Association, Dr. Nelson Adams, is also in the audience because we believe that over the 200 years history—plus history of this Nation, our community has suffered the most from health disparities. Our people have been dying much younger than the others. Our people suffer from many more chronic diseases than others, so this is a very timely bill. This is to be commended, Mr. Chairman, members of the Committee, for having this bill at this particular time so that we could have the discussion and debate to move this country forward.

I would like to make four basic observations about the bill, why this bill is so timely and so important. The first thing is that this bill requires the data collection. If we are not collecting the data, we don't know what the problem is. If we are not collecting it by race, we are not collecting it by language, we just don't know what the problem is. We can't design the right programs, we can't evaluate the success of the program to see if the program is going in the right direction. So, the first and fundamental thing is to really continue to have a system in place that monitors and evaluates the program and health of our people.

The second thing that this bill does, it strengthens the government agencies that are already involved in elimination of health disparities. As is very evident that we can see, Dr. Garth Graham testified before us and so did Dr. Ruffin that these agencies need

to be strengthened because their work is incomplete. They have a lot more work that needs to be done and in addition, other government agencies such as CDC, the Social Security Administration and others need to participate in this effort to really start to collect the data so we could have a Nation where we know what is going on in terms of the health status of our people.

The third issue that we like this thing is particularly because it provides and improves the health services to the people. Lack of access to care and poor quality of care are two big elements in creating disparities. In many cases we know about the African American community. One out of every four African Americans is uninsured. One out of every three Hispanic Americans is uninsured. They don't have access to care and if we can improve the access to care and improve the quality of care that the people receive it will go a long way in eliminating the disparities.

And, finally, the last issue deals with the workforce. Hispanic community and African American community people of color constitute 25 percent of all Americans, but we have only 6 percent of the Nation's doctors. Many studies have shown that when the doctors speak the same language, when the doctor is familiar with the culture of the patient, there is better patient-physician communication. There is better relationship. There is better compliance. There is better acceptance of the treatment. Patients get well soon and these are very important things. If we can't do that, then we need to have cultural competency so that the other providers become aware of other patients' cultures and provide them with appropriate treatment. This bill provides for creating the cultural competency and providing the good care.

And, finally, as an immigrant, I will tell you, America is all about the future. Somebody did such wonderful work that we are enjoying the fruit today. In a globalized marketplace the people who are going to succeed are the folks who have the best educated and the best, healthiest people around. If we continue not paying attention to the health disparities, and these health disparities continue to persist, we are going to have workers by 2050, the majority of the workers are going to be the people that we call today, minorities. With sick people, we can't compete in the work marketplace, and that will seriously threaten the strength of the United States of America as a Nation and will really threaten, also, our lifestyle that we are used to. So, Mr. Chairman, members of the Committee, I beg you, I urge you this is a timely thing for us to do as a Nation, to take action so all Americans could have the equal right to health, life, liberty, and happiness. Thank you, very much and appreciate it.

[The prepared statement of Dr. Akhter follows:]

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24 June 2008

Congressional Testimony
Mohammad N. Akhter, M.D., M.P.H.

Presented before the Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Addressing Disparities in Health and Healthcare:
The Merits of the Health Equity and Accountability Act of 2007 (H.R. 3014)

Mr. Chairman, distinguished members of the Committee, distinguished panelists, fellow citizens – good morning. I am humbled by the privilege of appearing before you today.

As we affirmed before the Health Subcommittee of the Committee on Ways and Means two weeks ago, disparities in health and healthcare remain the primary reason the National Medical Association (NMA) has stayed in business.

At that hearing, we outlined the context for our continuing work in this area, and it is illustrative to reiterate those highlights before this audience. Our reasoning is twofold. First, said context will be unfamiliar to some in this audience. Second, and perhaps more importantly, it would explain our support for the **Health Equity and Accountability Act of 2007 (H.R. 3014),** and all related legislation currently under consideration in the Congress.

NMA Has Always Been Concerned About Disparities

NMA has been responding to inequities in healthcare throughout its 112-year history. In the summer of 1963, the NMA's House of Delegates wrote a letter to President Kennedy advocating the institution of a Federal program devoted to the healthcare of America's elderly. In most cases, these seniors had no advocate to articulate their increasing need for care as their health status declined. This was a disparity our members could ill afford to ignore.

Amidst strident opposition from voices much louder than ours, the entitlement we now know as Medicare would be signed into law two years later. Our conviction had paid off! Elderly and disabled Americans could now be enrolled in a program into which they would contribute in their most productive years, and reap the benefits in their twilight years.

Early Advocate for Medicare

Medicare is now in crisis for a variety of reasons, not the least of which is a growing access problem due to reimbursements to the physicians who sacrificially serve Medicare beneficiaries. If the 10.6% pay cut under Medicare goes through on schedule next week, many of our members will limit the number of seniors they can see on a daily basis. The predictable exacerbation of health disparities among minority seniors, especially African American seniors, is preventable. The reimbursement problem must be fixed. We urge members of the Committee to be attentive as the debate on this issue continues this week, and vote in favor of allowing seniors to maintain access to their doctors, their medicines, and all other equipment necessary for them to thrive.

The National Health Disparities Report

Toward the end of the last century, we advocated for an independent report on health disparities in America. In March of 2002 these independent experts convened by the Institute of Medicine (by federal mandate) told the nation what NMA had been saying for more than a hundred years – **disparities exist, and unless we commit to reducing or eliminating them they will persist, indefinitely**. Entitled *Unequal Treatment*, this seminal publication is now the gold standard in disparities research. For the purpose of this hearing, the most important legacy of Unequal Treatment is the recommendation that led to the *National Health Disparities Report* (NHDR), an appropriate report card on how well America is faring in reducing or eliminating disparities in health and healthcare.

The 2007 edition of the National Health Disparities Report rendered the following (sober) verdict:

- Overall, disparities in health care are not getting smaller;
- Progress is being made, but many of the biggest gaps in quality have not been reduced;
- Lack of insurance remains a major barrier to reducing disparities.

We submit that lasting reform that would reduce (and reverse) the inequities that have long preoccupied our members would require the following key considerations.

Coverage – unless all Americans have access to healthcare of the highest quality, tens of millions will continue to depend on emergency rooms as their first line of defense. This scenario, by definition, exacerbates disparities. Ambulances are turned away hundreds of times a day all over America because emergency departments have no other way of dealing with overcrowding. That could one day be one of you, ladies and gentlemen, your premium health coverage notwithstanding.

The following statistics provide some context relative to the coverage problem:

- Among Blacks (12% of the general population), 57% were privately insured, 18% were on Medicaid/public programs, and 26% were uninsured *(Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis, March 2007)*;
- Among adults aged 19-64 who are uninsured:
    - 54% reported no regular source of care
    - 26% postponed seeking care due to cost

- 23% needed care but did not get it
- 23% could not afford prescription drugs *(Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data).*

Prevention – prevention is always better than cure. All the arguments that "we cannot justify spending money upfront because we can't afford it" ignore back end costs for which we may not have the resources when the time comes. The Medicare trustees have warned us of the dwindling resources in the program – it will be a tragedy if we have no Plan B when the money runs out.

The following data should raise an appropriate alarm:

- Total national spending on public and private health care amounted to approximately $2 trillion during 2005, of which more than 75% went toward treatment of chronic disease. *(Partnership to Fight Chronic Disease, CDC);*
- Eliminating, poor diet, inactivity, and smoking – would prevent:
  - 80% of heart disease and stroke
  - 80% of type 2 diabetes
  - 40% of cancer *(CDC)*;
- Direct medical costs associated with physical inactivity totaled nearly $76.6 billion in 2000 *(CDC).*

Coordination of Care – many seniors have to deal with co-morbidities, meaning that they are forced to see multiple providers and visit multiple facilities to manage multiple diseases. This is especially true of those seniors from minority populations, and exacerbates rather than reduces disparities.

A November 2007 study from Johns Hopkins University showed that among 'Non-White' U.S. adults with chronic disease:

- 32% received conflicting advice (from providers);
- 25% received duplicate tests;
- 25% were given duplicate prescriptions *(Partnership to Fight Chronic Disease: Almanac of Chronic Disease, 2008).*

Needless to say these realities would be untenable in any population, but seniors are among the most vulnerable. Their contribution to the Medicare system during their working lives should entitle them to an infrastructure that does not fail them in their hour of need.

Workforce Diversity – as *Baby Boomers* age their need for medical care grows. The providers who will deliver this care in minority communities need to be available, and well trained. The programs that would train these professionals are an endangered species, and unless we defend these programs, disparities in those communities will get worse. Our need to fully fund these programs has never been greater.

The Association of American Medical Colleges (AAMC) can shed some light on the gravity of this challenge. For instance:

- In 2004, Black physicians made up **3.3%** (30,598) of physician population;

- The overwhelming majority of physicians graduating from U.S. allopathic medical schools are White. Blacks, Hispanics/Latinos, and Native Americans comprise only 6.4% of all physicians graduating from U.S. allopathic medical schools;
- Diversity in the physician workforce contributes to increased access to health care for the underserved, increased satisfaction in patient care, and expanded options for patient care *(American Medical Colleges Diversity in the Physician Workforce: Facts & Figures 2006).*

Cultural Competency – even in some of our nation's finest health care institutions, many minorities feel they are not well treated, either because the provider does not speak their language or because the provider does not fully understand their concerns. The result is poor communication that often leads to inaccurate diagnoses, poorly designed treatment plans, and poor compliance by the patient. This combination of factors costs the system multiple billions every year.

H.R. 3014 AND RELATED LEGISLATION

In view of the foregoing, NMA is eager to collaborate with the Congress on all pieces of legislation seeking to improve the health status of minority communities and vulnerable populations. H.R. 3014 is one such vehicle.

In the interest of full disclosure, we have also endorsed the Minority Health Improvement and Health Disparity Elimination Act, S. 1576, sponsored by Senator Edward Kennedy. As you know, S. 1576 has a companion bill here in the House, H.R. 3333, introduced by Congressman Jesse Jackson, Jr.

The following provisions of H.R. 3014 are of particular interest to the NMA:

- Provide for health care workforce diversity activities, including:
  - (1) a technical clearinghouse on health workforce diversity; and
  - (2) Regional Minority Centers of Excellence Programs.
- Require the Department of Health and Human Services (HHS) to collect data on race, ethnicity, and primary language.
- Establish the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care.

As minority physicians, we remain concerned that there may not be enough health care providers in America to serve vulnerable populations as the demographics of our nation continue to change in the next three decades. Any effort to keep the 'pipeline' well oiled will find an advocate in our organization.

Further, we have embarked on a Cultural Competency initiative at the NMA that we hope will be a great service to our nation in the coming years. We will be happy to elaborate on this program during the question and answer period.

All our efforts are futile however if we do not have an efficient way to measure progress. The NHDR is a great step forward, but HHS' ability to collect data on race, ethnicity, and primary language across the board is fundamental to reducing or eliminating disparities in health and

health care. We look forward to the discussion about this provision, and its implications for the America our children and grandchildren will inherit long after we have exited the national stage.

Taking the Long View

Our nation has changed since those days when most of the American population was of European descent, and the life expectancy was less than 50 years. The sick-care system designed for that era has run its course. Reform may be all we can handle now, but transformation is really what the system requires.

Maintaining America's leadership in the global economy requires the healthiest and best-educated workforce. By 2050, the majority of this workforce will be made up of populations we currently refer to as minority. If the disparities we are discussing today persist until then, the strength of our nation will be undermined, and our standards of living in mortal danger. We must take bold action now.

Thank you once again, Mr. Chairman, for the opportunity to testify. The National Medical Association, and its constituency of 30,000 physicians and tens of millions of underserved patients, stand ready to assist you and the new administration as we move toward a more efficient healthcare system.

# # #

Mr. PALLONE. Thank you, Doctor. Before we move forward, we are not going to be able to—we will try to go to as many of you as you can, but that was the bell for the Medicare Physicians Reimbursement bill, to vote. So, we may be able to do a couple more and then we will have to break and go vote and come back, just so you know. Dr. Satel.

STATEMENT OF SALLY SATEL, M.D., AMERICAN ENTERPRISE INSTITUTE

Dr. SATEL. Thank you Chairman Pallone, Representative Deal, other distinguished members. My name is Sally Satel. I am at the American Enterprise Institute, as you mentioned. I am also a staff psychiatrist at the Oasis Drug Treatment Clinic in northeast Washington, D.C.

The point I would like to emphasize today is that efforts to improve the health of minorities will be most successful when they target the factors associated with socioeconomic disadvantage in general. And also, that such disadvantage is not limited to racial and ethnic groups. It applies to all Americans living at the lower reaches of the socioeconomic ladder. Living there has meaningful implications for one's health. The most obvious, of course, being access to treatment services, but that is certainly not enough. We must also work on factors that impede the capacity of patients to get the most out of the healthcare system once they enter it.

And the key here is engagement, and I see that as a theme running through H.R. 3014. What do I mean by that? Well, some aspects are obvious. Patients won't be engaged if they can't communicate with their providers. This level, naturally, entails language and interpreter services, a big part of the bill. But it also entails several other things. For example, it is very important to establish continuity of care with the same clinician. Patients who see the same doctor, visit to visit, have an opportunity to establish rapport, which in turn leads to better adherence with treatment and conscientiousness about self care.

A 2006 Commonwealth Fund Survey found those adults who have a stable healthcare setting that provides them with timely, well organized care and enhanced access to providers is a setting in which racial and ethnic disparities and access and quality are reduced or even eliminated.

In addition to the importance of continuity of care is the aspect of simply having enough time with one's doctor. I happen to work in a clinic where it is quite amazing. I can spend as much time with my patients as I want, but that is because we don't take government funding, and the standard 15 minutes, which most doctors spend, is simply not enough to elicit concerns, including complaints about side effects, a big reason why compliance is often bad, the patients needs and values and preferences. A 1994 Harris Pole, also for the Commonwealth Fund, actually one of the largest, most detailed, and most ethnically diverse surveys I have ever seen, asked patients what the main complaint—they surveyed eight ethnic groups and what was their main complaint about getting care and it was their physicians failure to spend enough time with them. And, of course, as you know, Medicare and Medicaid reimbursement create disincentives against those kinds of rich clinical

encounters. Codes might be expanded to pay for a decent rate for what we call cognitive and evaluative services to save money down the line. Phone calls to patients between visits, home visits by nurses, this kind of thing. Other many useful accommodations are simple but so important: night hours, child care on-site, patient navigators, things like this.

But accessibility and engagement are not ends in and of them selves. They are means to empower patients to become involved with their own self-management, and I worry that there is not enough emphasis on the responsibility that patients have to take, as well. Especially those with diabetes, hypertension, asthma, cardiovascular disease, it is very hard to manage yourself when you are poor. The grind of daily stresses without a financial cushion and everything that comes with the chaotic lifestyle that so many of my patients have, makes it very hard to watch your diet and exercise and check your blood glucose, but many patients also want to participate if we can make those kinds of activities available to them.

I will just give two examples. Vanderbilt University has an expert in rheumatoid diseases that has a self-help course for patients with rheumatoid arthritis. It has led to reduction in pain and medication and physician visits that resulted in a savings that were 10 times the cost of that course itself. Another example and examples of collaboration between communities and their resources within communities are so important. For example, there is a local community health center in Massachusetts that has paired with the local YMCA to enable patients with diabetes to exercise with a resulted improvement in diabetes control. These examples illustrate why more decentralized neighborhood-based care will be the most responsive to needs of specific communities. The staff will be drawn from those communities, speak the language, they will know the culture, and this is an organic way of achieving a more accommodating and culturally compatible health service.

In closing, reducing health differentials between racial and ethnic groups depends, of course, on improved access to care, quality of care, and most relevant, in my view, to today's hearing: patient's capacity for self care. This depends upon strengthening their engagement in treatment and this is a strategy that applies to all underserved and low-income Americans, irrespective of race and ethnicity. Thank you, so much.

[The prepared statement of Dr. Satel follows:]

STATEMENT OF SALLY SATEL

Chairman Pallone, Representative Deal, and distinguished members of the Committee, my name is Sally Satel. I am a resident scholar at the American Enterprise Institute and a lecturer at Yale University School of Medicine. I also serve as the staff psychiatrist at the Oasis Drug Treatment Clinic in northeast Washington D.C.

Thank you for the invitation to present my views on the determinants of health status.

The point I would like to emphasize today is that efforts to improve the health of minorities will be most successful when they target the factors associated with socioeconomic disadvantage that predispose individuals to poor health and suboptimal care. Such disadvantage is not limited to racial or ethnic groups.

Before turning to practical interventions that can be deployed within the health care domain—and, indeed, there are many—it is important to acknowledge that the clinical setting represents only one of many realms that contributes to health. This

recognition helps frame reasonable expectations of interventions that originate at the level of the healthcare system.

SOCIOECONOMIC BASIS OF HEALTH—"UPSTREAM" FACTORS

In a larger, social context it appears that educational attainment is one of the strongest predictors, if not the strongest predictor, of adult health. Failure to complete high school in the United States is associated with a considerably higher likelihood of developing many chronic diseases before the age of 65 years.

Why does education create most of the association between higher social status and higher health status? The mechanisms are complex and not fully understood but scholars generally believe that good education enables children to develop self-control, problem-solving dispositions, and not least, a sense of future. As adults, those who are well-educated feel more in control of their lives; they have more opportunities to obtain decent jobs, jobs with health benefits, more autonomy, and financial security to help cushion setbacks. They are better informed about health matters (including new technological innovations) and tend to have a more positive view of the benefits of such interventions. Also, better educated individuals tend to be part of social networks that reinforce their healthy life styles norms.

The elements of "social capital" briefly summarized above serve to motivate individuals to invest in themselves (e.g., to refrain from smoking and excessive alcohol consumption, to exercise, observe diet, make use of preventive and primary care, consume care in a timely manner, and so on. And the healthier people they are, the more energetically they can advance occupationally; the less likely they are to suffer depression). Thus, the benefits of early education are all encompassing and cumulative.

Practically-speaking, quality childhood education—and the family and community circumstances that facilitate it—is not a plausible target for a health committee, but it is nonetheless the best single source of healthier future generations.

Nonetheless, there are interventions that individual physicians can perform during clinical encounters that will make an important, though an inevitably more modest, contribution to improving health outcomes of all patients on the lower reaches of the socioeconomic ladder.

The key to making those interventions work is the ability to engage patients in their care. The initiatives described in H.R. 3014 are targeted at facilitating such engagement through improved patient-clinician communication. Patients who are more engaged in treatment, particularly those with chronic diseases, are more likely to take action in managing their conditions. The end-point measure of true success will be improvement in patient health. This health-promotion approach transcends race and applies to all individuals of lower socioeconomic status.

FACILITATING ENGAGEMENT

Establish continuity of care with same provider—Patients who see the same doctor from visit to visit have the opportunity to establish a rapport with him or her (which, in turn, will lead to better adherence with treatment regiment and conscientiousness about self-care).

The Commonwealth Fund 2006 Health Care Quality Survey finds that when adults have health insurance coverage and a stable health care setting that provides patients with timely, well-organized care, and enhanced access to providers, racial and ethnic disparities in access and quality are reduced or even eliminated.

Expand the average length of the doctor visit—Doctors must be able to spend sufficient time with each patient—more than the standard 15 minutes, at least —in order to elicit patients' concerns (including complaints about side-effects), needs, values, and preferences.

According to a 1994 Harris poll for the Commonwealth Fund—one of the largest, most detailed and most ethnically diverse surveys ever conducted—found that the main complaint of almost all patients, regardless of ethnic or racial group, was the doctors' "failure to spend enough time with me." And of those who were dissatisfied enough to change doctors, only three percent of Asians and two percent of blacks who changed doctors did so on the basis of the physician's race or ethnicity. The most common complaints were "lack of communication," "didn't like him or her," "couldn't diagnose problem," and "didn't trust his or her judgment."

Medicare and Medicaid codes should be expanded to pay (and pay a decent rate) for cognitive, evaluative services including activities such as phone calls to patients between visits and home visits by nurses who will also involve the patients' families in the monitoring process.

Cultural sensibility—Practical accommodations can help health providers care for low-income patients of any race or group. These include translation services and

education of medical staff about local anthropology such as healing customs, dietary patterns, and commonly used remedies.

Take the example of black pediatrician Lynn Smitherman and colleagues, who wrote a 2005 paper in Pediatrics entitled, "Use of Folk Remedies Among Children in an Urban Black Community: Remedies for Fever, Colic and Teething." On a radio show she explained that she wrote the paper because she hadn't heard of any of the remedies-her mother and grandmother did not use any of these treatments with her when she was a child-and assumed that many of her colleagues might not be familiar with them either.

The importance of local customs was made compellingly clear in an account of the...

Perhaps one of the most compelling ethnographic accounts of the diabetes epidemic in East Harlem, New York City (Spanish Harlem) that appeared in the New York Times ("Living at the Epicenter of Diabetes—Defiance and Despair," January 10, 2006). Similarly, many black trainees or physicians may not be any more aware of certain folk beliefs than whites.

Perhaps one of the most compelling ethnographic accounts of the diabetes epidemic in East Harlem, New York City (Spanish Harlem) appeared in the New York Times ("Living at the Epicenter of Diabetes—Defiance and Despair," January 10, 2006).

The reporter quotes a resident of East Harlem saying:

"We've got cultural differences. Here, for a guy to eat a salad, he's a wimp. He'll eat a big portion of rice and beans and chicken. The women can't be chumps, either. A woman can eat a salad but has to eat it on the low. She has to do it quiet. They make fun of you: What are you, a rabbit?"

The article also notes that many people with Type 2 diabetes find it hard to believe they are truly sick until they develop complications (pain, dysfunctional eyesight, infections, etc). Only pain and disability can successfully compete for attention in an overburdened life—and then it is already too late.

Finally, the mere grind of being poor, the overwhelming personal and family and occupational problems, the social disruption and instability, and the lack of safety nets, pushes self-care into the background. The importance of watching one's diet, exercising, checking blood glucose, quitting smoking or drinking, is surpassed by more pressing daily realities. Add to this a higher likelihood of clinical depression, demoralization, and stress in this group and the risk of non-adherence multiplies.

Thus, it is important to create conditions in which clinicians can spend ample time with patients to address lifestyle issues in a cultural context in order to improve adherence with treatment and lifestyle (diet, exercise, etc) for which patients, themselves, bear responsibility as well. Clinic nurses, LPNs, and support staff with whom the physicians work are very likely to share ethnic backgrounds with the patients because they tend to be drawn from the community in which the patients live, as they are in my clinic in the Northeast. To the extent that such commonality plays a role in helping patients engage in self-management, it will enhance the health of minority patients.

These realities strongly suggest that more decentralized and neighborhood-based care will be most responsive to the needs of the under-served community.

Foster health literacy to facilitate adherence with treatment and to facilitate patient self-management and sense of control—A patient's accurate understanding of the nature of his illness and the purpose of various therapies and, perhaps most important, some sense of control over his condition, is essential to self-care and treatment adherence. An important new study from an economist at Columbia University documented that differences in patient self-management trigger a racial mortality gap even when access and treatment for chronic heart failure are equalized. The authors estimate that targeting compliance patterns could reduce the black-white mortality gap by at least two-thirds.

It is important to assume a balance and avoid putting all the emphasis on the clinician. As Theodore Pincus, professor of medicine at Vanderbilt University and expert in rheumatoid disease, has noted, "Emphasis on the predominant role of health professionals rather than patient actions in health outcomes may also distract from powerful health-promoting activities." He describes a self-help course for patients with rheumatoid arthritis that led to a reduction in pain and physician visits, resulting in savings that were 10 times the cost of the course. The patients' improved sense of control over their illness through self-management rather than knowledge or changes in behavior explains the improved outcomes. "Patient education programs directed at reduction of feelings of helplessness and improved self-efficacy may result in considerably greater cost containment and better outcomes in

chronic diseases than do current efforts to restrict medications and visits to specialists," he writes.

Common Sense Local Innovations—Consider other meaningful interventions:

- Educational modules that prepare and coach patients to ask questions and present information about themselves to their doctors;
- Grassroots outreach through black churches, social clubs, and worksites;
- Patient "navigators" to help negotiate the system;
- Clinic night hours/child care on site: a great boon to patients with hourly-wage employment who risk a loss of income, or even their jobs, by taking time off from work for doctors' appointments;
- Active pharmacists who issue reminders, provide education to ensure patients grasp what they need to know; hotlines.

A key element here is that these services need to be reimbursed by Medicare and Medicaid.

Again, it is vital that healthcare systems have the flexibility to respond to the patients they serve. The National Association of Community Health Centers, for instance, offers examples of innovations, including collaboration between a community health center and a local YWCA in Massachusetts which enabled patients with diabetes to exercise (with resultant improvement in diabetic control).

CONCLUSION

Reducing health differentials between racial and ethnic groups depends on improved access to care, quality of care, and—most relevant to today's hearing—patients' capacity for self-care. The latter depends upon strengthening their engagement in treatment, a strategy that applies to all underserved and low-income groups irrespective of race and ethnicity.

Reiterating a point made earlier, it is important to recognize that one of the most powerful determinants of good health is high-quality education. A decent education can instill in children the belief that they can shape their futures, as well as the desire and ability to take an active part in fostering their own good health. Once begun in childhood, these affirmative attributes can last a lifetime, from, say, 8 to 80.

Mr. PALLONE. Thank you Doctor. We are going to have to recess. We have two votes, actually. One is on the Medicare bill and then there is a motion to adjourn, but I understand they are 15 minutes each, so we are talking about maybe between the—maybe a half an hour, or so, before we come back, and unfortunately this is what today is shaping up to be. So, we will stand and recess for about 30 minutes until these votes are completed.

[Recess.]

Mr. PALLONE. We will reconvene. I know we don't have all our witnesses here, but we will start with Mr. Knatt.

STATEMENT OF THEODORE KNATT, M.D., GREATER BATON ROUGE MUSCULOSKELETAL GROUP

Dr. KNATT. Mr. Chairman Pallone, Representative Solis, I want to thank you for having the opportunity to testify before you. My name is Theodore Knatt. I am an orthopedic surgeon practicing in Baton Rouge, Louisiana. I am also the Chairman and cofounder of Greater Baton Rouge Surgical Hospital in Baton Rouge. It is a physician owned facility that was built primarily to provide care for the minority population to improve the quality of care, as well as improve the quality of the working conditions for minority physicians.

Again, I appreciate this opportunity to participate in this hearing on healthcare disparities. I commend Representative Hilda Solis and the 110 other members of Congress who have cosponsored H.R. 3014 for their efforts to draw attention to this nationwide problem and propose solutions to this complex issue. I do not need to intro-

duce—an introduction to the problems of healthcare disparities. It is a daily part of my life as a physician treating minority and low income patients.

While I can't provide any quick fix national solutions, I can discuss what my colleagues and I do, every day, to try and improve the quality of our patient's health and to increase their access to medical and surgical services. We are addressing healthcare disparities one patient at a time. Louisiana, unfortunately, is a textbook case of the problems that lead to healthcare disparities. Many of our citizens are poor and others lack health insurance. Regardless of race, poverty is a key factor in the adequacy of healthcare that individuals receive. Race and ethnic background play a role also. It is no secret that many African Americans do not trust the traditional medical establishment. This is a major reason that we built our hospital. The cultural history of our Hispanic citizens and Native Americans also affect how they respond to mainstream medical care. Too often, patients and physicians are talking past one another.

Another issue, particularly in Louisiana, since the devastation of Hurricane Katrina is the availability of medical care. Hospitals were destroyed in the storm and many have not been rebuilt. Physician's practices were disrupted and doctors were moved away because the patients left. We assisted with their recovery and took in some of those displaced patients and physicians.

Our hospital, Greater Baton Rouge Surgical Hospital, is predominantly owned by African American physicians. Because we are also invested in this hospital, we are motivated to make sure that it is safe, efficient, an economical place to deliver medical care as well as surgical services. Also, because we own the hospital, we have a say in its government, as well as direct control of the care that we are providing. We help to make administrative decisions that are needed in the best interest of the patient. I am proud to say that the National Medical Association is at the forefront fighting for the resolution of healthcare disparity and recognized our facility with the National Merit Award last year.

Prior to our development, I was totally unaware of what difference we could make in assisting with improving healthcare for minorities. We built our hospital to meet the medical and surgical needs of the African American patients in the community where we practice. Although we continue to work at other hospitals, we wanted to create an environment of trust for our patients and give them a sense that they were human beings and not just numbers. Greater Baton Rouge Surgical Hospital accepts all patients regardless of their ability to pay.

Approximately 85 percent of our patients are African Americans, more than 30 percent are on Medicare, about 10 percent are Medicaid, and many of these are children. That number would be even higher if we offered obstetric care. The balance may or may not have health insurance. We don't care. Everyone is seen, everyone is treated. Many of our patients do have good health insurance and could choose almost any other facility in Baton Rouge. However, they come to us. It is our trust factor that I mentioned earlier.

One of the great frustrations we experienced before building this hospital was the fact that we could not provide the kind of medical

and surgical care that we thought our patients needed. All too often, minority patients had multiple medical problems. In addition to needing a hip or knee replacement or repair, they are also overweight, diabetic, and have cardiovascular challenges. Too many surgeons in too many hospitals do not want to treat these patients, so they are told that they are not appropriate for surgery and sent home, where they deteriorate further.

Since building our hospital we have been able to reverse this situation. We have established a close knit group of physicians from many disciplines who work with us to help our patients improve their overall health status. For example, I often see patients in my office who need orthopedic surgery, but the patient is also overweight, hypertensive, and has uncontrolled diabetes. Like it or not, this is the reality of much of minority medicine. I know that this patient is not a good candidate for surgery at this time, but instead of sending him or her away, I develop a plan to improve their health status so that they can eventually get the orthopedic procedure or surgical procedure they need. Through this network of healthcare providers I mentioned, I get the diabetes under control, get the hypertension properly managed.

Mr. PALLONE. Dr. Knatt, if you could summarize, because you are about 30 seconds over.

Dr. KNATT. I appreciate the opportunity to present to you a model that has helped improve the disparity in healthcare in Baton Rouge, Louisiana. Thank you for the opportunity to present my testimony.

[The prepared statement of Dr. Knatt follows:]

STATEMENT OF THEODORE KNATT

Mr. Chairman and Members of the Subcommittee:

My name is Theodore Knatt. I am an orthopedic surgeon practicing in Baton Rouge, LA. I am also Chairman and cofounder of Greater Baton Rouge Surgical Hospital, a physician owned hospital that serves the minority population in our part of Baton Rouge.

I appreciate the opportunity to participate in this hearing on health disparities and H.R. 3014, the Health Equity and Accountability Act of 2007. I commend Representative Hilda Solis and the 110 other Members of Congress who have cosponsored this bill for their efforts to draw attention to this nationwide problem and propose solutions to this complex issue. Health disparities are pervasive in our society, and it is the obligation of all health providers to find ways to reduce them.

This is an effort that will require support from government at every level, active participation from all members of the health care community, and also the efforts of those who currently suffer the consequences of health disparities. If our society creates improved access to medical services, then those in need will have to take advantage of those opportunities. As a physician, I am all too familiar with the problem of patient compliance with the treatment regimen prescribed by their physicians. It is a frustrating part of every doctor's work. All too often we see patients fail to heed the advice and counsel we have provided to them. There is no question that we have to break down artificial barriers to good medical care, but we must also find ways to encourage patients and families to take advantage of what we can offer.

H.R. 3014 proposes ambitious steps to eliminate health disparities. As a practicing physician I am not in a position to predict whether all of them will make a difference. I only know that my daily job is to see that my patients have access to the care they need, when they need it. I cannot eliminate every cause of health disparities, but I can do my best to make sure that my efforts help my patients overcome these barriers to good health.

I do not need an introduction to the problem of health disparities. It is a daily part of my life as a physician treating minority and low income patients. It was part of my life growing up in New Iberia, LA, and one of the important factors that made

me decide to become a physician. While I can't provide any national solutions, I can discuss what my colleagues and I do every day to try to improve the quality of our patients' health and to increase their access to medical and surgical services. We are addressing health disparities one patient at a time. While the Federal Government can play an important role in helping reduce health disparities, unless you can find a way to get that minority, rural, or low-income patient directly connected to a sympathetic health care provider, these barriers to good health will be with us for a long time.

Louisiana unfortunately is a textbook case of the problems that lead to health disparities. Many of our citizens are poor and others lack health insurance. Regardless of race, poverty is a key factor in the adequacy of healthcare that an individual receives. It's not just the inability to pay that causes this. Many people, even though poor, are too proud to take "charity" and wait until the last possible moment before seeking medical help.

Race and ethnic background play a role also. It is no secret that many African Americans do not trust establishment medicine. That is a major reason we built our hospital, as I will explain shortly. The cultural history of our Hispanic citizens and Native Americans also affect how they respond to mainstream medical care. Too often, patient and physician are talking past each other.

Physical barriers, like rivers and lakes, also keep people from getting medical services. Now, that may be hard for the Members of the Subcommittee to understand, since you live and work in a city with excellent public transportation and numerous bridges across the Potomac. In our state, however, there is no public transportation in many areas and water is a significant barrier, particularly if one has to travel many miles to find a way across. I hope as the Subcommittee considers ways to address health disparities, all of you will make a point to see first hand where the people who experience health disparities actually live.

Even if transportation is not an issue, custom and culture play an important role in the way people view mainstream medicine. As a physician trained in the latest orthopedic techniques, I know what modern medicine can do to help people in need. But unless we pay attention to the individual's cultural background, those medical miracles might as well be locked in a closet.

Another issue, particularly in Louisiana since Hurricane Katrina, is the availability of medical care. Hospitals were destroyed in the storm, and many have not been rebuilt. Physician practices were disrupted, and doctors have moved away because their patients moved away. Some areas simply do not have a hospital and no one seems eager to come build one.

I think that H.R. 3014 tries to address many of these issues and I know that all of you want to make progress in reducing health disparities in this country. I understand that legislation is the tool that you have to solve problems facing our society. But that is your job, not mine, so perhaps the most useful thing I can do today is tell you about our hospital in Baton Rouge, why it was built and how we use that facility to reduce barriers to care, one patient at a time.

Our hospital, Greater Baton Rouge Surgical Hospital, is predominantly owned by African American physicians. We are fortunate to share ownership with United Surgical Partners International, Inc. They bring management and financial expertise to our hospital. Most importantly, because they provide essential hospital management, the physicians, investors and non investors, are free to practice medicine and provide care that would not otherwise be available to our community. Because we are also invested in this hospital, we are motivated to make sure that it is a safe, efficient and economical place to deliver medical and surgical care. Also, because we own the hospital and have a say in its governance, we directly control how care is delivered and can make administrative decisions needed for the best patient care. I am proud to say that the National Medical Association has honored our facility with a National Merit Award.

We built our hospital to meet the medical and surgical needs of the African American community where we practiced. Although we continue to work at other hospitals, we wanted to create an environment of trust for our patients and give them a sense that they were human beings, not numbers. One of the major barriers that keep African Americans from seeking medical care is the simple fact that they do not trust establishment hospitals or health care providers who have no sense of their cultural history, preferences or biases. My colleagues and I knew that we could establish trust if we built our own hospital. We have succeeded in building that trust. Many of our patients come long distances to seek care at our facility because they trust us.

Greater Baton Rouge Surgical Hospital has been open for 3 years. We have 10 inpatient beds, four operating rooms and one procedure room. Our physicians perform more than 3,000 procedures annually. Interestingly, non investing physicians

refer more patients that the investors do. They have confidence that their patients will be treated with dignity. We are in the process of expanding our physical plant because of the patient demand, and primary care physicians will be joining with us to work in our clinics so we can expand the array of services we provide. Currently we offer general surgery, gynecology, ophthalmology, spine and hand surgery, and sports medicine. We accept all patients, regardless of their health insurance or economic status. Approximately 85 percent of our patients are African American. More than 30 percent are on Medicare. About 10 percent are Medicaid, and many of these are children. That number would be even higher if we offered obstetrics. The balance may or may not have health insurance. We don't care. Everyone is seen. Many of our patients do have good health insurance and could choose almost any hospital in Baton Rouge. However, they come to us. It is the trust factor that I mentioned earlier.

We have a facility designed to address emergencies that may arise in the course of patient care or to stabilize patients who come to our hospital, but need medical services that we do not provide. We maintain a transfer arrangement with another hospital and the local EMS personnel handle these transfers to insure that the patient is provided the highest level of safety possible while being moved from one hospital to another. In the three years we have been open, we have not had to transfer an admitted patient because of an emergency that was beyond our capacity to address. Our nurses are ACLS certified, one of many steps we take to maintain high quality at our facility.

One of the great frustrations we experienced before building this hospital was the fact that we could not provide the kind of medical and surgical care that we thought our patients needed. All too often, minority patients have multiple medical problems. In addition to needing a hip or knee replacement or repair, they are also obese, diabetic and have cardiovascular complications. Too many surgeons and too many hospitals do not want to treat these patients, so they are told that they are not appropriate for surgery and sent home, where they deteriorate further. We knew that we could help these patients with an organized approach that addressed their medical complexities so that they could become good candidates for surgery.

Since building our hospital, we have been able to reverse this situation. We have established a close knit group of physicians from many disciplines who work with us to help our patients improve their overall health status. For example, I often see patients in my office who need orthopedic surgery, perhaps knee or hip replacement because of a lifetime of hard work standing in a serving line at a cafeteria. The patient is also overweight, hypertensive and has uncontrolled diabetes. Like it or not, this is the reality of much minority medicine.

I know that this patient is not a good candidate for surgery at this time, but instead of sending him or her away, I develop a plan to improve their health status so that they can eventually get the orthopedic procedure they need. Through this network of health care providers I mentioned, I can get the diabetes under control, get the hypertension managed properly, and with good nutritional counseling, put the patient on the path to a healthier diet and healthier weight. When this has been done, I can then operate on the patient safely and with a good outcome. This takes time and costs money, but the end result for the patient is certainly worth the effort. In an effort to be as economical as possible, we do not admit these patients for weeks while addressing their medical complexities. This is the most expensive way to meet the patient's needs and exposes them to needless risk of infection or other complication like blood clots from extended hospitalization. To the greatest extent possible, my colleagues and I work to keep these patients out of the hospital, until the day comes for their surgery.

We do not cherry pick our patients, as has been suggested of physician owned hospitals. We work to improve the health of our patients to prepare them to be good candidates for surgery. Are my patients healthier than some in the community hospital? Absolutely, and it is because my colleagues and I have worked hard to get them to that point.

Even if we cannot achieve the health goals for our patients, we will still provide care. I frequently operate on ASA level 4 patients, the most complex cases, at our physician owned hospital. Because of the skill of our staff, we are able to achieve good outcomes.

We built our hospital to address the health problems of Baton Rouge's African American population some of which were not being met at other facilities. In some cases, there is simply the lack of trust this population has with the medical establishment. Other cultural issues play a role, as well. Certainly, if we could train more African American physicians, this would help overcome at least part of this problem. I am sure that among Hispanic and Native American populations similar problems of trust and culture exist that could in part be addressed if we trained more physi-

cians and other health providers from those groups. However, as we all know, the rates of entry into the physician ranks by these populations are very low and have remained so for many years. I know that H.R. 3014 proposes ways to deal with these shortages. That may be one of the most important parts of this legislation.

However, health disparities are not just a function of race or ethnic background. Economics plays an important role as well. That is why we accept all patients regardless of ability to pay. I am proud to say that we don't use a collection agency to harass those individuals who can't pay their bills. I believe that even with the number of uninsured people in this country, if all hospitals worked together to address these economic hardships financial barriers to care would begin to fall across the country.

Access to health care can be limited by distance from facilities. In Louisiana, we have parishes that have few, if any, hospitals. Ever since Katrina, few people seem to want to build hospitals in many of those areas. That is why I drive 90 miles to New Iberia to provide care. I also work in a parish largely populated by low income whites, whose poverty prevents them from getting the medical care they need. My colleagues at our hospital perform similar outreach, travelling to outlying areas to bring modern medicine to areas where this is in short supply. Our hospital operates satellite clinics to extend our reach to other areas where there is a need for our services.

My fellow physician investors built the Surgical Hospital to improve access to care for African Americans who were not receiving what they needed. Our role in the community and surrounding areas has expanded and will continue to do so. I can assure the Subcommittee, however, that if we had not been able to build this hospital we never would have accomplished what we have.

As this Subcommittee knows, access to medical services also depends on the availability of facilities where that care can be provided. Health disparities increased in Louisiana after Hurricane Katrina because many hospitals were damaged or destroyed. Rebuilding our capacity has not been easy especially if physicians are involved in the effort. For example, St. Bernard Parish was heavily damaged by Katrina and remains in a very poor state. The two hospitals were destroyed and have not been replaced. Local physicians wanted to build a hospital with the support of a management company. However, other hospitals outside of the Parish objected. That pressure, combined with the uncertainty created by the debate over physician ownership in Congress, ultimately caused the physicians to abandon the effort. There is still no hospital in the Parish. It seems clear that health disparities are not only related to poverty or race, but also to community hospital greed and national political activity. For those members of Congress who are actively opposing physician ownership of hospitals like ours, I don't know who you think you are helping. Certainly not the residents of St. Bernard Parish who must travel long distances to get hospital care.

Greater Baton Rouge Surgical Hospital is not alone among physician owned hospitals in trying to reduce disparities in health care in this country. Doctors Hospital at Renaissance in McAllen, TX, serves a greatly underserved Hispanic population. Most of the physician owners are also Hispanic, which helps reduce the cultural and language barriers that can prevent people from seeking and receiving timely medical care. St. Joseph's Hospital in inner city Houston, serves underserved African Americans and Hispanics. Local physicians, working with a corporate partner, kept the hospital open so these people could have convenient access to care. A similar effort is underway at another Houston hospital, with physician leadership and investment.

In Honolulu, Asian physicians have purchased two hospitals that were going to close. Their effort will mean that the local Hawaiian and Asian populations will continue to have easily accessible, culturally appropriate health care.

Local physicians worked with the town of Troy, Alabama, to rescue the only hospital in the town. Their willingness to risk their own capital was the difference between success and failure.

The Kansas Medical Society works through county medical societies to try to get medical services to people who are uninsured. Physician owned hospitals, including the best orthopedic facility in the state, are teaming with the county societies to make their services available to these underserved individuals.

Native Americans are among the most poorly served patients in our nation. Poverty, cultural issues, geographically remote reservations and a myriad of health problems combine to create one of the most difficult health situations in this country. An over extended Indian Health Service cannot meet all of these needs. However, physician owned hospitals particularly in Western states like Colorado, Montana, and South Dakota provide important services to all ages at reservations in several states.

The many programs outlined in H.R. 3014 are just one measure of the immensity of the health disparities problem in this Nation. As physicians, we try to reduce them one patient at a time. However, I can assure this subcommittee that my colleagues and I could not accomplish what we do if we had not built our hospital in Baton Rouge. The success of our facility for patients, and the success of other physician owned hospitals across the country, should be applauded and encouraged. Any step, however small, that reduces health disparities and improves care for patients should be nurtured. Instead, I see too many Members of Congress apparently determined to stop what my colleagues and I have been able to do, by outlawing physician ownership of hospitals. I just don't understand it. I invite you to come to my part of Baton Rouge. You will quickly understand why health care innovation is so essential if we are to improve health outcomes in this community and why building our hospital was a turning point in improving care for African Americans in our area.

In conclusion, Mr. Chairman, thank you for having this hearing and shining light on a major problem in our health care system. Thanks to all of the Members of the Subcommittee for their interest in learning more and working on solutions. Those of us in the trenches trying to battle these barriers ask only that you and your colleagues work on a bipartisan basis to provide some solutions involving the entire healthcare community. Our experience, and the experience of others, shows that there is a role that the physician owned hospital can play in this effort. I hope you recognize this as well and will silence our critics whose primary aim in life seems to be their financial health and control of the system, not the health of their patients. If H.R. 3014 is passed by Congress, I urge you to make sure that physician owned facilities can participate equally with other hospitals.

I would be happy to try to answer any questions the Subcommittee members may have.

Mr. PALLONE. Thank you very much. I hate to do that, but we have a large panel. And next is Ms. Murguia, who is from La Raza.

STATEMENT OF JANET MURGUIA, J.D., PRESIDENT AND CEO, NATIONAL COUNCIL OF LA RAZA

Ms. MURGUIA. Sure. Thank you. Good afternoon, Mr. Chairman and thank you for the opportunity to testify today. Restoring equity to our healthcare system is a major priority for NCLR and for the Latino community and we do appreciate being part of this important discussion. I would like to, specifically, thank Congresswoman Hilda Solis and her colleagues in the Tri-caucus for their leadership on this vital issue. This is an important bill. She has been a great champion on these issues. It has been nearly a decade since the last health disparities legislation was enacted. That legislation had a significant impact on improving research, investigating how racial and ethnic minorities fair within the healthcare system. As a result, it is clear that Latinos and other racial and ethnic minorities continue to face significant challenges in accessing high quality care.

According to the Agency for Healthcare Research and Quality, AHRQ, healthcare may be growing worse for Latinos. Since AHRQ started regular collection of health disparities data in 2002, the gap in healthcare has been seen to grow wider between Hispanic and white individuals. Some key reasons that Latinos continue to face disparities include the fact that we are still the Nation's highest level of uninsured. More than one in three, or 34.1 percent of Latinos is uninsured. Latinos are more likely than other Americans to participate in the workforce, but less likely to have health insurance.

Furthermore, entire sectors of the Latino population have been cut off from important safety net programs. Legal immigrants, in

particular, are barred from Medicaid and CHIP for their first 5 years of legal residency. Barriers to linguistically appropriate care, Latinos who are still learning English face considerable difficulty in accessing information, enrolling in healthcare programs and receiving the treatment that they need. As a result, these individuals are more likely, than other Americans, to experience adverse outcomes if they manage to get care at all.

We also see discrimination in healthcare settings. In 2004 NCLR commissioned a testing study evaluating treatment of Latinos in the greater Washington D.C. area and the benefit system and found evidence that discrimination was taking place on the basis of national origin. In the study, NCLR found that 80 percent of Latinos in the test experienced at least one serious hurdle in obtaining benefits.

The lack of healthcare providers is still another important factor that remains. Latinos are far underrepresented in the health workforce. This in turn undercuts access to the quality of care. Given these trends, H.R. 3014 is a desperately needed piece of legislation. Using many of the recommendations of the Institute of Medicines, Unequal Treatment Report, the Congressional Tri-caucus has crafted a comprehensive set of changes that will improve our healthcare system. We know that this bill will restore access to critical programs for some legal residing immigrant children and pregnant women and seal our hopes that this strong start will be expanded on as intended by the bills sponsors, covering all lawfully residing children and pregnant women.

H.R. 3014 encourages effective communication in healthcare settings, especially by facilitating language access and culturally linguistic appropriate care. The legislation increases accountability in healthcare by ensuring that the Office of Civil Rights, under HHS, has the authority to pursue full enforcement of civil rights law for persons who are discriminated against in healthcare settings. And the bill promotes diversity in healthcare workforce by expanding programs to increase the number of health professionals form diverse populations, and by expanding cultural competence training. It supports community based approaches to healthcare and service delivery by helping to bring effective health promotion and health service programs to scale.

This legislation also increases resources for community health centers and other community based programs which are often the center of care for the medically underserved. We strongly, on behalf of the Latino community and NCLR, encourage votes supporting this legislation and we ask the Committee to ensure its swift consideration in the coming months. We look forward to supporting and working with you on the Committee. Thank you very much.

[The prepared statement of Ms. Murguia follows:]

RESTORING EQUITY IN THE HEALTH CARE SYSTEM: ADDRESSING HEALTH DISPARITIES THAT LATINOS FACE

Submitted to:

U.S. House of Representatives
Subcommittee on Health
Committee on Energy and Commerce

Submitted by:

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June 24, 2008

Chairman Pallone, Ranking Member Deal, and members of the Subcommittee, thank you for providing me with the opportunity to testify today. I also want to extend special gratitude to Congresswoman Solis and the Tri-Caucus for their leadership in addressing health disparities that racial and ethnic minorities face within the national health care discussion by continuing to advocate for passage of H.R. 3014, the "Health Equity and Accountability Act."

I am Janet Murguía, President and CEO of the National Council of La Raza (NCLR). NCLR is a private, nonprofit, nonpartisan organization established in 1968 to reduce poverty and discrimination and improve opportunities for this nation's Hispanic community.* As the largest national Hispanic civil rights and advocacy organization in the United States, NCLR serves all Hispanic subgroups in all regions of the country and reaches millions each year through its network of nearly 300 affiliated community-based organizations.

Over the past decade, NCLR has focused on improving the health status of Latinos to enable them to pursue the great opportunities that this country offers—to excel academically, climb the economic ladder, open small businesses, and live healthier lives. NCLR was drawn into the area of health policy when Congress first proposed eliminating Medicaid eligibility for legal immigrants in the mid-1990s. Since then, NCLR has led coalition efforts to restore legal immigrant access to Medicaid, create access to the State Children's Health Insurance Program (SCHIP), and address the significant barriers to health care that Latinos face. In addition, NCLR's Institute for Hispanic Health has conducted health promotion and other health programs with its Affiliates for more than 15 years. Through these efforts, we have come to understand the acute limitations in access to health care for Hispanic Americans and the enormous impact this can have on the well-being of the larger American population.

Latinos and other racial and ethnic minorities face considerable challenges within the health care system. Deep-rooted inequities have created obstacles to obtaining health coverage and the critical services that are needed to maintain good health. Recently renewed conversation about health care reform provides NCLR with optimism that leadership will develop new policies that guarantee affordable and quality health care for all Americans. However, to ensure permanent progress, it is essential that current weaknesses are addressed at every possible opportunity.

In my testimony today, I will provide background on the Latino community and health disparities to explain why it is important to focus on Latinos as part of the broader health care debate. I will then describe some of the issues that contribute to Latinos' poor quality of and access to health care. Finally, I will then provide recommendations to address each issue.

Background

The last decennial Census reported that from 1990 to 2000, the Latino community grew by 58%.[1] As of July 2007, there were an estimated 46 million Latinos in the U.S., constituting 15%

* The terms "Hispanic" and "Latino" are used interchangeably by the U.S. Census Bureau and throughout this document to identify persons of Mexican, Puerto Rican, Cuban, Central and South American, Dominican, Spanish, and other Hispanic descent; they may be of any race.

of the total U.S. population.[2] The Latino community is expected to continue to flourish in the coming years, accounting for 60% of U.S. population growth between 2005 and 2050.[3] While data show that the U.S. population is aging, Latinos remain a relatively young group, with a median age just under 28 years old, compared to a median age of 37 years for the entire U.S. population.[4] Further, more than one-third (34%) of Latinos are children under the age of 18.[5] These projections make it clear Latinos and their families will have increasing impact on this country in the coming years.

Like all who live in the U.S., Latinos will face difficulties in fully contributing to this country if they cannot sustain good health. There are many indicators that raise concern for the state of Latino health. Latinos are more likely to report a fair or poor health status than non-Hispanic Whites. For example, 13% of Latinos and 14.4% of non-Hispanic Blacks reported fair or poor health, compared to 8% of non-Hispanic Whites.[6] In addition, Latinos have a high risk of developing chronic diseases such as diabetes, overweight/obesity, certain pulmonary diseases, and stroke, all of which come with substantial long-term health consequences.[7]

Health Disparities: A Broad Overview

Latinos' health care status is characterized by inadequate access to and low quality of health care services. Each year, a report by the Agency for Healthcare Research and Quality (AHRQ) documents the challenges that American families face in receiving core health services. These challenges have increased each year for Latinos and other medically underserved communities. According to the 2007 National Healthcare Disparities Report (NHDR), disparities grew in 67% of the core measures of health care access between non-Hispanic Whites and Hispanics.[8] Latinos were less likely than any other measured racial or ethnic group to access a range of health services, including office visits, emergency room care, and dental care.[9]

Similarly, the gaps in quality of care between non-Hispanic Whites and Hispanics worsened in 60% of the core measures of quality.[10] There are compelling data demonstrating that Latinos are less likely to have interactions with their health care providers that would result in a fuller picture of their health and appropriate medical intervention. More than one in ten (12.2%) Hispanic adults felt their health providers sometimes or never listened carefully, explained things clearly, respected what they had to say, and spent enough time with them. Even when Latinos seek to meet most basic care needs, there are significant deficiencies. For instance, while Mexican American[†] adults had the second-highest levels of obesity nationwide (28.1%), they were less likely to be advised about engaging in physical activity by their doctor than any other racial or ethnic group. In addition, Latinos were less likely to be told that they were overweight.[11] An especially alarming finding from the research is that Latinos are not receiving critical primary care procedures, such as cancer screenings; going without care that is essential for detecting and treating disease before it becomes burdensome.[12]

[†] Mexican Americans represent approximately 60% of the Latino population, making them the largest subgroup of Latinos. Most national data collected on obesity and associated comorbidities are collected from this subgroup. While this data provides insight into health of the Latino population, it does not fully represent the diversity of Latinos.

Key Contributors to Latino Health Disparities

There are several key factors that impede Latinos' ability to access high-quality services. Some of the issues surfacing in the NHDR that Latinos experience include a lack of insurance or a specific source of ongoing care, patient-provider communication barriers, discrimination, and the lack of diversity in the health care workforce.[13] In order to ensure that Latinos receive health care services that foster good health status, there must be a commitment to addressing all of these issues.

A. Uninsurance

Latinos are more likely than their peers to report a lack of health coverage as a major barrier to health care. In most health care scenarios, from filling medication prescriptions to scheduling a visit to the doctor, Latinos are more likely than their peers to report that they delayed a range of medical services due to financial or insurance reasons.[14] Latinos are 2.8 times more likely to be uninsured than their non-Hispanic White peers.[15] Most traditional pathways to health coverage are closed to Hispanics. While the Latino workforce participation rate is higher than those of their peers, they are much less likely to be offered insurance. In 2006, just 40% of Hispanics were covered by employer-based insurance, compared to 66% of non-Hispanic Whites and 49.2% of non-Hispanic Blacks.[16] This disparity persists across all income levels, regardless of industry concentration or eligibility for coverage.[17] In addition, while Medicaid and SCHIP provide approximately 10 million low-income or medically-needy Hispanics, Congress has barred a sector of the population from participating in these programs. Restrictions enacted in 1996 deny immigrants access to federal means-tested public benefits, including health care, for at least five years after obtaining legal residency, and some legal immigrants never become eligible. Thus, uninsured Latinos and immigrants are much less likely to access health care, including emergency care, than their insured counterparts.[18]

B. Language Barriers and Communication

Language barriers not only discourage Latinos and their fami lies from enrolling in health programs for which they are eligible, they can also lead to serious and potentially life-threatening health consequences in the health care setting, including misdiagnoses, poor medical care, and inappropriate prescriptions or hospitalizations.[19] These barriers affect Americans from all walks off life, regardless of citizenship status. Approximately 24 million people speak English "less than very well" or are deemed limited-English-proficient (LEP) when receiving health services. Almost half of those who are LEP are U.S. citizens.[20]

The effects of limited communication for LEP patients can be severe. In a study of hospitals accredited hospitals by the National Joint Commission accredited hospitals, researchers found that 49% of LEP patients who had access to care experienced an adverse event that caused some physical harm, compared to 30% of English-speaking patients.[21] Furthermore, LEP patients without access to language assistance were less likely to adhere to patient regimens. One major

disparity exposed was that over one-quarter (27%) of LEP patients had trouble understanding their medication instructions, compared to 2% of LEP patients who had access to interpreters.[22]

C. Discrimination

Discrimination appears to be a factor in Latino access to health care, particularly among Spanish speakers. An NCLR study conducted by the Equal Rights Center in 2005 found that language barriers and related discriminatory practices at the District of Columbia's Department of Human Services (DHS) have drastically limited access to such medical services as Medicaid for the District's large Spanish-speaking community. According to the report, 80% of Spanish-speaking Latinos who participated in on-site visits and telephone testing faced at least one serious hurdle in obtaining vital medical benefits at DHS.[23]

D. Provider Diversity

Minorities who participate in the health workforce have been shown to be more likely than their White counterparts to work in medically-underserved communities, including those of minorities. However, they are underrepresented in almost every sector of the health workforce. Latinos represent just 4.2% of registered nurses, 5.7% of physicians and surgeons, and 6.7% of physician assistants.[24] Investing in the diversification of the workforce will help increase capacity to provide culturally appropriate treatment to many populations and increase access to bilingual care.

Strengthening the Health Care System for Racial and Ethnic Minorities

The "Health Equity and Accountability Act" (H.R. 3014) addresses many of the underlying barriers that limit access to care for Latinos and other racial and ethnic minorities by considerably improving the health care infrastructure. NCLR believes that Americans will be best served by passing this legislation in its entirety. The provisions of this bill are particularly important to improving the health care system for Latino families because they:

- *Restore access to critical programs for some lawfully residing immigrant children and pregnant women.* H.R. 3014 restores federal Medicaid and SCHIP eligibility for vulnerable populations, such as domestic violence victims petitioning under the Violence Against Women Act (VAWA) and persons with Temporary Protected Status, improving the access that legal immigrants can have to important safety net programs. NCLR would also recommend that this program be extended to all lawfully residing children and pregnant women, as sponsors in Congress have intended.

- *Encourage effective communication in health care settings.* By increasing funding for the provision of language services, codifying national standards on culturally and linguistically appropriate care, and encouraging the development of new language assistance strategies for health providers, among a number of other provisions, this legislation improves opportunities for better communication that lead to positive health outcomes.

- *Increase accountability in health care.* H.R. 3014 ensures that the Office for Civil Rights (OCR) under the U.S. Department of Health and Human Service has the authority to pursue full enforcement of civil rights law for persons who are discriminated against in health care settings. It will foster accountability for disparate treatment of persons due to their national origin. Moreover, it ensures that OCR can create an action plan that protects those covered under Title VI of the Civil Rights Act.

- *Promote diversity in the health workforce.* This bill increases resources to foster the development of minorities in health professions, including through expansion of such programs as the Health Career Opportunities Program and Centers of Excellence, which are among the very few that currently facilitate minority access to health careers. The provisions contained within H.R. 3014 will also expose many health professionals to a diverse range of populations by providing resources for medical institutions to conduct cultural competence training.

- *Support community approaches to health care delivery.* Many community-based organizations have created models to address health care disparities that are culturally appropriate and tailored to the populations that they serve. This legislation increases support for these programs by helping to bring common community practices to scale. Programs are targeted toward different regions and populations, such as the rural community, to ensure that their unique barriers are addressed. Of particular importance, this legislation offers financial resources to ensure that community heath workers, known as *promotores* in the Latino community, have the ability create and conduct programs on health promotion and address disproportionate levels of chronic disease. Additionally, this legislation increased resources for Community Health Centers (CHCs), which are often at the center of care for the medically-underserved. Nearly 40% of the patient population of CHCs is Latino.

Conclusion

There are a multitude of barriers that prevent not just Latinos but also many other Americans from connecting with health care. However, the United States has the capability to guarantee equity within our health care system by supporting effective health care programs and ensuring the enforcement of civil rights programs. H.R. 3014 provides policymakers with a road map for closing gaps in health care. It opens several points of entrance to the health care system for Latinos and immigrants and encourages measures for culturally and linguistically appropriate services. H.R. 3014 also provides financial resources for proven community-based programs to conduct health promotion activities, particularly in communities with low health literacy, and to expand and enhance outreach and enrollment efforts that open health insurance channels for Latinos and other Americans. NCLR looks forward to working with the Committee and members of Congress to pass this important legislation.

Thank you for the opportunity to provide this testimony today.

Endnotes

[1] U.S. Bureau of the Census, *The Hispanic Population*, Washington, DC, May 2001, http://www.census.gov/prod/2001pubs/c2kbr01-3.pdf (accessed June 18, 2008).
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[4] Percent of population calculated by NCLR using data from U.S. Bureau of the Census, "Table 6: Median Age of the Population by Race and Hispanic Origin for the United States and States: July 1, 2007." Conducted by the Population Division. Washington, DC, May 2008, http://www.census.gov/popest/states/asrh/tables/SC-EST2007-06.xls (accessed June 18, 2008).
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[8] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007* (Rockville MD: February, 2008).
[9] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007*, "Appendix D: Data Tables," (Rockville MD: February, 2008), http://www.ahrq.gov/qual/nhdr07/index.html (accessed June 19, 2008).
[10] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007.*
[11] Agency for Healthcare Research and Quality, "Appendix D."
[12] Examples of screenings and diagnostics that Hispanics are less likely to receive include mammograms, colon cancer screenings, pap smears, and cervical cancer screenings. Agency for Healthcare Research and Quality, "Appendix D"; National Center for Health Statistics, "Table 60."
[13] Agency for Healthcare Research and Quality, "Appendix D."
[14] According to the NHDR, 18.6% of Latino adults and 11.2% of Latino children reported that they sometimes or never received appointments for routine care as soon as they wanted, a rate higher than any other measured for a racial or ethnic group. Agency for Healthcare Research and Quality, "Appendix D."
[15] Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2007.*
[16] Percent insured calculated by NCLR using data from U.S. Bureau of the Census, *Current Population Survey*, "Table HI01. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2006." Washington, DC, 2007.
[17] Kara Ryan, *Healthy Choices or Bad Medicine?* (Washington, DC: NCLR, forthcoming).
[18] Dana P. Goldman, James P. Smith, and Neeraj Sood, "Immigrants and the Cost of Medical Care," *Health Affairs* 25, no. 6 (November-December 2006): 1700-1711; Peter J. Cunningham, "What Accounts for Differences in the Use of Hospital Emergency Departments Across U.S. Communities?" *Health Affairs* 25, no. 4 (July-August 2006): 324-336.
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[24] U.S. Department of Labor, *Household Data Annual Averages*, "Table 11: Employed persons by detailed occupation, sex, race and Hispanic or Latino ethnicity." Conducted by the Bureau of Labor Statistics. Washington, DC, 2005 http://www.bls.gov/cps/cpsaat11.pdf (accessed June 19, 2008).

Mr. PALLONE. Thank you. Mr. Lesley.

STATEMENT OF BRUCE LESLEY, PRESIDENT, FIRST FOCUS

Mr. LESLEY. Thank you. Good afternoon, Chairman Pallone, Congresswoman Solis, and staff of the House Subcommittee. I am Bruce Lesley, President of First Focus, a bipartisan children's advocacy organization dedicated to making children and families a priority in Federal policy and budget decisions. I appreciate the opportunity to testify today in support of the Health Equity and Accountability Act and thank Congresswoman Solis and Christensen for their leadership on this legislation aimed at reducing health disparities by improving access to healthcare research, and education of the diseases and illnesses that are having a disproportionate impact on minorities.

There is much that can and should be done to improve healthcare delivery systems in this country in order to better—to ensure better quality and appropriate care for all people, regardless of their race, ethnicity, cultural heritage or economic status. I am grateful that you are exploring these issues today. The Health Equity and Accountability Act is an important and timely proposal and it is our hope that passage of the bill will put our Nation on the critical path toward reducing, eliminating disparities for all Americans, including children across the healthcare spectrum. We should strive for nothing less.

Unfortunately, as First Focus Advisory Board member and pediatric expert Dr. Glenn Flores has noted, very little attention to health disparities has been directed at children. According to Dr. Flores, in a recent report on disparities by the Agency for Healthcare Research and Quality, there were more than three times as many disparity measures for adults as there were for children and only 15 percent of measures were child specific, and in the Institute of Medicine's comprehensive health disparities monograph, only 5 percent of the studies addressed disparities in children, at all.

However, we do know that minority children typically fare far worse than white children across the spectrum of health outcomes. From infant mortality, obesity, and dental care to asthma, diabetes and environmental illnesses, which is an issue also Congresswoman Solis has legislation on. Minority children have higher rates of disease and more limited access to care than the non-minority population. As Dr. Flores adds, minority children in American often face a triple threat of greater risks of suboptimal medical and oral health status, impaired access to medical and dental care and lower receipt of prescription medications and essential medical and dental services.

The statistics are startling. For example, we know that elevated blood levels are far more common in African American children, as opposed to white children, four times more, so. The incidence of Type 2 diabetes is running faster among the American Indian and Alaska Native children and young adults than any other ethnic population and is 2.6 times the national average. And Latino preschoolers, the fastest growing population of children in the United States, experience 2.5 times more tooth decay than white children.

These are just examples of many health disparities for children that are included in my testimony.

While there are many factors that contribute to these grim statistics, chief among them is that minority children face significantly higher rates of uninsurance when compared with white children. Nearly two-thirds, or 64 percent, of the 9 million children in the United States who area uninsured belong to a racial or ethnic minority. This morning there was also testimony about rural Americans and the fact is rural Americans, rural children, are disproportionately uninsured as well.

The bottom line is that we are failing our Nation's children, our next generation of leaders, by denying them the opportunity to fulfill their promise due to the lack of a healthy start in life. The disparities in access care, coverage treatment, and outcomes are abysmal and unacceptable. They are highlighted by the fact that on the average day 76 babies die before reaching their first birthday. If we did nothing else, as a society, we cannot let that figure stand. For this reason I would like to highlight the need to pass the Healthy Start Reauthorization bill by Congressman Towns and Upton, bipartisan legislation, as infant mortality is on the rise again, and it is also an issue of health disparities.

For all these reasons, the Health Equity and Accountability Act must be advanced as quickly as possible. While we appreciate all the efforts by Congress in recent years to enact legislation to address health disparities, these issues have become urgent ones and we cannot let more time pass without taking critical steps to address them.

We applaud the provisions of the bill that would, one, give States the option to provide coverage under SCHIP and Medicaid for legal immigrant children and pregnant women. This is legislation by Republican Congressman Diaz-Balart that is also included in the bill, provide grants to support community health worker programs, which improve enrollment strategies among minority communities including the use of promotoras to guide families through the enrollment process. That is in the bill, but also a freestanding piece of legislation by Congresswoman Solis. Ensure the availability of culturally and linguistically appropriate healthcare services, require data collection and analysis on disparities, provide grants to increase the number of minority health professions, Support training programs for providers who treat an increasing diverse patient population and improve research and education on diseases that are found to be more prevalent in minority communities. Thank you for the opportunity to provide this testimony and welcome any questions.

[The prepared statement of Mr. Lesley follows:]

FIRST FOCUS

MAKING CHILDREN & FAMILIES THE PRIORITY

TESTIMONY OF
BRUCE LESLEY, PRESIDENT, FIRST FOCUS

HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH

HEARING ON THE HEALTH EQUITY
AND ACCOUNTABILITY ACT (H.R. 3014)

JUNE 24, 2008

Good morning Chairman Pallone, Ranking Member Barton, and members and staff of the Health Subcommittee. I am Bruce Lesley, President of First Focus, a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions.

I appreciate the opportunity to testify today in support of the *Health Equity and Accountability Act* (H.R. 3014), legislation aimed at reducing health disparities by improving access to health care, research, and education on the diseases and illnesses that are having a disproportionate impact on minorities.

The issues you are considering today have not only been of great professional interest to me – through my work on Capitol Hill and for the National Association of Children's Hospitals – they are also deeply personal to me because I grew up in El Paso, Texas, and I started my professional career working for a public hospital just a few miles from the US-Mexico border.

At Thomason Hospital in El Paso, the medical staff provided care to a largely Hispanic patient population that also included American Indians from the Tigua Reservation. While Thomason had an excellent medical, resident, and nursing staff that came from all across the country and from around the world, many had little knowledge or understanding of the region and its diverse cultures. Many could not speak Spanish and few took the time to learn even the most basic of phrases to communicate in any depth with patients since they were only going to be in the region for a few years.

Sadly, despite the high quality of care provided at Thomason, the health disparities among patients were obvious – some were rooted in poverty, some due to the educational level of heads of household, some due to lack of basic health care coverage or reasonable access to primary care, and some due to cultural and ethnic bias on the part of the medical staff.

There is much that can and should be done to improve health care delivery systems in this country in order to ensure better quality and appropriate care for all people, regardless of their race, ethnicity, cultural heritage or economic status. I am grateful that you are exploring these issues today and want to make the committee aware that First Focus fully supports the *Health Equity and Accountability Act*. It is an important and timely proposal and it is our hope that passage of this bill will put our nation on the critical path toward reducing and eliminating disparities for all Americans across the health care spectrum.

Let me stop for a moment and tell you a little bit about my organization. First Focus is a national, bipartisan advocacy organization focused on advancing stronger federal policy and investment to improve the lives of our nation's children. Our policy work focuses on health, education, child welfare, and family economics and the Federal budget. In all of our work, we are committed to giving voice to children and families who slip through the cracks, those who are often overlooked or marginalized in research, programs, policy, and access to care. On the health front, our core mission is to improve health care access and quality for all of our nation's children.

Unfortunately, as First Focus Advisory Board member and pediatric expert Dr. Glenn Flores has noted, very little attention to health disparities has been directed at children. According to Flores, "...in a recent report on disparities by the Agency for Healthcare Research and Quality, there were more than three times as many disparity measures for adults as there were for children and only 15% of measures were child specific, and in the Institute of Medicine's comprehensive health disparities monograph, only 5% of studies addressed disparities in children."[1]

[1] Glenn Flores and Sandra C. Tomany-Korman, "Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in U.S. Children," *Pediatrics*, Vol. 121, Number 2, February 2008.

However, we do know that minority children typically fare far worse than white children across the spectrum of health outcomes. From infant mortality, obesity, and dental care to asthma, diabetes, and environmental illnesses, minority children have higher rates of disease and more limited access to care than the non-minority population. As Dr. Flores adds, "...minority children in America often face a 'triple threat' of greater risks of suboptimal medical and oral health status, impaired access to medical and dental care, and lower receipt of prescription medications and essential medical and dental services."[2]

The statistics are startling, for example:

- African-American children are almost 60 percent more likely than white children to have an unmet medical need.[3]
- Latino children are more than 31.2 times more likely than White children to lack a regular place to receive health care.[4]
- Elevated blood-lead levels are four times as common in Black children (3.5 percent) as in White children (0.9 percent).[5]
- Emergency department visit rates for African-Americans are 2 to 4 times higher than that of whites (21/100 for African-Americans versus 4/1000 for whites) as are asthma hospitalizations (and deaths).[6]
- Asthma hospitalization rates are 240 percent higher for non-Hispanic black children than whites.[7]
- The rate of asthma among Latino children is two and a half times higher than among non-Hispanic white children.[8]
- The incidence of Type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population and is 2.6 times the national average.[9]
- Non-Hispanic white children were more likely to have had a dental contact in the past six months (63%) than non-Hispanic black children (47%) or Hispanic children (47%).[10]
- Latino preschoolers—the fasted growing population of children in the United States—experience 2.5 times more tooth decay than white children.[11]

Such disparities cannot be explained away as just a matter of socioeconomic differences. Poverty or educational attainment alone cannot account for the vast differences in outcomes for minorities and whites. A number of scholars, including Acevedo-Garcia, have noted that "Infant mortality rates decline as mothers' education level rises for all racial and ethnic groups, but education does not erase

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[2] Ibid.

[3] Children's Defense Fund, "Improving Children's Health: Understanding Children's Health Disparities and Promising Approaches to Address Them," June 2006.

[4] Ibid.

[5] Children's Defense Fund, *The Healthy Child Campaign*, 2006.

[6] Christine L.M. Joseph, L. Keoki Williams, Dennis R. Ownby, Jacquelyn Saltzgaber, and Christine C. Johnson, "Applying epidemiologic concepts of primary, secondary, and tertiary prevention to the elimination of racial disparities in asthma," *The Journal of Allergy and Clinical Immunology*, Volume 117, Issue 2 (February 2006): 233-240.

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[8] Congressional Hispanic Caucus, "Health and the Environment Task Force Priorities," June 10th, 2008.
[9] http://www.hhs.gov/news/press/2003pres/fsindian90803.html

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[11] Congressional Hispanic Caucus, "Health and the Environment Task Force Priorities," June 10th, 2008

the racial gap. African American women with college or graduate degrees face infant mortality rates that are higher even than among white women with less than a high school education."[12]

While there are many factors that contribute to these grim statistics, chief among them is that minority children face significantly higher rates of uninsurance when compared with white children. Nearly two-thirds, or 64 percent, of the 9 million children in the U.S. who are uninsured belong to a racial or ethnic minority.[13] More specifically:

- Latino children are three times as likely as white children and nearly twice as likely as African-American children to be uninsured.
    - Rates of white children who are uninsured : 7.5 percent
    - Rates of African-American children who are uninsured: 13.4 percent
    - Rates of Latino children who are insured: 21.0 percent[14]

The bottom-line is that we are failing our nation's children, our next generation of leaders, by denying them the opportunity to fulfill their promise due to the lack of a healthy start in life.

During the debate last year on the reauthorization of the State Children's Health Insurance Program (SCHIP), Congress focused significant attention on another important data point – that is two-thirds of our nation's uninsured children are currently eligible for but not enrolled in coverage under SCHIP or Medicaid. The numbers are worse for minority children. More than 80 percent of uninsured African American children and 70 percent of uninsured Latino children appear to be eligible for but not enrolled in public health coverage programs.[15]

The SCHIP legislation that was passed by Congress last year included several provisions that would have helped to improve outreach and enrollment to these populations. We were disappointed that SCHIP reauthorization was not completed last year. We want to highlight for the Committee that Congress must reauthorize SCHIP before March of next year to improve coverage and access to care for our nation's most vulnerable children.

As you know, one of the most pressing issues facing our nation's poorest children is the looming implementation of the SCHIP directive issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007. By limiting states' abilities to tailor SCHIP programs to meet the needs of their citizens, the directive will cut off or limit coverage for scores of children from working families who play by the rules, work hard, and do their best to provide for their kids. Without a doubt, the rolls of uninsured children will grow further if Congress does not take action to stop the implementation of this directive. We urge Congress to take quick action to ensure that no child in America is denied health care as a result of this short-sighted administrative action.

It is fair to say that we are very concerned that our nation is headed in the wrong direction when it comes to its investments in children and their healthcare. In the last few years, we have taken serious steps backwards when it comes to addressing health disparities and improving health care access and outcomes.

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[12] Dolores Acevedo-Garcia, et al, *Unequal Health Outcomes in the United States: A Report to the U.N. Committee on the Elimination of Racial Discrimination*, January 2008.

[13] U.S. Census Bureau , "Table H108. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children under 18 (All Children): 2006," *Current Population Survey 2006.*

[14] Robert Wood Johnson Foundation, "Covering Kids and Families: The State of Kid's Coverage," August 9th, 2006

[15] Urban Institute analysis of data from the U.S. Census Bureau's Current Population Survey, 2004, as reported in *Going Without: America's Uninsured Children* (Washington: Robert Wood Johnson Foundation, August 2005).

In fact, in recent years there have been a host of policy changes that have contributed to and in some instances exacerbated the disparity gap:

Citizenship Documentation. For instance, in 2007, CMS imposed citizenship documentation requirements that, according to states, have cut few, if any, immigrant children, but have led to the loss of coverage for thousands of American children, particularly African-American children in desperate need of health care. In an article in the *Lawrence Journal* this past week, the State of Kansas estimates that $1 million was spent complying with the citizenship documentation requirements that has only stopped one illegal immigrant from getting coverage while denying an estimated 20,000 eligible Kansans health insurance coverage. Republican Senator Majority Leader Derek Schmidt said of the situation, "...[the federal government] ha[s] imposed a bunch of ancillary mandates on states, which are akin to trying to push a wet noodle up a hill with your nose. State taxpayers are picking up the dollars and cents costs of a failed federal policy."

Funding for Critical Programs, Such as Healthy Start, the Maternal and Child Health Programs, and Health Professions. Congress has failed to reauthorize the Healthy Start program – a critical initiative working to ensure that women living in communities with high infant mortality rates have access to early prenatal care and infant care. In addition, Congress also has cut funding for Healthy Start and the Maternal and Child Health Block Grant despite the fact that the U.S. infant mortality rate is 25th in the world and our maternal mortality rate is 30th. We also have cut funding for health workforce programs and the HHS Office of Minority Health, which provide important assistance for getting minority health professionals into medically-underserved neighborhoods.

Legal Immigrant Health Improvement Act. Congress has failed to pass legislation that would lift the five-year waiting period for legal immigrants to receive health coverage. A newborn, a child with cancer, a child with diabetes, or a child with a raging ear infection cannot wait five years for health care. Half of our nation's states have responded to this inhumane policy by providing coverage to these children with state funding, but no child should be denied coverage for a period of up to five years.

American Indian Healthcare. Although some might suggest that health disparities are related to immigration status, it should be noted that American Indians, the population that has been in this country longer than any other, experience some of the worst health disparities in the nation. Congress should pass the *Indian Health Care Improvement Act* as soon as possible and focus attention on American Indians in all federal programs by, at the very least, doing no harm. Congress has, for example, failed to include American Indian communities as possible grant recipients for meth grants or breast and cervical cancer treatment due to an oversight that took years to fix.

Medicaid and SCHIP Quality Improvement for Children. Over the past few years, Congress and the Department of Health and Human Services (HHS) have undertaken numerous efforts to improve quality of care, health disparities, and information technology (IT) in Medicare and the Veterans Administration health system while specifically exempting Medicaid and SCHIP from such improvements, chief among these examples is the President's Executive Order on quality and health IT improvements. Studies at AHRQ, the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) often fail to address the special circumstances or needs of children as well so that quality improvement and the focused reduction of health disparities for children has largely gone unaddressed in federal policy.

These disparities in access, care, coverage, treatment and outcomes are abysmal and unacceptable. They are highlighted by the fact that on the average day 76 babies die before reaching their first birthday. If we did nothing else, as a society, we cannot let that figure stand.

Importantly, by design, the *Health Equity and Accountability Act* is not just about minority health, as it also recognizes and prioritizes the elimination of gender and rural health disparities. For example, recognizing that minority and rural communities disproportionately are eligible but not enrolled in public programs, you will note that the legislation makes a priority for outreach and enrollment grants to children in both minority and rural communities, and along the U.S.-Mexico border where uninsured rates are the highest in the nation.

For all of these reasons, the *Health Equity and Accountability Act* must be advanced as quickly as possible. While we appreciate all of the efforts by Congress in recent years to enact legislation to address health disparities, these issues have become urgent ones and we cannot let any more time pass without taking critical steps to address them. We applaud the provisions of the bill that would:

- Give states the option to provide coverage under SCHIP and Medicaid for legal immigrant children and pregnant women;
- Provide grants to support community health worker programs which improve enrollment strategies among minority communities, including the use of *promotoras*, to guide families through the enrollment processes;
- Ensure the availability of culturally and linguistically appropriate health care services;
- Require data collection and analysis on disparities;
- Provide grants to increase the number of minority health professionals;
- Support training programs for providers who treat an increasingly diverse patient population; and,
- Improve research and education on diseases that are found to be more prevalent in minority communities.

This is the right bill at the right time. If enacted, it would be an important step forward and would make significant improvements in health care access, research and programs for all racial and ethnic minorities, including children, who, as the data shows, lag behind white children in almost every health indicator. One in every five children in America lives in poverty – one in every five. This bill will not solve all of our problems, but is will be a significant step in the right direction in ensuring that every child has a healthy start in life regardless of family circumstance. That is something that First Focus fights for every day and is why we stand as strong supporters of this legislation.

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Thank you for the opportunity to provide this testimony. I welcome the opportunity to answer any questions you might have.

Mr. PALLONE. Thank you. Ms. Yang, or Ms. Jang, I am sorry.

STATEMENT OF DEEANA JANG, J.D., POLICY DIRECTOR, ASIAN AND PACIFIC ISLANDER AMERICAN HEALTH FORUM

Ms. JANG. Thank you, Chairman Pallone and Committee staff for inviting me to testify on disparities in health and healthcare. I also want to thank Congresswoman Solis for your leadership, along with members of the Congressional Tri-caucus in taking a comprehensive approach to achieving health equity through introduction of H.R. 3014. My name is Deeana Jang and I am the policy director for the Asian and Pacific Islander American Health Forum, a national advocacy organization dedicated to improving the health and well being of Asian Americans and Pacific Islanders.

Contrary to the popular perception that Asian Americans are successful, wealthy, and healthy, Asian Americans and Pacific Islanders do experience disparities in health coverage, access to care, quality of care and health outcomes and disease prevalence. Asian American and Pacific Islander communities are not homogenous. There is a lack of data on specific ethnic subgroups that mask disparities that these communities experience. For example, 17 percent of Asian Americans and 24 percent of Pacific Islanders are uninsured compared to 12 percent of non-Hispanic whites, but the rates of uninsurance for some subgroups are even greater. Factors such as language, cultural barriers, and citizenship requirements prevent many Asian Americans and Pacific Islanders from accessing quality care. H.R. 3014 contains many provisions that will improve access to health coverage, access to healthcare services, improve the quality of care and increase investments in community-based approaches to achieve health equity.

I want to focus on just a few of the provisions that address these issues. Accurate, timely, disaggregated data by race, ethnicity, and primary language on Asian Americans and Pacific Islanders are vital to developing and monitoring programs and policies aimed at improving health equity. We support H.R. 3014's provisions to develop standards for collection and reporting of data on race, ethnicity and primary language and require its collection by all HHS programs using, at minimum, the 1997 OMB revised standards and, when possible, disaggregating by ethnic subgroups.

More needs to be done to improve data collection on smaller populations, including Asian Americans and Pacific Islanders. On the National and State level, data on Asian Americans and Pacific Islander health are either reported as other or reported as one group, which again masks those disparities. We support policies that improve the collection, analysis, and reporting of data on Asian Americans and Pacific Islanders, including translation of survey instruments and use of bilingual interviewers, over sampling and pooling data on smaller populations, increasing funding for community based participatory research and providing resources for more data collection at regional, State, and community levels.

Language barriers can reduce access to healthcare, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors, and lead to adverse outcomes. More than a third of Asian Americans and 12 percent of Pacific Islanders speak English less than very well. More funding for lan-

guage assistance, technical assistance for providers and more enforcement of civil rights laws are necessary components to ensuring that limited English proficient persons can access quality healthcare. Although States can get Federal matching funds from Medicaid and SCHIP for the cost of language services, only about a dozen States have taken advantage of this option. Providing 100 percent funding through H.R. 3014 will certainly provide a greater incentive for States to reimburse providers for these costs.

Barriers to participation in Federal Healthcare programs must be removed for immigrants and other non-citizens, including Pacific Islanders. Over 40 percent of Southeast Asians and about half of all Pacific Islanders are poor, or near poor and have high rates of uninsurance. Removing barriers and expanding eligibility for public programs will go far to addressing coverage for these populations. Thirty two percent of Asian Americans and 22 percent of Pacific Islanders are noncitizens. Thirteen percent of Asian Americans are noncitizens residing in the United States for less than 6 years. Since 1996, legal immigrants and low income families have been barred from receiving Medicaid or SCHIP during their first 5 years in the U.S.

Furthermore, citizens of the Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau are ineligible for public programs, as well, even though they are allowed to work and travel to the U.S. Many of these Pacific Islanders have health issues for which they are unable to access care. We support the provisions in H.R. 3014 to allow states to cover lawfully residing immigrant children and pregnant women. We urge the Committee to include all lawfully residing immigrant children and pregnant women, including permanent residents and qualified battered women who are ineligible because of the 5 year bar. H.R. 3014 would also provide eligibility for public health programs for citizens of the Republic of the Marshall Islands, the Federated States of Micronesia, and Palau.

We have additional comments about other sections of H.R. 3014, including promoting a diverse and culturally competent workforce, supporting community-driven approaches to achieve health equity and having accountability on the Federal Government level. These are included in our written testimony. We look forward to working with the Committee to move this critical piece of legislation as soon as possible. Thank you very much.

[The prepared statement of Ms. Jang follows:]

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AMERICAN HEALTH FORUM

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HOUSE COMMITTEE ON ENERGY AND COMMERCE

HEARING ON H.R. 3014, "THE HEALTH EQUITY AND ACCOUNTABILITY ACT OF 2007"

STATEMENT OF DEEANA JANG, JD, POLICY DIRECTOR ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM (APIAHF)

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH OF THE HOUSE COMMITTEE ON ENERGY AND COMMERCE

JUNE 24, 2008

Summary of Testimony of Deeana Jang, J.D., Policy Director,
Asian & Pacific Islander American Health Forum
Before the Subcommittee on Health of the House Committee on Energy and Commerce
June 24, 2008

- The Asian & Pacific Islander American Health Forum ("Health Forum") is a national advocacy organization dedicated to improving the health and well-being of Asian American and Pacific Islander (AA and PI) communities through policy, programs and research.

- AAs and PIs experience disparities in health coverage, access to care, quality of care and health outcomes and disease prevalence. AAs and PIs are not heterogeneous and disparities are greater for specific ethnic subpopulations. For example, 17% of AAs and 24% of PIs are uninsured compared to 12% of nonHispanic Whites, but the rates of uninsurance for some subgroups are even higher (Koreans, 31%; Vietnamese, 21%) Factors such as language, cultural barriers and citizenship requirements prevent many AAs and PIs from accessing quality care.

- H.R. 3014, the "Health Equity and Accountability Act of 2007," contains many provisions that will improve access to health coverage, access to health care services, improve the quality of care and increase investments in community-based approaches to achieve health equity.

- Accurate, timely, disaggregated data by race, ethnicity, and primary language on AAs and PIs are vital to developing and monitoring programs and policies aimed at improving health equity. Data on race and ethnicity need to be standardized, collected and reported by all HHS programs using, at minimum the 1997 Office of Management and Budget Revised Standards, and when possible, for smaller population groups.

- Language barriers can reduce access to health care, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors and lead to adverse outcomes. More than a third of AAs and 12 percent of PIs speak English less than very well. There is a need for more research on the provision of culturally and linguistically appropriate health care. More funding for language assistance, technical assistance for providers and more enforcement of civil rights laws are necessary components to ensuring that limited-English proficient persons can access quality health care.

- Barriers to participation in Federal health care programs must be removed for immigrants and other noncitizens including Pacific Islanders.

- A diverse and culturally competent healthcare workforce is critical to improving access to quality care.

- Community-driven strategies such as the Racial and Ethnic Approaches to Community Health (REACH) 2010 program and the Minority AIDS Initiative and support for community health workers must be expanded.

- The Office of Minority Health, the Office for Civil Rights and the National Center for Minority Health Disparities must be strengthened and given more authority to coordinate and hold accountable HHS agencies to the Nation's goal to eliminate health disparities as articulated by Healthy People 2010.

Thank you, Chairman Pallone, Ranking Member Deal, and members of the House Energy and Commerce Subcommittee on Health, for inviting me to testify on disparities in health and health care. I also want to thank Congresswoman Solis for your leadership, along with members of the Congressional Asian Pacific American Caucus, Congressional Hispanic Caucus and Congressional Black Caucus, in taking a comprehensive approach to achieving health equity through your introduction of H.R. 3014, the "Health Equity and Accountability Act of 2007."

The Asian and Pacific Islander American Health Forum ("Health Forum") is a national advocacy organization dedicated to improving the health and well-being of Asian American and Pacific Islander (AA and PI) communities through policy, programs, and research. We advocate on health issues that impact AA and PI communities, provide community-based technical assistance and training to address chronic diseases, HIV/AIDS, and domestic violence in AA and PI communities, and convene regional and national conferences on AA and PI health. To achieve optimal health and well-being of AAs and PIs, the Health Forum promotes policies that:

- Increase access to health care coverage and services;
- Improves the quality of health services including culturally and linguistically competent services;
- Improves data and research on AA and PI health;
- Promotes a diverse health care workforce; and
- Increases investment in community-driven health programs.

H.R. 3014 includes provisions that address all five of these policy priorities. My testimony today will highlight some of the major provisions and how they would impact AA and PI communities. First, I want to provide an overview of disparities in health care and health status experienced by AAs and PIs.

Disparities in Health Coverage among AAs and PIs

As a group, Asian Americans and Pacific Islanders are more likely to be uninsured than non-Hispanic whites. Specific AA and PI groups face extremely high rates of uninsurance: from 2004-2006, 24 percent of

Native Hawaiians and Pacific Islanders and 31 percent of Korean Americans were uninsured.[1]

The high rate of uninsurance in several Asian American communities is related to their employment in small businesses that do not offer health insurance benefits. For example, more than half of Korean Americans work in businesses with less than 25 employees. Yet, only half of employees in such firms are provided coverage through their employer. As a result, Korean Americans have one of the lowest rates of employer-sponsored health coverage among AAs and PIs, 49 percent, compared to South Asians who have the highest rate at 75 percent.[2]

Public programs such as Medicaid and SCHIP also play an important role in reducing uninsurance in AA and PI communities. Gains in coverage by these programs, between 1997 and 2004-2006, helped protect AAs and PIs from declines in job-based coverage. This helped decrease the number of uninsured AAs and PIs from 21 percent to 19 percent over that same period.[3] An expansion of public programs is critical for individuals who do not have access to affordable coverage through an employer or the private market.

Disparities in Access to Care

Health insurance coverage is an important predictor of access to health care in AA and PI communities. From 2004 to 2006, uninsured Asian Americans were more than 4 times as likely as insured Asian Americans to lack a usual source of care.[4]

However, disparities in access to care remain regardless of health coverage. Nonelderly AAs and PIs were more likely to lack a usual source of care than non-Hispanic Whites (18 percent vs. 14 percent).[5] Similarly, 52 percent of nonelderly uninsured AAs and PIs lacked a usual source of care, compared to 46 percent of non-Hispanic uninsured Whites. Factors such as language and cultural barriers prevent many AAs and PIs from accessing quality care.

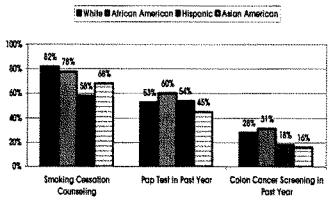
Disparities in Quality of Care

Findings from the Commonwealth Fund's 2001 Health Care Quality Survey concluded that Asian

Americans experience poor access to quality care on a range of measures."[6] Asian Americans reported greater communication difficulties and lower levels of satisfaction during their health care visits.[7] They were also "the least likely to feel that their doctor understands their background and values, to have confidence in their doctor, and to be as involved in decision-making as they would like to be."[8]

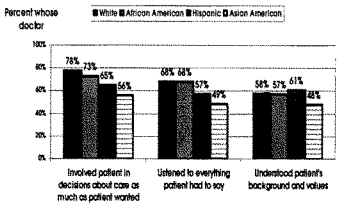
Despite having higher rates of certain health conditions, many AAs and PIs do not receive the recommended levels of prevention, counseling, or care they need. The 2001 and 2006 Health Care Quality Surveys revealed that Asian Americans were significantly less likely to receive preventive services such as cancer screenings or cholesterol checks, or counseling about smoking cessation, diet, weight, exercise, and mental health.[9] Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.[10]

Figure 1: Preventive Care and Physician Counseling



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Figure 2: Asian Americans Experience Communication Problems with their Doctors



SOURCE: The Commonwealth Fund 2001 Health Care Quality Survey

Disparities in Health Outcomes and Disease Prevalence

The lack of health coverage, limited access to health care, and the lack of culturally and linguistically competent services can manifest in harmful, and even fatal ways:

- Cancer deaths are increasing at a faster rate among AAs and PIs than any other racial and ethnic population. For example, the risk of death for Asian American women with breast cancer is 1.5 to 1.7 times higher than that for white women.[11] This is due in part to the relatively low screening rates and late stage diagnoses that occur among AA and PI women.

- Although statistics on the overall prevalence of diabetes in AA and PI communities are unavailable, it is the fifth leading cause of death among AAs and PIs. In Hawaii, AAs and PIs aged 20 and over are more than 2 times as likely to have diagnosed diabetes as whites after adjusting for population age differences. In California, Asian Americans are 1.5 times as likely to have diagnosed diabetes as non-Hispanic whites. Despite the importance of managing diabetes, nearly half of AA and PI adults with diabetes in California had not received a foot exam in the past year, compared with less than 30 percent of Whites and African Americans.[12]

- Asian American women aged 15-24 and over 65 have the highest suicide rates across all racial and ethnic groups.[13] Furthermore, Asian American girls have the highest rates of depression across both race/ethnicity and gender.[14]

Strategies to address disparities in coverage, access and quality

There are six important strategies included in H.R. 3014 that address disparities in coverage, access and quality:

1. Standardizing the collection, analysis and reporting of data on race, ethnicity and primary language in an accurate and appropriate manner.
2. Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.
3. Removing barriers to enrollment in public health programs based on citizenship status.
4. Promoting a diverse and culturally competent health care workforce.
5. Increasing investment in community-based health promotion programs.
6. Improving accountability and evaluation.

Importance of collection of data on race, ethnicity and primary language

Accurate, timely, disaggregated data by race, ethnicity, and primary language on Asian Americans and Pacific Islanders are vital to developing and monitoring programs and policies aimed at improving health equity.

In 1999, Congress requested that the Institute of Medicine (IOM) assess the extent of health disparities; explore factors that may contribute to inequities in care; and recommend policies and practices to eliminate them.

Its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," found significant disparities in the quality of health services received by minorities — even when insurance status, income, age, and severity of condition were comparable. The IOM study further revealed that minorities are less likely to be given appropriate cardiac medications, undergo bypass surgery, and receive kidney dialysis or transplants. Sadly, they are also more likely to receive last-resort procedures, such as lower limb amputations for diabetes. Subsequent research suggests that these disparities continue to this day for both minorities and women. For example, a recent study released by the Robert Wood Johnson Foundation found that the rate of leg amputation is four times greater in African American Medicare beneficiaries than in whites.[15] Another recent study published in *Health Affairs* found that, although there were some variations related to geography and socioeconomic status, overall, Asian Medicare beneficiaries were less likely than whites to receive mammography and colorectoral cancer screening services and all three diabetic services.[16] The National Healthcare Disparities Report in 2006 found that Asians receive lower quality of care compared with whites for one-third of the core measures tracked in the report, and for 75 percent of those measures, the gaps in quality were not improving over time.[17]

To help close the disparity gap, the IOM recommended that the Federal government: (1) collect and report data on health care access and utilization by patients' race, ethnicity, and socioeconomic status; (2) include measures of disparities in performance measures; and, (3) monitor progress toward the elimination of health care disparities. In 2001, the Commonwealth Fund went a step further by recommending that quality measurement and reporting tools, such as the Health Plan Employer Data and Information Set collect and report health data by race, ethnicity, and primary language. However, no comprehensive action has been taken on these recommendations; it is long overdue. There are a number of policies and practices that have created barriers to the collection and reporting of race, ethnicity and primary language data.

OMB Revised Standard on the Collection of Race and Ethnicity Data

In 1997, the Office of Management and Budget (OMB) revised the standards for collection of race and ethnicity data by the Federal government. This policy was of great significance to AA and PI communities,

because a major change included the Federal government requiring the collection of data on Asian Americans separate from Native Hawaiians and Other Pacific Islanders. Following the revision, the U.S. Department of Health and Human Services adopted a "Policy Statement on Inclusion of Race and Ethnicity in DHHS Data Collection Activities."[18] That policy clarified that the OMB standards do not require that race and ethnicity be included in data collection and reporting, but that HHS's policy is that "data on race and ethnicity will be included in all data collection and reporting activities." Unfortunately, this policy has never been fully implemented, and most HHS recipients, including states and private industry, are not required by HHS funding agencies to collect or report this data. The policy also does not require HHS programs to collect data on primary languages spoken by the beneficiaries of HHS services and programs. ***We support the provisions in Title III of H.R. 3014 to promote data collection, analysis, and reporting by race, ethnicity, and primary language among federally supported programs. Specifically, we support the required collection of data using at minimum the OMB standards, but also collecting data for additional ethnic subgroups.*** We further support the collection and reporting of race, ethnicity and primary language by region and state. AA and PI populations are concentrated in several regions of the United States including the West Coast and the Pacific, Mid-West and major cities on the East Coast. Therefore, more granular data on specific subgroups may be more readily available on regional or state levels.

Health Insurance Portability and Accountability Act

As part of the 1996 Health Insurance Portability and Accountability Act (HIPAA), Congress included provisions for the development of standards for electronic data interchange. Under the HIPAA rule implementing this provision, HHS could adopt a standard set by a standard setting organization accredited by the American National Standards Institute (ANSI) or adopt another standard if it will reduce costs for health plans and providers or if no standard has been adopted by an ANSI accredited organization, HHS may act on the recommendation of the National Committee on Vital and Health Statistics. With respect to standards for the collection of data on race, ethnicity and primary language, ANSI did not adopt a standard requiring that race and ethnicity data be collected,

but designated it as a "situational" standard in its claims data set. ***We support the provisions in H.R. 3014 that require the establishment of a new data code set for primary language and the designation of racial, ethnic and primary language code sets as "required" for claims and enrollment datasets.***

Medicare Data

Medicare data has provided a rich source of information about racial, ethnic, and socioeconomic disparities in health and health care among Medicare beneficiaries. And while there have been some improvements in the quality of data collected on race and ethnicity, there remain much more that needs to be done to improve the quality and accuracy of data. For example, an analysis of 2002 Medicare administrative data show that only 52 percent of Asian beneficiaries and 33 percent of both Hispanic and American Indian/Alaska Native beneficiaries were identified correctly.[19] Medicare's data on race and ethnicity come from Social Security's administrative records and are collected on a consistent basis when an individual applies for a Social Security number. The way the data is collected was not (and has not been) updated when the Office of Management and Budget revised the standards for collection of race and ethnicity data in 1997. In addition, since the late 1980's, most applications for Social Security numbers are made through the Enumeration at Birth process, and questions regarding race and ethnicity are not included. Finally, 12 percent of Medicare beneficiaries are enrolled by Medicare health plans that are not required to collect or report data on race, ethnicity or primary language.[20]

APIAHF is part of the Out of Many, One (OMO) Data Task Force, a coalition of advocates working to eliminate racial and ethnic health disparities. At the request of OMO, the Congressional Tri-Caucus has sent a letter to the Social Security Administration requesting information on the status of its efforts to improve data collection on race, ethnicity and primary language. ***We support the provision in H.R. 3014, the Health Equity and Accountability Act of 2007, that requires the Social Security Administration to collect data on the race, ethnicity, and primary language of all applicants for social security numbers or benefits.***

OMO and APIAHF are also supporting language in pending Medicare legislation in the Senate to grant authority to the Secretary of Health and Human Services to require Medicare plans and providers to report race,

ethnicity, and gender-specific data as part of the quality measures they are currently required to collect and report. We support the provisions included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) that would require collection of data on race, ethnicity, and primary language of each applicant for and recipient of Medicare benefits in conformity with the 1997 revised OMB standards and further disaggregation, where practicable, for additional population groups. Such provisions would help identify and eliminate disparities in the quality of health services that minorities and women enrolled in the program receive.

In addition to enacting these critical provisions of H.R. 3014, more needs to be done to improve data collection on smaller populations including Asian American and Pacific Islander subgroups. Important health and surveillance data on AAs and PIs continues to be collected and reported at the federal and state level as "Other/Unknown," or the data is not collected, reported, or analyzed. This lack of data is made even more acute by the growth and diversification of AA and PI communities over the last 20 years. It is still difficult to know the health status of specific AA and PI ethnic groups such as Hmong, Laotians, Asian Indians or Micronesians. It is also difficult to disaggregate socioeconomic groups such as new immigrants or the poor. We support policies that improve the collection, analysis and reporting of data on AAs and PIs including translation of survey instruments and use of bilingual interviewers, oversampling of smaller populations, bridging of datasets, pooling data over a number of years, increasing funding for community-based participatory research and providing resources for more data collection at regional, state and community levels.

Ensuring that effective communication takes place between provider and patient through the provision of competent language assistance.

Language barriers can reduce access to health care, jeopardize the quality of care, lower patient satisfaction and adherence, increase the risk of medical errors and lead to other adverse outcomes. More than a third of Asian Americans and 12 percent of Pacific Islanders speak English less than very well. The rate of limited English proficiency is even higher for specific groups: more than half of Vietnamese, Hmong, Cambodian, Laotian, Bangladeshi, and Taiwanese are limited English proficient. Research indicates that the use of trained interpreters

and especially the use of language concordant health providers can improve access to and quality of care for persons with limited English proficiency.[21] Research also shows that Medicare beneficiaries who are limited English proficient in English are less likely than those who are proficient in English to have access to a consistent source of care and less likely to receive important preventive care, including cancer screening tests.[22] However, more research is needed to determine the impact of language services on the health and health care of limited English proficient populations. ***We support the provisions in H.R. 3014 to***:

- Require the Agency for Healthcare Research and Quality to expand research related to the barriers to health care and mental and behavioral health services faced by LEP individuals, the impact of cultural and language services on the quality of health care and the health status of LEP individuals, the attitudes and knowledge of health care providers and administrators regarding these barriers, and what are the most effective means of providing language assistance;
- Require the Secretary of HHS to contract with the Institute of Medicine to publish a report on Federal efforts to ensure that all individuals have meaningful access to culturally and linguistically appropriate health care services; and
- Establish a grant program to promote innovations in culturally competent and linguistically accessible health care programs.

Medicare programs should ensure that meaningful access to enrollment and health care services is provided for persons with limited English proficiency.

Under Title VI of the Civil Rights Act of 1964, all recipients of Federal financial assistance are required to provide meaningful access to its programs, services and activities, including those that are not directly Federally funded, to persons with limited English proficiency. Not all Medicare programs are considered Federal financial assistance. While Medicare Part A providers are considered recipients of Federal financial assistance, providers (e.g. individual physicians, who only receive Medicare Part B and no other form of Federal financial assistance, e.g. Medicaid) are not obligated to comply with federal civil rights law.[23] This has caused some confusion as new

Medicare programs have been initiated with a mixture of Part A and Part B funds, e.g. Part C, and other sources so that determining whether participants in some Medicare programs are required to comply has become more complex. ***We support the provision included in Title I of H.R. 3014 requiring Medicare Part B providers to comply with Federal civil rights laws.*** We also support the provision in H.R. 3162 to require the HHS Inspector General to prepare and publish a report on the extent to which Medicare providers and plans are complying with Title VI and are providing culturally and linguistically appropriate services as described in the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care.

Furthermore, Executive Order 13166 requires that all Federal agencies develop plans to ensure that programs conducted by the Federal government are accessible to persons with limited English proficiency.[24] Therefore, outreach and enrollment in the Medicare program conducted by the Centers for Medicare and Medicaid Services (CMS) should be accessible for persons with limited English proficiency. We are concerned that while CMS translated much of the outreach materials for enrollment in the Medicare Part D program, there remain issues of inaccessibility to telephone assistance and enrollment materials. We are also concerned that Medicare informational materials, applications and beneficiary notices are not available in languages other than English and Spanish. ***We support the provisions of H.R. 3014 that require all Federal agencies that conduct health care-related activities to prepare a plan to improve access to federally conducted health care-related activities by LEP persons.***

The Federal government should provide reimbursement for the cost of language assistance and provide technical assistance to providers to ensure that high quality and effective language assistance is available in a timely manner.

Health care providers from across the country have reported inadequate funding of language services to be a major barrier to LEP individuals' access to health care and a serious threat to the quality of the care they receive.

- 63% of hospitals encounter patients with LEP daily or weekly; an additional 17% encounter LEP patients at least monthly.

- 65% of internal medicine physicians have active patients who are LEP.

Almost every major health organization (including the AMA, AHA, ANA, AAP, AAFP, ACP, ANA, APHA, APA, NACHC, NAPH, NASW, NMA and NHMA), **supports government payments for language services as necessary to ensuring quality healthcare**. Over 75 organizations have endorsed the Language Services in Healthcare Statement of Principles which supports funding mechanisms to ensure language services are available where and when they are needed.

- The American College of Physicians recommends that Medicare should pay for the added expense of language services and the additional time in providing clinical care.
- The American Hospital Association stated that resources should be targeted to improving language services for all patients with LEP.
- According to a recent article in *Pediatrics*, discussing results from a survey of pediatricians supported by the American Association of Pediatrics, reimbursement for language services is associated with greater use of professional interpreters.

Medicaid and State Children's Health Insurance Program Reimbursement

Although CMS has clarified that states can get federal matching funds for the provision of language services in its Medicaid and State Children's Health Insurance Programs, according to the National Health Law Program, only about a dozen states have taken advantage of this option. ***H.R. 3014 provides for 100 percent Federal funding for language assistance services in the Medicaid and SCHIP programs -- a much greater incentive for states to take action to pay for interpreters and translators.***

Medicare

Although the regulations for Medicare Advantage require managed care plans to "ensure that services are provided in a culturally competent manner to all enrollees, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds,"[25] it is unclear whether and how Medicare Advantage

plans are paying for language services and if they need or should have additional payments. Most managed care plans pass on the requirement to their contracted providers without specific funding or incentives. So while the managed care plans may have contractually agreed to provide language assistance, their payment policies may in fact create a disincentive for providers to participate and use language services.

We recognize that determining the best methodology and structure to provide reimbursement in the Medicare program is complex given the payment structure of the various providers, including in- and out-patient hospital care, physician care and managed care. ***Therefore, we support H.R. 3014's provisions to establish demonstration projects in different settings, a report to include recommendations on how to extend language services to all Medicare providers, and evaluation of the projects to assess the impact of the projects on access, utilization, efficiency, cost-effectiveness, patient satisfaction and impact on some health outcomes.***

Technical assistance for health providers

While obtaining more Federal support to pay for the cost of language services is essential, many providers remain in need of technical assistance to develop their language access plans and policies and to implement them. Federally assisted health providers are obligated to provide language assistance services to everyone who wishes to access their services regardless of whether they are covered by Medicaid, SCHIP or Medicare. ***The establishment of the Robert T. Matsui Center for Cultural and Linguistic Competence in Health Care, as provided in H.R. 3014, will provide this needed support and assistance.***

Barriers to participation in Federal health care programs must be removed for immigrants and other noncitizens

In order to ensure coverage and access to health care for all, federal programs including Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP) must remove barriers to eligibility for immigrants and other noncitizens such as some Pacific Islanders.

Coverage of AAs and PIs in public programs grew in part due to federal and state efforts over the last decade to reduce barriers faced by minority and immigrant communities. Many AAs and PIs qualify for public programs but remain uninsured because of language and cultural barriers in the enrollment process, misinformation about eligibility, and other family hardships such as food and housing insecurity. There are others who do not qualify even if they are low-income and legal immigrants. Since 1996, legal immigrants in low-income families have been barred from receiving Medicaid or SCHIP during their first five years in this country, even if they meet all other requirements for the programs. Citizens of the Republic of the Marshall Islands (RMI), the Federated States of Micronesia (FSM), and the Republic of Palau are ineligible for public programs as well, even though they are allowed to work and travel in the US. Many of these Pacific Islanders have health issues for which they are unable to access care. For example, approximately 6000-8000 Marshallese live in Northwest Arkansas. As a group, they have higher propensity for diabetes, high blood pressure, cancer and related complications because they delay seeking care, yet they are ineligible for most federally funded programs.[26]

To address these disparities in coverage, many states developed strategies to help enroll individuals with limited English proficiency in Medicaid and SCHIP.[27] States also took additional steps to simplify enrollment and renewal procedures for children.[28] And, nearly half of states have continued to provide coverage for legal immigrants during their first five years in the country through state-funded programs.[29]

We support the provisions in H.R. 3014 to allow states to cover lawfully residing immigrant children and pregnant women in SCHIP and Medicaid. We urge the Committee to include ALL lawfully residing immigrant children and pregnant women including permanent residents who are ineligible because of the five year bar. H.R. 3014 also provides eligibility for Medicaid and SCHIP for citizens of RMI, FSM and the Republic of Palau. In addition, other barriers such as excessive citizenship documentation in the Medicaid program must be repealed.

Ensuring a diverse and culturally competent healthcare workforce

A diverse healthcare workforce is critical to improving access to quality care, access to culturally and linguistically appropriate care, and patient choice and satisfaction for minority, AA, and PI communities.

Although statistics suggest that Asian Americans as a whole are well-represented among physicians, a comprehensive look at the healthcare workforce reveals that many groups are poorly represented.[30] For example, findings from a survey conducted by the California Medical Board indicate that there are shortages of many AA and PI subgroups in California's physician workforce. Less than 0.05 percent of California's physicians, or an estimated 90 of the 61,861 physicians in the state, were Cambodian, Laotian, Hmong, or Samoan.[31] In 2005, the Association of American Medical Colleges reported 3,111 Asian American medical school graduates nationally compared to 45 Native Hawaiian or Pacific Islander medical school graduates.[32]

Even less progress has been made in reporting data on the diversity of AAs and PIs in other health professions, such as nursing, dentistry, and allied health, which include many frontline healthcare workers, such as community health workers, health educators, and outreach workers. This limited data suggests that AAs and PIs are underrepresented as nurses, psychologists, and health services researchers.[33]

Fortunately, academic institutions and state medical associations are taking steps to address the lack of data on AA and PI subgroups in health professions. The California Medical Association sponsored legislation, which was enacted in 2001, requiring the California Medical Board to survey physicians when they renew their licenses. Every two years, physicians are asked to identify their ethnicity from a list of 28 ethnicities, and to indicate if they speak any of 34 languages listed.[34] In 2007, the University of California became the first public higher education institution to collect and report data on AA and PI subgroups through its undergraduate application.[35] ***By requiring health and allied health profession schools to collect and report data on the race, ethnicity, and language proficiency of students, H.R. 3014 would improve the data we need to diversify the health care workforce.***

The shortage of AAs and PIs in the health professions is a serious concern because many AA and PI communities continue to be medically underserved, with little or no access to culturally and linguistically appropriate primary and mental health care, and because the needs of AAs and PIs are often not considered in broader health research agendas. The U.S. Surgeon General noted in 2001 that nearly half of AAs and PIs have

problems accessing mental health services because of the lack of providers with appropriate language skills.[36] From 1986 to 2000, only 0.01 percent of Medline articles mentioned Asian Americans and Pacific Islanders.[37]

Efforts to increase the diversity of AAs and PIs in the healthcare workforce are also limited by the lack of a standard definition and process for determining underrepresentation in the various health professions.[38] Because public and private agencies and academic institutions use different definitions and this determination serves as the basis for allocating funds from numerous programs, AA and PI communities are often excluded from programs that seek to increase diversity in the health professions. For example, the Health Resources and Services Administration (HRSA), within HHS, utilizes a definition of underrepresented minorities that includes Native Hawaiians and Pacific Islanders but excludes "Chinese, Filipino, Japanese, Korean, Asian Indian, Thai, and Vietnamese/Southeast Asians." We urge HHS to adopt a standard definition of "underrepresented minorities" that considers the inclusion of specific AA and PI subgroups that are underrepresented in specific health professions.

The shortage of AAs and PIs in health careers is also closely linked to the inequalities in educational opportunities that face many AA and PI communities. Ten AA and PI groups have lower than average rates of high school completion, and three groups have the lowest rates among racial and ethnic groups.[39] ***The Health Forum supports the provisions in H.R. 3014 that reauthorize and increase funding for financial resources, such as scholarships and loan repayment, and pipeline programs for minorities who are underrepresented in the healthcare workforce.*** Specifically, these provisions would:

- Authorize $100 million in grants for educational institutions committed to health workforce diversity.
- Provide career development support to promote diversity among health professionals.
- Establish Regional Minority Centers for Excellence Programs in underserved regions.
- Reauthorize the Health Careers Opportunity Program at $50 million in FY2008.
- Reauthorize the Program of Excellence in Health Professions Education for Underrepresented Minorities for $50 million for FY2008.
- Authorize $50 million for the Health Professions Student Loan Funds.

- Reauthorize the National Health Service Corps' scholarship and loan repayment programs and authorize training grants for community health centers.
- Reauthorize the loan repayment program for CDC employees.

I would also like to highlight the importance of frontline healthcare workers, interpreters, and bilingual and bicultural providers in our efforts to diversify the healthcare workforce. ***We urge the Committee to consider workforce development and training strategies that would increase the availability and competency of health care interpreters and bilingual and bicultural health professionals.*** Strategies could include the recruitment and training of bilingual and bicultural members from underrepresented communities, the provision of ESL and job training, as well as changes in health professions programs that include cross-cultural education and training on how to work with interpreters.

Increasing investment in community-based health promotion programs

H.R. 3014 increases investment in community-driven strategies and solutions, provisions that the Health Forum strongly supports. When addressing health disparities in minority communities, it is important to engage and partner with communities. While improvements in health systems are important, multiple strategies are needed to address the root causes of disparities, including social, economic, and cultural factors that may impact health and health disparities.

H.R. 3014 would codify the Racial and Ethnic Approaches to Community Health (REACH) 2010 program, within the CDC, which funds 40 grantees to develop and evaluate strategies that reduce health and health care disparities. Currently, only 6 of the 40 grantees address disparities faced by AA and PI communities. With additional support, the REACH program could build on its successful base of programs, expand technical assistance and training, disseminate lessons learned, and award grants to additional communities.

In Santa Clara County, California, a coalition funded by the REACH 2010 program is working to increase awareness and use of breast and cervical cancer screening among Vietnamese women, who face a rate of cervical cancer that is 5 times the rate of cervical cancer in white women. Despite the importance of regular Pap

tests in detecting cervical cancer, more than 25 percent of Vietnamese women have never had a Pap test. With assistance from a lay health worker, 48 percent of women received their first test Pap test, 52 percent of women received a second pap test within 18 months, and 4,187 women enrolled in a reminder system.

The evaluation of this program, as well as many others, demonstrates the impact that community health workers can have on health promotion and prevention in AA and PI communities. As community members who work in community settings, community health workers are uniquely effective in bridging the gap between communities and health systems. Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, assist people in receiving the care they need, give informal counseling and guidance on health behaviors, advocate for individual and community health needs, and provide some direct services such as first aid and blood pressure screening. ***The Health Forum supports the provision in H.R. 3014 that would establish grants to promote positive health behaviors in women and children through the use of community health workers.*** We hope the subcommittee will also consider other policies and funding streams that would support the growing field of community health workers.

The Health Forum also supports other provisions in H.R. 3014 that direct resources toward evidence-based health programming and the elimination of health disparities in communities, such as increased funding for the Minority AIDS Initiative, and the development of cancer prevention and treatment demonstrations for racial and ethnic minorities.

Improving Accountability and Evaluation

Finally, H.R. 3014 improves accountability and evaluation within HHS by expanding the role of key agencies within the department. The Institute of Medicine concluded that civil rights enforcement is an important component of a comprehensive strategy to address health care disparities, but too often this work is relegated to a low priority. ***We support the IOM's recommendation of providing greater resources to the Office for Civil Rights to enforce civil rights laws within health care and human services settings.***

As the lead office within HHS for addressing minority health needs, the Office of Minority Health (OMH) supports health promotion and disease prevention programs in communities of color, and cultural and linguistic competence in health care systems. We support an increase in funding for OMH programs as well as an elevated role in overseeing and evaluating minority health and health disparity efforts across HHS.

H.R. 3014 would strengthen the National Center on Minority Health and Health Disparities (NCMHD) within the National Institutes of Health. We also support recommendations from the IOM report, *"Examining the Health Disparities Research Plan of the National Institutes of Health: Unfinished Business,"* to improve planning and coordination of health disparities research across NIH.

Conclusion

We look forward to working with you and other members of Congress to move forward on this historic piece of legislation to achieve health equity in America.

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Mr. PALLONE. Thank you and we will now have questions from the panel and start with myself, and I wanted to start with Dr. Lavizzo-Mourey. Some would try to downplay the importance of addressing racial and ethnic disparities by changing the debate to focus on income and education. And while income and education do matter in terms of health outcomes, isn't it true that disparities continue to exist even after looking at income and education?

Dr. LAVIZZO-MOUREY. That is absolutely right, Mr. Chairman. The Institute of Medicine Report demonstrated that even controlling for race, for income, and education, disparities continue to exist. Now, I will give you one specific example: the condition of low birth weight among African American women, the children of African American women. Even controlling for college education, we still see a marked disparity in the incidence of low birth weight, so it is important to not only focus on education and socioeconomic status, but also on race and ethnicity.

Mr. PALLONE. And the problem I see is if you don't do that and you don't focus on race and ethnicity, then you wouldn't collect the data. In other words, the importance of improving and collecting data on race and ethnicity would be thrown aside. So, if you want to comment on that.

Dr. LAVIZZO-MOUREY. One of the critical things to actually making improvements is knowing at a local level what disparities exist. So, for example, we know with amputation rates there is a four fold difference between blacks and whites, but when you look at specific States, the variation is sometimes larger than that and sometimes smaller than that. We give specific examples in our written testimony. Without collecting that data by race and ethnicity we aren't going to know on a State or regional or local level how to focus resources to really address the problem.

Mr. PALLONE. OK. Now, let me issue another question about the uninsured, and maybe I will ask Bruce Lesley to join in on this as well. A number of studies have shown that minorities are more likely than whites to be uninsured and lack of insurance coverage impedes access to healthcare which causes people to forego needed care and leads to worse outcomes and greater costs in the long run. Can we really address disparities without making sure that everyone is covered? In other words, how important is that in this whole issue of addressing disparities?

Dr. LAVIZZO-MOUREY. It is critical. We funded a number of studies that show that there are devastating consequences, both physical and economic, of not having coverage and access, but it is not the whole story. In addition, we know that in order to actually reduce the disparities we have to focus on issues of quality that are addressed in this bill, so one is not sufficient, you need both.

Mr. PALLONE. Now, if I use an example with the SCHIP program, which you know we have been trying to push throughout this Congress, in this subcommittee to expand it, and I know you have been a strong supporter of SCHIP and Medicaid and expansion. What do you think? Would an expanded SCHIP or more robust Medicaid make significant strides in reducing health disparities, in your opinion?

Dr. LAVIZZO-MOUREY. We absolutely know that when children have access to high quality care, they have better health outcomes.

You can look at vaccination rates. You can look at other specific conditions, so yes we know that having access to care will make a dramatic difference.

Mr. PALLONE. Did you want to address that too, Mr. Lesley?

Mr. LESLEY. Yes, absolutely. There has been a number—

Mr. PALLONE. And maybe beyond the health insurance, what else do you suggest we do?

Mr. LESLEY. Sure. There is a number of studies that have shown—for example, there was a recent study on SCHIP in New York and in New Jersey and then also in California on the expansions of SCHIP and the importance of how they have dramatically reduced health disparities. It was the, in some instances, actually eliminated disparities on some indicators. I also think that what is so great about the legislation is that you are also including things like the community health workers provisions and other provisions that are, as part of the legislation, that also have shown and demonstrated dramatic reductions in disparities.

Mr. PALLONE. And then the last thing I was going to ask is about a Federal solution, and you know this is not only important for this year, but next Congress. I mean, do you think that you need a Federal solution for disparities, because some would argue that you could address this more on a local level or a state level. What do you think about the need for a Federal approach?

Mr. LESLEY. Well, I think a Federal approach is critical because what you see is the—with all the differentials, you are seeing closing of the gap in areas where we are having expansions of coverage and not in other areas, and so the gains that were made in California due to the economic problems—in California there is actually regressing on some of their coverage and we are beginning to see signs of increased disparities and problems for children, particularly, that we know of in SCHIP, for example, and so without a Federal solution and really providing that overlay, for example, the areas of the southwest and the south will continue to fall behind. And you can look at the U.S.-Mexico border, for example, they have the highest rates of uninsured in the country and huge health disparity issues for Hispanic communities along the border and Native American communities and unless we do something nationally and really raise the level for all children those disparities will continue.

Mr. PALLONE. Well, my time is up. I agree with you, but beyond that, I think particularly when you talk about Native Americans, if you don't have the Federal approach, it is going to——

Mr. LESLEY. Right.

Mr. PALLONE. Unfortunately, a lot of times the States and the locals really don't pay much attention at all to them. I am sure that is true for others, but I know it is true for them. Thank you. Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman, and I want to applaud the testimony of some of our witnesses here and want to thank you for your interest. This is a work in progress as you can tell, and I am very excited about the fact that some of the things that you all have discussed have been around for awhile. The problem is, we haven't seen sufficient funding. We didn't really get a whole lot into what NIH and the Office of Civil Rights can do, but I would like to hear, maybe from Dr. Lavizzo-Mourey to tell me a little bit

about what you think we ought to be doing in terms of helping to build up research and the capacity to have professionals that we can attract into this field and where do we need to place them?

Dr. LAVIZZO-MOUREY. We have invested, for about 30 years, in trying to increase the pipeline of healthcare professionals, physicians, nurses, health providers of all kinds, but also people working in public health, and I think there are some critical things that we have learned, and one is that the pipeline needs to start early. It has to involve not only the college years, but the pre-college years and needs to extend well beyond the terminal degree of professional school to ensure that people have the skills that they need at the specialty level and very importantly, particularly for nurses, that they are encouraged to take faculty positions that they can then inform and educate the next generation. So the main point I want to make is that it is a long pipeline and we have to invest at all levels or it will only be as strong as the weakest link there.

Ms. SOLIS. Would you say that over the last 7 years we have done a sufficient job in funding some of these, say, particular positions for loan repayment? We talked a little bit about that earlier, on the first panel.

Dr. LAVIZZO-MOUREY. I am not going to able to comment specifically about the funding of those.

Ms. SOLIS. Would anyone on the panel want to address that?

Ms. MURGUIA. Well, I would just add that I think that we haven't seen enough funding. There are, I think, opportunities here to reach out into these communities and get to these individuals at earlier stages. There are other approaches too and I think as a community based—we represent a number of community based organizations that do work in health promotion and in health clinics, but we—one of our programs, which is recognized by the Department of Labor because we have a health career pathways, and what we have started is a lot of individuals who had been health promoters working as either interpreters or going in and accompanying some of these patients, we have been able to find ways to create a pathway for them to then become nurses aides or then to go on and to become physicians' assistants or then to become nurses, and we are working with community colleges. But there are programs, if we are collaborating, where we can see further development of health professions in a community-based way.

Ms. SOLIS. And, Mr. Lesley, you talked a little bit about community workers, or the promotoras program and that was a part, actually, an area that we tried to get in the CHAMP Act too, to increase outreach and just make sure that we get a hold of these populations that are not receiving care. In your testimony, you didn't get a chance to touch on it, but I wanted to go back to citizenship documentation and some of the barriers that really creates for people who are legally here, who are eligible for services and the barriers that they are confronting, given a misguided, in my opinion, regulation that is actually keeping U.S. citizens from healthcare. Could you elaborate on that?

Mr. LESLEY. Yes, absolutely. There have been a number of studies that actually have shown that the—at a high cost. There was actually a story last week in a Kansas newspaper that talked about that they have now done the analysis of the citizenship documenta-

tion provision, it has cost them over a million dollars to implement. They have prevented one person from getting coverage that shouldn't have gotten coverage, but thousands of—20,000 people who should have gotten coverage have been denied due to various documentation problems. So, at an enormous cost, really haven't achieved the goal of the program, but have been, on the flip side, actually dumped people from coverage and so it is one of those things that we certainly support getting rid of that provision or modifying it substantially as it was included in the CHAMP act.

Ms. SOLIS. And why is it important, Ms. Jang, to provide legal immigrant healthcare coverage to women and children?

Ms. JANG. Well, we know having early prenatal care really helps in terms of outcomes for both the mother and the child, so it is very important. It saves money. For every dollar spent on prenatal care, you save $3 in complications later on, so it is very important to get children and pregnant mothers the care that they need, when they need it.

Ms. SOLIS. And Dr. Knatt, you talked about your experience there in Louisiana. Some of us were able to go out and visit some of the makeshift clinics and actually saw the hospital in New Orleans, Louisiana that was devastated. And I understand that it still has not come back the way it should be, and there are obviously healthcare disparities that exist in and around that community and I know you didn't get to say your entire statement, but are you in support of this type of legislation?

Dr. KNATT. Oh, absolutely. I think that healthcare disparities are quite prominent in the U.S., particularly in our area and what we have done has helped to almost eliminate it.

Ms. SOLIS. Do you think the Federal government should be involved in this? I mean, because you are obviously coming from the private practice here, but is that something that you think would be welcomed?

Dr. KNATT. Yes, I think it is something that should be addressed at the national level. They mentioned earlier that the workforce needs to increase, but I think it needs to go beyond that. We need to increase the workforce. We also need to protect that workforce without giving them any unfair favoritism. There is a lot of pressure when minority physicians go into a community. I think that the percentage of physicians should reflect the percentage of the population in the United States.

Ms. SOLIS. And is my time up?

Mr. PALLONE. Your time is up, but I am not worried about it, so just keep going.

Ms. SOLIS. I just wanted to ask Dr. Akhter if he could, also, just elaborate—he talked about the African-American physicians and I know a group out where I live in Los Angeles, a Hispanic and Latino medical group that provides sufficient services. Their main problem or question to me is always lack of adequate reimbursement and, of course, keeping and competing with other neighboring for-profit hospitals. Can you elaborate on that? What I find really discouraging is that many of our Hispanic doctors who want to stay in east Los Angeles or other very hard pressed areas, financially can't and they are not given the kind of encouragement by other entities to give them the capital they need to continue on the pri-

vate sector. So, if you could elaborate a little bit on that and explain that to us?

Dr. AKHTER. I think the fundamental problem is lack of health insurance. That is really at the bottom of this. When you see one out of every four African American are uninsured, one in three Hispanic uninsured, then you can start to see that in those communities where our minorities live, there are many more—proportionately many more people who are uninsured. So, it was very difficult for a provider to go into that community and make it as a business. If every third person walking in is going to have no insurance to pay, you have difficulty, and then reimbursement rates are so low. So, we really have great disincentive for people to go and practice in minority communities and that is something that we really need to change and that needs to be changed at the National level. Remember, this is not an African American problem, Hispanic problem, Asian problem. It is an American problem. It is a national issue and needs to be addressed at the national level.

Ms. SOLIS. And I would concur with you. During our first panel, Congressman Moran talked about the inequities that exist in rural America. I agree with his statement wholeheartedly and know that there are economic issues, socioeconomic, literacy issues that just abound. They affect those that are least able to defend themselves, so I understand that that is something that we have to work on. As we work through this legislation we can build more support from our colleagues in the rural area. Yes?

Mr. LESLEY. Congresswoman Solis, I think that is a very important issue and one of the things I think that is a great step that the legislation provides and, for example, CHAMP provided last year is the idea that, for example, today you are all voting on the Medicare physician payment issue. Lots of issues have gone on. I think we did a Congressional Quarterly search on quality issues and Medicare and you get hundreds of hits. One of the important steps that reauthorization of SCHIP will do is address—start to deal with these issues of quality and payment and—that really have been, have not happened on the SCHIP Medicaid side to the extent that they have been going on in Medicare, and the information technology. And what that has meant is that, really, kids and families, low income families have been left behind in that discussion.

Mr. PALLONE. Thank you, and thank you Congresswoman Solis, and thank all of you really. I know this is a very important issue and I think that you have done a very thorough job today of analyzing what we face and the significance of this bill. We have got a lot more work to do, but this is certainly a good beginning. Let me remind you that we may submit additional questions to be answered in writing. The clerk should get those to you—well, the members will submit it to the clerk within the next 10 days and then soon after that we would send those written questions to you, but if you could respond to those in writing, we certainly appreciate it, and I also want you to know that as far as this subcommittee and myself and Ms. Solis is concerned we do intend to try to address the issues that you have brought up here today. We are not just going to hear them today and say that is the end of it, so thank you again and without objection—oh, I am sorry. I do have

one more thing—bit of business here. We have a number of items for the record so I am going to ask unanimous consent that the following materials be included in the record. First is the Tri-caucus letter of support for a hearing on H.R. 3014. Second is local, State and National organizations letters of support for the hearing. Third is testimony from Representative Donna Christensen, then we have a statement from Representative Mike Honda, a statement from Kaiser Permanente Medical Care Program, an AdMe Tech letter to myself and Ranking Member Deal on the issue of prostate cancer, my own opening statement since I wasn't here in the beginning and various newspaper articles, a report and a statement from Representative Ed Towns. So, without objection, so ordered and without objection this meeting of the subcommittee is adjourned. Thank you.

[Whereupon, at 1:43 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Congress of the United States
Washington, DC 20515

May 21, 2008

The Honorable John D. Dingell
Chairman
Committee on Energy and Commerce
Washington, DC 20515

The Honorable Frank Pallone
Chairman, Subcommittee on Health
Committee on Energy and Commerce
Washington, DC 20515

Dear Chairman Dingell and Chairman Pallone:

As members of the Congressional Hispanic Caucus, Congressional Black Caucus, and Congressional Asian Pacific American Caucus (known as the TriCaucus), we are writing to respectfully request that the Committee on Energy and Commerce quickly move to hold a hearing on H.R. 3014, the *Health Equity and Accountability Act of 2007*. This bipartisan legislation will improve the health of communities of color in urban, rural, and insular areas in addition to Indian Country, and will reduce persistent health disparities that leave millions of Americans in poor health and more likely to die prematurely.

The *Health Equity and Accountability Act of 2007* is one of the top priorities of the TriCaucus. Our legislation will improve access to culturally and linguistically appropriate health care, reduce disparities in rural populations, increase the diversity of the health professional workforce, strengthen and coordinate data collection, and expand access to health information technology. This legislation has the support of more that 300 national and local organizations and more than 100 Members of Congress.

Not since May 2000 has the Committee on Energy and Commerce held a hearing on health disparities. Meanwhile, underserved communities across the country continue to suffer unnecessarily from disparities in health care services with lasting effects. We urge the Committee to hold a hearing on H.R. 3014, the *Health Equity and Accountability Act of 2007* prior to the July 4th work period, and we are prepared to work with you and your staff to facilitate a successful hearing on this issue.

Thank you for your attention to this matter. We look forward to continuing to work with you to improve public health for all communities, regardless of geography, race or ethnicity.

Sincerely,

Hilda L. Solis
Chair, Congressional Hispanic Caucus Task Force on Health and the Environment

Madeleine Z. Bordallo
Chair, Congressional Asian Pacific American Caucus Health Task Force

Donna M. Christensen
Chair, Congressional Black Caucus Health Braintrust

Joe Baca
Chair, Congressional Hispanic Caucus

Mike Honda
Chair, Congressional Asian Pacific American Caucus

Carolyn Cheeks Kilpatrick
Chair, Congressional Black Caucus

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April 25, 2008

Honorable John D. Dingell, Chair
Committee on Energy and Commerce
U.S. House of Representatives

Honorable Frank Pallone, Jr., Chair
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Dear Chairman Dingell and Subcommittee Chair Pallone:

We the undersigned local, state, and national organizations are writing to express our strong support of H.R. 3014, the "Health Equity and Accountability Act of 2007." We also request that you take action to hold a hearing on this important legislation early in 2008. The provisions in H.R. 3014 are critical to reducing health disparities and restoring equity to healthcare coverage for individuals most in need of assistance, by improving access to health care and health care education for underrepresented minorities. H.R. 3014 would go a long way toward closing health care and quality gaps for communities of color as well as language minorities, gaps that have been well-documented for many years.

We are pleased with the provisions of this legislation that create alternative coverage opportunities for many low- and moderate-income immigrants and their families. Despite a robust presence in the workforce, many immigrants and their families are unable to connect with health coverage that bridges them with necessary health care services. H.R. 3014 takes a critical step to grant states the option to cover lawfully-residing immigrant children and pregnant women under the Medicaid and State Children's Health Insurance Program (SCHIP); these children are currently barred from coverage for five years after their arrival in the U.S. These health care restorations will help to ensure that needy children have a healthy start so that they can fully develop and grow. And we know that every dollar spent on prenatal care saves $4 or more in longer-term medical costs. This provision is a long-standing priority for addressing a core barrier to health care: the lack of health coverage.

HR 3014 also will improve the quality of health care for all communities of color by promoting culturally- and linguistically-appropriate services and care for individuals with language barriers. Successful health care delivery depends on the ability of both patient and provider to experience effective communication. The bill provides federal support for the provision of language services through Medicare, Medicaid, and SCHIP reimbursements for participating providers. The legislation also makes available critically-needed funds for development and implementation of language interpretation services, and supports training for health care providers using models of cultural competence that will benefit rural areas and Indian Country. The bill would enhance the health literacy of consumers and offer support to community health workers who promote cost-effective prevention strategies.

The need for change in our health care system is rising to the top of the national agenda. We must make deliberate attempts to ensure that those who are most in need of quality health care

services are included. We cannot continue to leave critical communities behind. H.R. 3014 addresses many of the most important causes of unequal access to health care and treatment. We urge you build upon your commitments and work together with us to pass the Health Equity and Accountability Act of 2007 as a critical part of making healthcare more accessible to everyone in our nation.

Sincerely,

NATIONAL ORGANIZATIONS

9to5, National Association of Working Women
ACORN
Afro-Americans C.A.R.E.
AIDS Action
Alzheimer's Association
American Arab Forum
American Association of Jews from the Former USSR
American Association of People with Disabilities
American Federation of Government Employees
American Friends Services Committee
American Heart Association/American Stroke Association
American Humane Association
American Lung Association
American Public Health Association
Americans for Democratic Action, Inc.
Asian & Pacific Islander American Health Forum
Asian American Justice Center
Asian Pacific American Legal Center
Asian Pacific Islander Caucus
Association of Asian Pacific Community Health Organizations
Association of Farmworker Opportunity Programs
Association of Maternal and Child Health Programs (AMCHP)
Bazelon Center for Mental Health Law
Break the Cycle
Campaign for America's Future
Catholic Health Association of the U.S.
Child Welfare League of America
Coalition on Human Needs
Community Action Partnership
COPE Health Solutions
Dads & Daughters
Easter Seals
Esperanza
Families USA
Farmworker Justice
First Focus
Hebrew Immigrant Aid Society (HIAS)
Ingram & Company
Institute of Social Medicine & Community Health

Integrated Community Solutions, Inc.
Japanese American Citizens League
Jewish Council for Public Affairs
Jewish Labor Committee
LAC COURTE OREILLES Vocational Rehabilitation Program
Leadership Conference of Women Religious
League of United Latin American Citizens (LULAC)
Legal Momentum on Immigrant Women Program
Lutheran Immigration and Refugee Service
Mental Health America (formerly NMHA)
Mexican American Legal Defense & Educational Fund (MALDEF)
Migrant Legal Action Program
Moms Rising
National Advocacy Center of the Sisters of the Good Shepherd
National Alliance of State and Territorial AIDS Directors
National Alliance to End Homelessness
National Asian Pacific American Women's Forum
National Association For Continence (NAFC)
National Association of Community Health Centers
National Association of Public Hospitals and Health Systems
National Association of Social Workers
National Center for Law and Economic Justice
National Council of Jewish Women
National Council of La Raza
National Gay and Lesbian Task Force Action Fund
National Health Law Program (NHeLP)
National Hispanic Council on Aging
National Hispanic Medical Association
National Immigration Law Center
National Institute for Reproductive Health
National Korean American Service & Education Consortium (NAKASEC)
National Latina Institute for Reproductive Health
National Latino Children's Institute
National LULAC Health Commission
National Migrant and Seasonal Head Start Association
National Minority AIDS Education Training Center -(NMAETC)
National Organization for Women
National Partnership for Women and Families
National Priorities Project
National Puerto Rican Coalition, Inc.
National Women's Health Network
National Women's Law Center
NETWORK: A National Catholic Social Justice Lobby
Our Bodies, Ourselves
PALS for Health
PHI-Health Care for Health Care Workers Initiative
Physicians for Reproductive Choice and Health
Planned Parenthood Federation of America
Poverty & Race Research Action Council
Religious Action Center of Reform Judaism
RESULTS

Results - Columbus, Ohio
Sargent Shriver National Center on Poverty Law
Service Employees International Union (SEIU)
Sisters of Mercy of the Americas
SisterSong Women of Color Reproductive Health Collective
Southeast Asia Resource Action Center (SEARAC)
Standard Homeopathic Company and Hyland's, Inc.
Tahirh Justice Center
The AIDS Institute
The Sikh Coalition
Union for Reform Judaism
United Methodist Women
USAction
Voices for America's Children
Women of Reform Judaism

REGIONAL, STATE, AND LOCAL ORGANIZATIONS

9to5 Bay Area -- *San Jose, CA*
9to5 Colorado -- *Denver, CO*
Access Health Care Long Island Coalition -- *Hempstead, NY*
Acercamiento Hispano de Carolina del Sur -- *Columbia, SC*
ACLU of Southern California -- *Los Angeles, CA*
Action for Children North Carolina -- *Raleigh, NC*
African Services Committee -- *New York, NY*
AIDS Action Baltimore, Inc. -- *Baltimore, MD*
AIDS Project of Central Iowa -- *Des Moines, IA*
Alaska Hispanic Affairs Council of Alaska, Inc.-- *Anchorage, AK*
Alliance for Multicultural Community Services -- *Houston, TX*
Altamed Health Services Corporation, -- *Los Angeles, CA*
American Indian Healing Center -- *Whittier, CA*
Americans for Democratic Action, Hawaii Chapter -- *Honolulu, HI*
Arc of Onondaga -- *Syracuse, NY*
Arizona Advocacy Network -- *Phoenix, AZ*
Asian Health Services -- *Oakland, CA*
Asociación Puertorriqueños en Marcha, Inc. -- *Philadelphia, PA*
Association for Children's Mental Health -- *Lansing, MI*
Atlanta 9to5 -- *Atlanta, GA*
Bellevue/NYU Occupational & Environmental Medicine -- *New York, NY*
Bristol Bay Area Health Corporation -- *Dillingham, AK*
California League of United Latin American Citizens -- *Antioch, CA*
California Church IMPACT -- *Sacramento, CA*
California Immigrant Policy Center -- *Oakland, CA*
California Pan-Ethnic Health Network -- *Oakland, CA*
California Primary Care Association -- *Sacramento, CA*
Carolynn's Montessori for Toddlers --*Petaluma, CA*
Catholic Healthcare West --*Pasadena, CA*
Cedar River Clinics - Feminist Women's Health Center of WA State -- *Seattle, WA*
Center for Civil Justice -- *Saginaw, MI*
Center for Independence of the Disabled in New York -- *New York, NY*

Center for Independent Living of South Florida, Inc. – *Miami, FL*
Center for People in Need -- *Lincoln, NE*
Central City Community Health Center -- *Los Angeles, CA*
Central Jersey Impeach Group and Mercer DFA -- *Princeton, NJ*
Chicano Federation of San Diego County -- *San Diego, CA*
Children's Alliance -- *Seattle, WA*
Chinatown Service Center -- *Los Angeles, CA*
Citizen Action of New York -- *New York, NY*
Citizen Action of Wisconsin -- *State of WI*
Citizen Action/Illinois -- *State of IL*
Claire Heureuse Community Center, Inc -- *Brooklyn, NY*
Clearinghouse on Women's Issues -- *Washington, DC*
Coalicion de Lideres Latinos -- *Dalton, GA*
Coalition for Asian American Children and Families (CACF) -- *New York, NY*
Coalition for Independent Living Options -- *West Palm Beach, FL*
Coalition for the Homeless of Nassau County -- *Fernandina Beach, FL*
Colorado NOW -- *Denver, CO*
Colorado Progressive Action -- *Denver, CO*
Colorado Progressive Coalition -- *Denver, CO*
Common Cause Oklahoma -- *Norman, OK*
Community Development Corp. Resource Consortium Inc. (CDCRC Inc) -- *Dayton, OH*
Community Health Councils -- *Los Angeles, CA*
Conexion Americas -- *Nashville, TN*
Congreso de Latinos Unidos, Inc. -- *Philadelphia, PA*
Connecticut Citizen Action Group -- *Hartford, CT*
Daughters of Mary and Joseph -- *Rancho Palos Verdes, CA*
Delaware Alliance for Health Care -- *Newark, DE*
Depression and Bipolar Support Alliance (DBSA) -- *Las Vegas, NV*
Detroit Medical Reserve Corps -- *Detroit, MI*
Dignity Housing -- *Philadelphia, PA*
Diocese of Jefferson City -- *Jefferson City, MO*
Disabled in Action of Greater Syracuse -- *Syracuse, NY*
District 1199C Training and Upgrading Fund -- *Philadelphia, PA*
Dominican Sisters of Houston -- *Houston, TX*
East Oakland Community Development Corporation -- *Oakland, CA*
Elim Transitional Housing, Inc. -- *Minneapolis, MN*
Epilepsy Foundation of Virginia -- *Charlottesville, VA*
Family Life Center, St. Mary's University -- *San Antonio, TX*
Family Planning Advocates of New York State -- *Albany, NY*
Farmworker Association of Florida -- *Apopka, FL*
Feminist Women's Health Center -- *Atlanta, GA*
First Mexican Baptist Church -- *San Antonio, TX*
Florida Consumer Action Network (FCAN) -- *Tampa, FL*
Friends Neighborhood Guild -- *Philadelphia, PA*
Gary Community School Corporation -Board of School Trustees -- *Gary, IN*
Georgia Rural Urban Summit -- *Decatur, GA*
Global Justice Ministry Metropolitan Community Churches -- *Abilene, TX*
Greater New York Labor-Religion Coalition -- *New York, NY*
Hands Across Cultures, Corp. -- *Espanola, NM*
Health Care for the Homeless Program at the Anchorage Neighborhood Health Center -- *Anchorage, AK*
Health Equity Associates, LLC -- *Havre de Grace, MD & Pittsburgh, PA*

Heartland Health Outreach -- *Chicago, IL*
Heartland Human Care Services -- *Chicago, IL*
HelpLine of Delaware and Morrow Counties, Inc. -- *Delaware, OH*
Hispanic Health Coalition of Georgia, Inc. (HHCGA) -- *Atlanta, GA*
Hispanic Ministry United Methodist Church -- *Frederick, MD*
HIV/AIDS Services for African Americans in Alaska -- *Anchorage, AK*
Hudson Center for Health Equity & Quality – *Tarrytown, NY*
Hudson Health Plan -- *Tarrytown, NY*
Human Services Coalition of Oregon (HSCO) -- *Portland, OR*
Hunger Action Network of NYS -- *Albany, NY*
Idaho Community Action Network (ICAN) -- *Boise, ID*
IHM Justice, Peace and Sustainability Office -- *Monroe, MI*
Illinois Maternal and Child Health Coalition -- *Chicago, IL*
Immigrant Rights Network of Iowa -- *Des Moines, IA*
Indianapolis Jewish Community Relations Council -- *Indianapolis, IN*
Intercommunity Housing Association -- *St. Louis, MO*
Iowa Citizen Action Network (ICAN) -- *Iowa City, IA*
Iowa Coalition Against Domestic Violence -- *Des Moines, IA*
Justice & Witness Ministries, United Church of Christ -- *Cleveland, OH*
Kentucky Youth Advocates -- *Jeffersontown, KY*
Kids in Common - A Voice for Children -- *San Jose, CA*
L.A. Gay & Lesbian Center -- *Los Angeles, CA*
Long Island Health Access Monitoring Project -- *Great Neck, NY*
La Clínica de La Raza, Inc. -- *Oakland, CA*
La Fe Policy Research and Education Center -- *San Antonio, TX*
Land Stewardship Project – *White Bear Lake, MN*
Latin American Research and Service Agency (LARASA) -- *Denver, CO*
Latino Family Services -- *Detroit MI*
Latino Health Steering Committee -- *Montgomery County, MD*
Latino Leadership, Inc. -- *Orlando, FL*
Latinos for Education & Justice, Inc. -- *Fairmount, GA*
Law Center for Families -- *Oakland, CA*
LawHelp.org/NY City Bar Justice Center -- *New York, NY*
Leadership Team, Sisters of Mercy Detroit – *Detroit, MI*
Legal Assistance Resource Center of Connecticut -- H*artford, CT*
Liberty Resources, Inc. -- *Philadelphia, PA*
Los Angeles 9to5 -- *Los Angeles, CA*
Los Angeles Unified School District -- *Los Angeles, CA*
Madison-area Urban Ministry -- *Madison, WI*
Maine People's Alliance -- *Portland, ME*
Marin County Department of Health & Human Services -- *San Rafael, CA*
Mary T. Inc. -- *Coon Rapids, MN*
Massachusetts Immigrant and Refugee Advocacy Coalition -- *Boston, MA*
Massachusetts Law Reform Institute -- *Boston, MA*
Maternity Care Coalition -- *Philadelphia, PA*
Medicaid Matters! Maryland -- *Baltimore, MD*
Memorial Sloan-Kettering Cancer Center -- *New York, NY*
Mental Health Association of Southeastern Pennsylvania -- *Philadelphia, PA*
Mexican American Opportunity Foundation -- *Montebello, CA*
MICAH (Metropolitan Interfaith Council on Affordable Housing) -- *Minneapolis, MN*
Michigan Citizen Action -- *Kalamazoo, MI*

Michigan Council on Crime and Delinquency -- *Lansing, MI*
Michigan Minority Health Coalition -- *Lansing, MI*
Milwaukee 9to5 -- *Milwaukee, WI*
The Minneapolis Urban League -- *Minneapolis, MN*
Minnesota Indian Women's Resource Center -- *Minneapolis, MN*
Minot Area Homeless Coalition, Inc. -- *North Dakota*
Missouri Immigrant & Refugee Advocates -- *St. Louis, MO*
Missouri Progressive Vote Coalition – *State of MO*
Montana People's Action/Indian People's Action -- *Missoula, MT*
National Asian Pacific American Women's Forum - DC Chapter -- *Washington, DC*
National Asian Pacific American Women's Forum- Los Angeles Chapter -- *Los Angeles, CA*
National Association of Social Workers - MN Chapter -- *St. Paul, MN*
National Council of Jewish Women/Greater Detroit Section -- *Southfield, MI*
National Organization for Women, Detroit Chapter -- *East Lansing, MI*
National Organization for Women of NJ -- *Trenton, NJ*
National Organization for Women, North Dallas Chapter -- *Plano, TX*
NDPeople.org -- *Bismarck, ND*
Nebraska Appleseed Center for Law in the Public Interest -- *Lincoln, NE*
New Hampshire Citizens Alliance -- *Concord, NH*
New Jersey Citizen Action -- *Newark, NJ*
New Mexico PACE -- *Albuquerque, NM*
New Mexico Voices for Children -- *Albuquerque, NM*
New York State Coalition Against Domestic Violence -- *Albany, NY*
New York Immigration Coalition -- *New York, NY*
Newman Center, Catholic Community at University of California, San Diego -- *San Diego, CA*
Next Step -- *Edison, NJ*
NICOS Chinese Health Coalition -- *San Francisco, CA*
Northern Manhattan Perinatal Partnership, Inc. -- *New York, NY*
Northwest Federation of Community Organizations -- *Seattle, WA*
Northwest Health Law Advocates -- *Seattle, WA*
Northwest Women's Law Center -- *Seattle, WA*
Ocean State Action (Rhode Island) -- *Cranston, RI*
Operation Fuel, Inc. -- *Bloomfield, CT*
Orange County Asian and Pacific Islander Community Alliance (OCAPICA) -- *Garden Grove, CA*
Oregon Action -- *Portland, OR*
Ounce of Prevention Fund -- *Chicago, IL*
PathWaysPA -- *Holmes, PA*
Pax Christi Northeast Florida -- *St. Augustine, FL*
Pax Christi Northwest Minnesota -- *Crookston, MN*
Pennsylvania Council of Churches -- *Harrisburg, PA*
Planned Parenthood Advocacy Project Los Angeles County -- *Los Angeles, CA*
Primary Health Care, Inc. -- *Urbandale, IA*
Progressive Maryland -- *Silver Spring, MD*
Project IRENE -- *Berwyn, IL*
Protecting Arizona's Family Coalition (PAFCO) -- *Phoenix, AZ*
Public Justice Center -- *Baltimore, MD*
The Reproductive Rights Coalition of Monterey County -- *Monterey, CA*
RESULTS Boston -- *Boston, MA*
Riverside School of Health Careers -- *Newport News, VA*
Rockland Immigration Coalition -- *New City, NY*
Roman Catholic Diocese of Syracuse -- *Syracuse, NY*

S.T.R.I.D.E.S. -- *Syracuse, NY*
Salem/Keizer Coalition for Equality -- *Salem, OR*
San Ysidro Health Center -- *San Diego, CA*
Savannah Deanery / Catholic Diocese of Savannah -- *Savannah, GA*
Senior Services -- *Seattle, WA*
Services, Immigrant Rights, and Education Network (SIREN) -- *San Jose, CA*
Siete del Norte CDC -- *Embudo, NM*
Sisters of Charity of Nazareth Congregational Leadership -- *Nazareth, KY*
Sisters of St. Francis of Philadelphia -- *Aston, PA*
Sisters of St. Joseph NW PA -- *Erie, PA*
Sisters of St. Joseph of Concordia -- *Concordia, KS*
South Central Family Health Center -- *Los Angeles, CA*
Southwest Creations Collaborative -- *Albuquerque, NM*
St. Anne's Place -- *Minneapolis, MN*
Support Center for Disparities Elimination, Inc. -- *Covington, TN*
Tennessee Citizen Action -- *Nashville, TN*
Tennessee Health Care Campaign -- *Nashville, TN*
Town of Buckeye Social Services/Community Action Program -- *Buckeye, AZ*
United Vision for Idaho -- *Boise, ID*
United Way of Beaver County -- *Monaca, PA*
Universal Health Care Action Network of Ohio (UHCAN Ohio) -- *State of OH*
University of Arizona Mel and Enid Zuckerman College of Public Health -- *Tucson, AZ*
Virginia Poverty Law Center -- *Richmond, VA*
Washington Community Action Network -- *Seattle, WA*
West Virginia Citizen Action Group -- *Charleston, WV*
Westside Health Services -- *Rochester, NY*
Wisconsin Council on Children and Families -- *Madison, WI*
Women Helping Women Lanai -- *Lanai City, HI*
YWCA Aurora -- *Aurora, IL*
YWCA of Hanover -- *Hanover, PA*
YWCA of Schenectady -- *Schenectady, NY*
YWCA of York -- *York, PA*
YWCA Omaha -- *Omaha, NE*
YWCA Orange County -- *New Windsor, NY*

cc: Honorable Nancy Pelosi, Speaker
Honorable Steny Hoyer, Majority Leader
Honorable James Clyburn, Majority Whip
Honorable Rahm Emanuel, Democratic Caucus Chair
U.S. House of Representatives

DONNA M. CHRISTENSEN
DELEGATE, VIRGIN ISLANDS

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SCIENCE AND TECHNOLOGY

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CONGRESSIONAL BLACK CAUCUS

MEMBER, CONGRESSIONAL CAUCUS FOR
WOMEN'S ISSUES

Congress of the United States
House of Representatives
Washington, DC 20515–5501

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Testimony to the Subcommittee on Health in the House Energy and Commerce Committee on H.R. 3014 – The Health Equity and Accountability Act of 2007

Congresswoman Donna M. Christensen
Tuesday, June 24, 2008

Thank you very much, Subcommittee Chairman Pallone, Ranking member Deal, Chairman Dingell and Ranking Member Barton, for holding this critically important hearing on an issue of grave concern to not only racial and ethnic minority Americans, who suffer every day from the inequality in access to health care and huge gaps in the quality of that care, but to all Americans.

Before I go on, I want to acknowledge and thank my good friend and colleague, Congresswoman Hilda Solis, not only for introducing H.R. 3014, but also for being a relentless advocate for health disparity elimination, for playing for the season, and not the game as it pertains to health equity; and for refusing to accept the status quo or half steps on the issue of health disparity elimination. Congresswoman Solis, I thank you for your leadership!

I also want to thank and acknowledge Majority Whip Clyburn and AJ his Policy Director, for engaging in today's historic hearing. A hearing has not addressed health disparity elimination since 2000. Mr. Clyburn, I, on behalf of not only the TriCaucus, but on behalf of the hundreds of thousands of Americans whose health, health care, and thus life opportunities have suffered as a result of the very health inequities that this bill seeks to ameliorate, thank you.

And, I want to thank the witnesses on the second panel, many of whom, like Dr. John Ruffin, Dr. Brian Smedley, Dr. Mohammad Akhter, Janet Murguia, Bruce Lesley, and Deeana Lang, represent the nation's premiere experts on health equity and who

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have been passionate advocates of this legislation. I applaud you for sharing your expertise with us today and for standing strong with us to make this day possible!

To put the issue in stark terms, today and every day, until something substantive is done, over 200 Americans of color will die prematurely from preventable causes – most in the prime years of their lives. That something which needs to be done, we assert is the enactment of H.R. 3014.

This bill is based on pre-existing health disparity elimination and health equity bills that have consistently built upon the Minority Health and Health Disparities Research and Education Act of 2000, which was signed by President Clinton on November 22, 2000. Once enacted, that law, among other things, created the National Center on Minority Health and Health Disparities at the National Institutes of Health, and the Director – Dr. John Ruffin – is here today to testify about this issue and this bill.

Since that historic day nearly eight years ago, we know – from myriad research reports, including those from the Agency for Healthcare Quality and Research – that despite some meager progress, there is still much work to be done.

We know that because of the poor health outcomes of racial and ethnic minority Americans, this country lags behind almost all other industrialized nations and some developing ones in health indicators such as maternal mortality and is ranked 41st in health status among all nations by the WHO.
To improve our world standing, the elimination of health disparities is the most critical factor to be addressed.

Today on average, racial and ethnic minorities are disproportionately afflicted with chronic and acute conditions – such as cancer, diabetes and hypertension –and suffer worse health outcomes, worse health status, and higher mortality rates than their white counterparts. For example:

- The infant mortality rate for African Americans and American Indian/Alaska Natives are *more than two times higher* than that for whites.

- African-American women are nearly four times more likely than white women to die during childbirth or from pregnancy complications;

- Although African American and Latina women experience lower incidence rates of breast cancer than white women, they experience higher mortality from breast cancer than white women.

- African American and Latina women make up 89% of all HIV/AIDS cases in women

- American Indian/Alaska Natives have diabetes rates that are nearly 3 times higher than the overall rate.

We are clear that closing these gaps in our health care system – gaps that have been ignored for far too long – will require a substantial investment. And, this investment must focus not only building a system that manages diseases and chronic conditions for the millions of American currently living with them, but on one that places a significantly higher priority on preventing them in the first place. We also know and will soon be prepared to demonstrate that such an investment represents health care savings over a relatively short period of time

We also know that solutions to health disparity elimination no longer exist solely in the public health realm, but that health disparity elimination is a cross-cutting issue that is driven, sustained and exacerbated by a myriad of social determinants that must be an integral part of our efforts if they are to be successful.

Additionally, we know – from numerous reports about health care reform – that efforts to improve and truly fix the health care system are not possible without attention paid to health disparity elimination.

In recent years, numerous discussions about health care reform – both on and off the Hill – have occurred and are slated to continue. Lawmakers, experts, advocates, providers, purchasers and consumers on both sides of the political aisle are in agreement that health care reform is necessary; that our nation's health care system is broken and must be fixed; and that without health care reform, we – as a nation – will suffer and be weakened on multiple fronts.

The elimination of health disparities is critical to the success of this effort. In fact, according to a recent report prepared for the Services Employees International Union (SEIU) and the National Conference of Black Mayors, written by Dr. Brian Smedley – who you will hear from on the next panel and who authored the historic 2003 IOM report of health disparities, if health disparity elimination are not an integral component of future health care reform discussions and efforts then "these disparities have the potential to unravel even the best efforts to contain health care costs and improve overall quality of care. In addition, their presence leaves U.S. health care systems poorly prepared to address the needs of some of the fastest-growing segments of the population."

It is important to know that the TriCaucus efforts around health equity began before so many of these studies emerged. In fact, we – working from an area of common ground that focused and continues to focus on health equity – banned together and actively engaged a broad base of expertise and input from national and regional health and health care organizations, academic institutions, leading policy analysts, and health care purchasers and providers to develop health disparity elimination legislation to begin to finally close gaps that have been persistent and refractory to change for far too long; to ensure passage of the Health and Health Disparity Research and Education Act and then to build on the progress to be made after that bill was enacted.

Mr. Cummings introduced the first TriCaucus health disparity bill that resulted from this process in the 108th congressional session on November 6, 2003. That effort

was built upon and followed by the Tricaucus's health disparity elimination effort in the 109th congressional session, when on July 28, 2005, Mr. Honda introduced the TriCaucus health disparity elimination bill. That bill – the Healthcare Equality and Accountability Act (H.R. 3561) – had a well-sponsored Senate complement and was based on a set of principles that were endorsed first by the Health Task force which you chaired, Mr. Chairman, and then by the Democratic Caucus.

In this Congress, on July 12, 2007, Congresswoman Solis took the pre-existing bills, Democratic Caucus consensus and subsequent momentum one step further when she introduced the bill on which today's hearing is focused.

So, today's hearing on this bill simply could not be better timed, as it complements the ongoing discussions about how we can find common ground around health and health care to ensure that all of this nation's citizens have access to health care, receive needed services, enjoy optimal health and thus have improved opportunities to achieve to their full potential in life.

I know, as you do, that there are other minority health bills – in both chambers – that try to address aspects of health disparity elimination. In truth, if it were up to me, there would be 1000 health disparity elimination bills introduced in both chambers every Congress, because that would indicate that a greater number of lawmakers wanted to address the issue, or even that we would have had substantive discussions between both Bodies that would have produced one bill we could all support. Unfortunately, neither is the case.

So, while I applaud the efforts of colleagues who are trying to address this timely issue with other bills, I, as the Chair of the Congressional Black Caucus Health Braintrust and the only physician of color currently serving in Congress, stand firmly with the other members of the Tri-Caucus on the strong provisions of H.R. 3014 and the need for a bill that broadly and meaningfully can impact this problem that is undermining the health, economy, strength and potential of our country.

So, this bill before us today– the Health Equity and Accountability Act of 2007 – is based on not only earlier efforts, but on long and hard worked for consensus from the Democratic Caucus in both chambers. It is not lack of content, or lack of effort, but lack of political will in past Congresses that has held back progress on this important piece of legislation.

Today with this hearing we are signaling a new political day and change in that will.

As our common interest in achieving health care reform has developed, I am pleased that this legislation – H.R. 3014 – is now front and center on the political table!

And let me say this: given the myriad discussions about the need for health care reform and given the 110 members who endorse this legislation, the time has come to move this bill!

HR. 3014 will not only improve the health and health care of our nation's most vulnerable residents, bolster our understanding of and efforts to monitor and gauge health disparity elimination across racial and ethnic and rural populations and help health care purchasers ensure that their precious health care dollars are not being wasted in a system that is wrought with geographic, gender, and racial and ethnic disparities that detrimentally affect health outcomes, but also will improve our standing in the world and – most importantly for the economic health and stability of our country – begin to reverse the skyrocketing and unsustainable rise in healthcare spending.

As the only African-American physician in Congress, I feel compelled to highlight the crucial role that workforce diversity does and will play in health disparity elimination. Studies indicate that racial and ethnic minority health care providers – all providers, including physicians, nurses, dentists, pharmacists, hospice care providers, ophthalmologists and social workers, as well as health care executives – are more likely than their white counterparts to treat racial and ethnic minorities and other underserved communities.

Additionally, racial and ethnic minority providers are more likely than white providers to be able to bridge gaps – particularly as it relates to the dynamics of the patient-provider relationship – because the existing gaps are those that simply must be lived and not taught from a textbook. Despite the documented need for diversity within the health care workforce, however, important programs – such as Title VII and Title VIII programs – as well as funding to the institutions, such as the Historically Black Colleges and Universities – which together bolster the diversity in our nation's health care workforce have been woefully under-funded.

Consequently, racial and ethnic minority providers are grossly under-represented across all aspects of the U.S. health care system. In fact, according to the Sullivan Commission Report:

- Together, African Americans, Hispanic Americans, and Asian Americans and American Indians make up about one-third of the U.S. population, but only 9 percent of the nation's nurses, 6 percent of its physicians, and 5 percent of dentists.

- Similar disparities exist in the faculties of health professional schools. For example, racial and ethnic minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties.

H.R. 3014 offers thoughtful solutions to ensure that these important programs and institutions receive the funding that they need to ensure that they can be an integral

part of the solution to ensure that our nation's health care workforce – on all levels – mirrors our nation's growing racial and ethnic diversity.

Without diversity within our nation's health care system and among our nation's health care executives, the racial, ethnic, and gender nuances that are known to have a direct and indirect impact on health, health care decisions and thus health care decisions will remain under-addressed, and as a result, millions of innocent, hard-working Americans will suffer poorer health outcomes and a lower quality of life and will continue to be at greater risk for premature death – and often preventable causes – during their most productive life years. Additionally, not only will greater diversity in the health care workforce boast positive health benefits, but it also will help ensure more prudent spending of precious health care dollars.

Another issue that is germane not only to health disparity elimination, but also to health care reform focuses on accountability and evaluation. As you all know, if we – as a nation – took the necessary steps to ensure that across all federal agencies and offices with health oversight and issues that affect health equity had a designated office of minority health or an office of health disparities, then efforts to not only measure, but to propose and implement solutions to close health care gaps would become a reality. In the Health Equity and Accountability Act, we not only work to strengthen and expand those existing entities – such as the Office of Minority Health at the Department of Health and Human Services and the National Center on Minority Health and Health Disparities at the National Institutes of Health – but we also propose the creation of Offices of Minority Health within the Centers for Medicare and Medicaid Services, the Food and Drug Administration, as well as to create an Office of Health Disparities within the Office of Civil Rights at the Department of Health and Human Services.

The creation of these offices will help ensure that federal efforts – and as important, federal resources – to achieve health equity not only remain on the national health care reform agenda, but also are coordinated as efforts to eliminate health disparities are launched. Additionally, these offices – though they will require an initial outlay of resources – would likely generate a positive return on investment; an investment that we should make today to improve the health, health care and health outcomes of millions of Americans today!

I also want to note the importance of ensuring that as health care reform efforts proceed, that they not only focus on health disparity elimination, but that they also prioritize the need for and potential of community-centric health disparity elimination efforts. Such efforts are included in the Health Equity and Accountability Act, as well as in another bill – the Health Empowerment Zone Act - which is included in H.R. 3014. This provision leverages not the expertise at the community level as it pertains to health disparities, but also the existing resources available to implement health disparity elimination efforts. This rationale – one that not only fully engages all sectors of communities most affected by health disparities, but also defers to those communities in terms of developing solutions – mirrors the direction that myriad health disparity elimination studies recommend. Fully engaging communities most affected is essential!

The Health Equity and Accountability Act of 2007 (H.R. 3014) is a bill that has not only engaged a broad base of ideas and expertise, but also adheres to the recommendations that have been offered by experts on both sides of the political aisle, such as those listed in the 2003 IOM Report on health disparities. It addresses the root causes of health inequity across racial and ethnic, and rural communities, and thus includes provisions that would ameliorate the social determinants of health that have created, sustain and exacerbate gaps in health care.

It is legislation that would improve and fortify the nation's health care system, thereby ensuring that those who purchase services – including employers – are getting the strongest return on their investment and it not only supports our existing health care workforce, but actively works to fortify it so that it meets the health and health care needs of our diverse nation tomorrow.

H. R. 3014 also would help ensure that the benefits of health information technology reach underserved areas and become a lynchpin of the new and more equitable healthcare system.

The provisions of H.R. 3014 are well thought out, crafted for maximum impact, and are designed to end the excess deaths that continue to increase more than 25 years after they were first described by then Surgeon General Margaret Heckler. As such, it is evident to our nation's key stakeholders who strive to achieve health equity and improve the quality of health care for all Americans, that this Tri-Caucus bill answers their calls and offers the solutions for which they have been searching.

And so it is no accident that more than 325 national and regional health and health care advocates, researchers, policy think tanks and providers, as well as 110 bipartisan members of Congress have already endorsed or sponsored the Health Equity and Accountability Act of 2008.

In closing, as the discussions on healthcare reform proceed, the central message I want to leave with this Subcommittee is that H.R. 3014 must be a key component of – and *not* an accessory to – the dialogue and resulting legislative solutions.

Additionally, I want to stress that while health insurance status is a known major driver in the health disparities we see today, so, too, are the social determinants of health -- race and ethnicity, gender, geography, environment and education – that numerous studies confirm have a direct and indirect impact on the health and well being of millions of Americans.

We, therefore, must ensure that efforts to reform our nation's health care system prioritize the achievement of health equity by focusing on and addressing the social determinants of health, as well as the differences in insurance status – both of which, together, are the root causes of all health disparities and the root causes of the absence of health equity.

The Health Equity and Accountability Act brings us a giant step forward in that respect because this bill addresses many of those issues.

Finally, I want to remind the members of this committee that while the Health Equity and Accountability Act was initially developed to specifically address racial and ethnic health disparity elimination, we have expanded its focus to achieving health equity -- to achieve equality in quality of health care. Consequently, this bill hones in on the root causes of *all* health disparities, not just racial and ethnic, but also gender and rural disparities. The Health Equity and Accountability Act includes provisions bolster and strengthen every aspect of our nation's health care system. It smartly addresses cultural and linguistic competence, data collection, accountability and evaluation, workforce diversity, improvements in health care services and the expansion of health care access.

The witnesses on the next panel – the very research experts whose incredible work drives and informs our efforts on the Hill –will provide a detailed overview of the extensiveness of health disparities and the compelling data that cannot and should not be ignored. Additionally, they will aptly highlight that racial and ethnic minorities, overall, are more likely than whites not only to lack adequate, reliable access to quality health care, but also are in poorer health and are more likely to die from preventable causes and during their most productive life years.

That said, I sincerely applaud the leadership of this committee and welcome future discussions about not only health care reform, but also about how we can work together to ensure that achieving health equity by enacting H.R. 3014 becomes recognized and championed as one of the first components of our collective health reform goals and objectives in the future. Together, we can accomplish this extraordinary success!

As I close, I want to say this: Oscar Wilde once said that "the world is divided into two classes, those who believe the incredible, and those who do the improbable."

This bill is the product of a bill that in 2000 unlocked the door of health equity – a door which while open, we have struggled to walk thorough... until today.

Today, I ask that all of you walk through that door with us; walk with us to achieve the improbable.

Thank you!

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PREPARED STATEMENT OF HON. MIKE HONDA

Thank you Chairman Pallone and Ranking Member Deal for the opportunity to comment on this morning's important hearing on H.R. 3014, the Health Equity and Accountability Act. As Chairman of CAPAC, I have the honor to speak on behalf of the Congressional Asian Pacific American Caucus on the health concerns and needs of the greater Asian American and Pacific Islander community.

Asian American and Pacific Islanders (AAPIA) are one of the fastest growing populations in our country today. Over the last 18 years, the AAPI community has more than doubled from seven million to over 15 million individuals and this is a community represented in every Congressional District across the country. My home county of Santa Clara County is nearly 30% Asian American and Pacific Islander, and as many as 12.8 percent of the 36 million residents of the State of California today are Asian American and Pacific Islander.

Nearly every American faces challenges today to accessing quality and affordable healthcare, but these challenges are unequally faced across the broader spectrum of our economically and ethnically diverse country. Asian American and Pacific Islanders, like Latino Americans and African Americans, struggle with overcoming the additional obstacle of healthcare disparities. The common needs of our various minority communities led to the introduction of health disparities legislation 6 years ago. We have worked hard as a tri-caucus to keep the issue of health disparities at the forefront of the health care debate.

Unlike other minority communities, however, the rapid growth and wide diversity in language and culture within the greater Asian American and Pacific Islander community presents its own unique healthcare challenges. Asian American and Pacific Islanders encompass 49 ethnicities and over 100 individual and distinct languages and cultures making several provisions contained by H.R. 3014 critically important to improving healthcare for AAPIs.

H.R. 3014 is the product of collaboration between the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Congressional Asian Pacific American Caucus, and comprehensively addresses from a public policy perspective the pressing issues faced by communities of color in our country. This bill, which has now been introduced in three consecutive Congresses, demands our attention and deserves this subcommittee's consideration. Its provisions have been scrutinized by the medical, health professional and academic communities and are based on Tri-Caucus facilitation with the advocacy community.

I appreciate the extraordinary leadership and work of Congresswoman Donna Christensen and Congresswoman Hilda Solis. It has been wonderful to work with them to as we move forward as a Congress to develop and pursue public policy that will reduce and eliminate healthcare disparities. This hearing is another, long-awaited step to achieving our goal of eliminating health disparities. Although the AAPI community is impacted by virtually every aspect of the bill, I want to highlight the data collection title of the bill and also comment about broader access challenges.

Today, the Federal Government lacks complete, adequate, and up-to-date medical data for minorities, but because of its diversity the data gap for the AAPI community is more glaring and consequential. Right now, if you search for diabetes information on the Centers for Disease Control and Prevention website, you will only find data categorized for "Black, White, and Hispanic or Non-White." The fact sheet prepared by the CDC states that, "African Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians or Other Pacific Islanders are at particularly high risk for type 2 diabetes and its complications," but that "The total prevalence of diabetes (both diagnosed and undiagnosed diabetes) is not available for Asian Americans or Pacific Islanders."

Although this one very specific example it nevertheless aptly illustrates the information gap for minorities, particularly for the AAPI community. We as a Congress simply cannot address or rightly aim to correct the health challenges facing our citizens if we do not even know what they are or have some authoritative, sound measure of the extent of impact and contributing cause.

Equally disconcerting is the fact that is has now been over a decade since the Office of Management and Budget (OMB) established new standards for the collection of federal data on race and ethnicity, yet their full adoption and implementation by certain federal agencies remains outstanding. The Social Security Administration (SSA), for example, has made no revision to its Social Security Card application to take into account the news standards. The OMB race and ethnicity-developed categories are by no means burdensome to implement—they simply establish the minimum categories of race as American Indian/Alaska Native; Asian; Black or African-American; Hispanic/Latino; Native Hawaiian/Pacific Islander, and White. Without

the use of these standards, inconsistency is in place across our government and we as policy-makers struggle to receive needed data and the work to make desired comparisons, measure correlation, and analyze data is compounded and made unreachable.

CAPAC believes that further disaggregation beyond the OMB standards established ten years ago is warranted today to accurately reflect the diversity of the AAPI community. However, we know this step cannot logically be taken or fully pursued into the spirit of the 1997 changes are adhered to by our Federal Government. Therefore, compliance with the 1997 standards and additional collection of data on primary language is a priority—H.R. 3014 requires such collection and disaggregation. Such compliance and additional data collection is imperative for tracking and eventually eliminating health disparities in the AAPI community. The improper or insufficient collection of data by the Social Security Administration leaves a lasting impact on our ability to monitor the quality of care and eliminates our ability to rely on what would otherwise be invaluable indicators for effective administration of the Medicare and Medicaid programs.

Apart from standards, compliance and consistency in application are other data collection priorities. H.R. 3014 strengthens data collection and analysis by requiring that racial and ethnic data be collected from the parent or legal guardian of minors and reported to the Centers for Medicare and Medicaid Services and other relevant agencies for proper analysis.

Finally, I would like to underscore the critical importance of cultural and linguistic competency in healthcare. This issue is vital for the AAPI community. Roughly a third of Asian and Pacific Islander Americans live in linguistic isolation; 70% of Cambodians, 68% of Laotians, 61% of Vietnamese, 52% of Koreans, 51% of Chinese, 39% of Tongans, and 22% of Samoans are classified as Limited English Proficient (LEP) and interaction with healthcare providers and social service agencies is hampered because of these language barriers. These barriers have severe effects on healthcare access, such as patients' ability to understand diagnoses, ability to understand prescription directions, and likelihood to return for follow-up and preventive care in the future. People have and will continue to die as a result of misinformation or mistranslation.

It is for these reasons, and for a host of others that will be addressed by the experts testifying before you today, I urge your attention to and focus on H.R. 3014. Health disparities for Asian American and Pacific Islanders are very real; and people are suffering everyday from these disparities. As we move toward a model of universal coverage or universal care it is important that we address these disparities now. Thank you for the opportunity to comment on this important issue.

A NONPROFIT CORPORATION FOR THE ADVANCEMENT OF MEDICAL TECHNOLOGIES

Dedicated to Innovative Solutions for Improved Patient Care and the Transfer of Medical Research and Technologies from Laboratories to Clinics

The Honorable Frank Pallone, Jr.
Chairman
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Rep. Nathan Deal
Ranking Minority Member
Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Dear Chairman Pallone and Ranking Member Deal:

I appreciate the opportunity to submit for the hearing record my thoughts on the issue of prostate cancer as it relates to health care disparities. I am the Founder and President of the AdMeTech Foundation, a non-profit organization based in Boston which has been working for a number of years to help create advanced imaging technologies for prostate cancer detection.

First, I would like to thank you for having this hearing to highlight the disparities that exist in healthcare. I am pleased to see Congress taking an in-depth look at the different health care needs that arise in our society. And, I am pleased that Congresswoman Solis and her cosponsors have put forth legislation that begins to deal with these issues meaningfully. However, in reviewing H.R. 3014, the Health Equity and Accountability Act of 2007, I was disappointed to find that prostate cancer detection is not explicitly addressed since in my view, there is a significant health care disparity between breast cancer detection and prostate cancer detection.

The goal of the AdMeTech Foundation is to end the era of blind prostate cancer care. Currently, imaging is not available for prostate glands as it is for other organs, making prostate cancer detection and treatment less accurate than the detection of cancer in other organs. Simply put, prostate care is not yet in the 21st Century, yet it afflicts more Americans than almost any other cancer.

While you may be aware that prostate cancer is the second most common cancer, behind only skin cancer in prevalence, it may not be known that African-American men are 60% more likely to develop prostate cancer during the course of their lives than their European-American counterparts. African-American men also tend to develop prostate cancer at a younger age and are afflicted with a more virulent strain causing one in every two and a half African American men stricken with prostate cancer to die.

It may also surprise you to find that prostate cancer research receives only one-third of the funding that breast cancer research receives through the National Institutes of Health (NIH); that does not take into account the disparity when compared with breast, cervical, and ovarian cancers. One out

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of every six men will develop prostate cancer within their lifetimes; however, their detection and treatment options are limited and archaic.

The Prostate-Specific Antigen (PSA) test and the Digital Rectal Exam (DRE) are currently the only pre-invasive indicators available for the detection of prostate cancer. While these tests are able to show abnormalities in the prostate, they are not particularly adept to detecting prostate cancer and oft times the results are inaccurate showing false positives and false negatives. Women, however, are able to get a yearly mammogram that can pinpoint the exact location of a 3mm tumor that can be easily removed or treated.

Within H.R. 3014, I was pleased to see that the legislation encourages the Director of the Agency for Healthcare Research and Quality to develop guidelines for the screening of prostate cancer and to set up a demonstration project to attempt to eliminate the disparities in the number of men who are screened for prostate cancer. I do not believe that this goes far enough in addressing the issue and would welcome the opportunity to work with your Subcommittee to explore how best to address the disparity that our organization and our supporters in the patient advocacy community have contended with – the lack of a male equivalent for a mammogram designed specifically for prostate cancer detection.

I think men deserve better. They deserve further research into why a racial disparity exists so we can better understand how to treat and prevent the disease. Men deserve to have a clear answer regarding their cancer and where their tumor is located prior to treatments that leave many men impotent and incontinent. As you may know, there is currently a bill pending in your Committee, H.R. 3563, the PRIME Act, that addresses the need for further research into prostate cancer imaging and creating a better PSA test. I am hopeful that some of our suggestions will have the same opportunity for Committee consideration as the helpful provisions in H.R. 3014.

Again, I thank you for having this hearing to highlight the disparities that exist in health care. I hope this conversation is able to continue and that you are able to develop a comprehensive bill that shines a light on all of the disparities that occur in our healthcare system.

Sincerely,

Faina Shtern, MD

PREPARED STATEMENT OF HON. FRANK PALLONE

Good morning. Today the Subcommittee is meeting to review H.R. 3014, the "Health Equity and Accountability Act of 2007," introduced by my colleague, Ms. Solis. I would like to thank you for all your work on this legislation. I would also like to highlight the efforts of the TriCaucus Members and thank all of them for their tireless work on this legislation. This hearing is long overdue and I am pleased that we have the opportunity today to address this very important topic.

Though we as a nation have made tremendous strides in improving the health of all Americans, there remain significant inequalities with respect to both access to health care and the quality of care provided among different ethnic groups in this country. As numerous reports have been published highlighting these gaps in our health care system, it is clear that action must be taken to address these inequalities.

For example, the mortality rate due to heart disease is highest among African Americans; cancer deaths are increasing at a faster rate among Asian Americans and Pacific Islanders than any other racial or ethnic groups; and the rate of new AIDS cases is three times higher among Hispanics than among Caucasians. I, personally, am also very concerned about the health disparities for American Indians and Alaskan Natives. The mortality rate among Indian infants is 150 percent higher than for Caucasian infants, and Indians are nearly three times as likely to be diagnosed with diabetes. Depression is rampant and suicide is two and a half times higher in this population than the national average—in fact, suicide is the second leading cause of death for Indian youth.

These disparities are not limited, however, to ethnic and racial divides, but are consistently also found between genders, geographic area, and among differing income groups. The National Center for Health Statistic's recent report highlights the longer life expectancy for women than for men. There are significantly more access-to-care obstacles for rural populations than there are for urban populations, and the 2002 Institute of Medicine report found that these disparities persisted even when factors such as insurance coverage and income level remained constant. Clearly, these disparities in health services and care are an all encompassing challenge that must be addressed.

Just recently, the Robert Wood Johnson Foundation—the largest health care foundation in the country—announced a $300 million dollar commitment to close the gap in health care disparities across ethnic, religious, and geographic lines. This project will seek to answer crucial questions through data collection in an attempt to better understand the causes of regional health variations. Part of the funds will also be used to pay for national experts who will help grantees tailor their quality improvement plans to their specific communities. Ultimately, this research will work to reduce disparities and provide the groundwork for national health reform models.

While the work of this and other philanthropic organizations is vital in our efforts to close the health disparities gap, more can be done on a federal level as well. With legislation such as the bill we are hearing about today, we can gather more information to develop a multi-faceted approach that will one day eliminate disparities in health.

The "Health Equity and Accountability Act," H.R. 3014, targets the underlying causes of the current health disparity crisis, including racial, ethnic, gender, and rural disparities. The bill would strengthen educational institutions and reinforce efforts to ensure culturally sensitive health care, such as overcoming language barriers. It would support programs to address the shortage of health care providers focusing specifically on those that address minority health care providers. Finally, it would establish community-centric initiatives to improve health care services and eliminate health disparities among legal citizens.

I would like to take this opportunity to clarify a point I know some in this room will try to raise. The intent of this legislation is to close the health gap for individuals who are legally present in this country. We actually used many of these provisions in the CHAMP bill. During our work on the CHAMP Act it came to our attention that we needed to clarify these provisions and we made the necessary changes at that time. The bill before us has not yet been clarified, but I do want to point out again, the provision in question is not intended to cover illegal immigrants but rather to provide legal pregnant women and children access to health care. It is my hope that the conversation this morning will focus on the goals of this bill, which are to eliminate the underlying causes of health care disparities. I hope that my colleagues on both sides of the isle would respect that rather than turning this health disparities hearing into a heated battle on immigration issues.

I would like to thank the witnesses for appearing before us today to share their expertise. I look forward to your testimony and your insight on how this legislation

would address some of the very prevalent health care disparities problems this country faces today.

I would especially like to welcome Dr. Risa Lavizzo-Mourey from the Robert Wood Johnson Foundation, which is located in my district. Thank you for coming down from my home state of New Jersey to testify. And Majority Whip Clyburn and Congressman Moran, it is a pleasure to have you both join us as well. I now recognize my colleague from Georgia, Mr. Deal, for 5 minutes for his opening statement.

BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
UNITES STATES HOUSE OF REPRESENTATIVES

STATEMENT OF CLOSE THE GAP
RE:
H.R. 3014, HEALTH EQUITY AND ACCOUNTABILITY ACT OF 2007
JUNE 24, 2008

Close the Gap, a Boston Scientific initiative, is a national effort to eliminate healthcare disparities in advanced cardiovascular care. The Close the Gap Steering Committee is a diverse group of leading physicians and administrators who have demonstrated success in addressing disparities in cardiovascular care (Exhibit attached). Close the Gap meets its objective to eliminate disparities in advanced cardiovascular therapies by influencing the decision point between patient and physician.

The Cardiovascular Disparities Problem

Heart disease is the number one killer of all Americans.[1] Cardiovascular disease is one of the leading causes of disability in the United States.[2] More women than men die of heart disease.[3] Disparities in care adversely impact the cardiovascular health of African

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[1] 1.National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) 2002.

[2] American Heart Association 2007 Statistics Update

[3] American Heart Association 2007 Statistics Update

Americans and Latinos.[4] Approximately 335,000 people die of Sudden Cardiac Arrest each year in the United States [5].

The vast majority of studies found that minorities received fewer clinically necessary procedures. Disparities exist even when studies adjust for insurance status, income, age and severity of conditions. Finally, disparities contribute to worse outcomes in many cases.[6]

The data are compelling:[7]

- African Americans with CAD or AMI are less likely to receive appropriate cardiac procedures and therapies and are less likely to be catheterized.
- Black Americans are 20%-50% less likely to undergo revascularization, less likely to receive beta blockers, thrombolytic drugs, and even aspirin therapy
- Black Americans are 42% less likely to receive implantable cardioverter-defibrillators
- Black Americans are 13% less likely to have coronary angioplasty and 33% less likely to have bypass surgery than whites.
- Comparisons with Latino populations are similar but less consistent.

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[4] Menash, George and et al; State of Disparities in Cardiovascular Health in the United States; Circulation, Mar 2005; 111: 1233 - 1241.

[5] American Heart Association, Heart Disease and Stroke Statistics –2005 Update.

[6] Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, March 2002.

[7] - Henry J. Kaiser Family Foundation. Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence. 2002.

The problem of cardiovascular care disparities is multi-factorial as noted by Kaiser's research findings:[8]

Patient-Level

- Patient preferences
- Treatment refusal
- Care seeking behaviors and attitudes
- Clinical appropriateness of care

Health Care Systems-Level

- Geographic availability of health care institutions
- Changes in the financing (health insurance access) and delivery of health care services
- Lack of interpretation and translation services
- Time pressures on physicians

Provider-Level

- Bias
- Clinical uncertainty
- Beliefs/stereotypes about the behavior or health of minority patients

Current Approaches

Numerous organizations, including but not limited, to the American Heart Association, Sudden Cardiac Arrest Association, American College of Cardiology as well as various medical institutions are focusing on this problem. Approaches such as cultural competency in medicine training, disease management efforts, quality improvement and community education purposed at targeted populations have proven modestly effective. Most recently the Dartmouth Atlas Project and the Robert Wood Johnson "Aligning Forces for Quality" aim to improve health care. We applaud these initiatives and believe a more targeted approach will yield adequate results within the next five years.

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[8] Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare, March 2002.

The Close the Gap Approach

We focus on reducing cardiovascular disparities by:

- Increasing awareness of cardiovascular risk factors through community programs, more high-risk patients can be identified and helped.
- Helping health care providers learn about disparities, cultural beliefs and compliance barriers, more patients will understand the value of cardiovascular therapies.
- Reviewing and enhancing medical guidelines, health care providers can help ensure that proven, effective cardiac therapies are being offered to all patients who need them.

Close the Gap utilizes a "relationship and partnership" approach at the point of care. We believe that all health care is local. Local teams comprised of non-healthcare leaders and physicians provide a level of influence unmatched by purely physician and/or healthcare professional based models. We prepare non-healthcare leaders to engage with our targeted population groups and pass the non-healthcare leader's credibility to those healthcare professionals responsible for care. Our strategy aligns three areas of influence in our targeted population's lives:

- Athletics.
- Faith-Based Organizations.
- Large employers (non medical businesses).

Close the Gap currently works in partnership with the following:

- Black Coaches and Administrators Association.
- National Coalition of Pastor's Spouses.
- Several NCAA member schools.
- Association of Black Cardiologists.
- National Black Church Initiative.
- Several large health systems.
- Discussions are underway with a number of large, national corporate partners.

We find that physicians and administrators believe that this approach fills a void in the disparities care effort as it focuses on the two most important individuals in the process: patient and physician. Additionally, Close the Gap focuses on quality measures by striving to expand the current Core Measures set for heart failure to include discussions of ICD therapy for patients upon discharge.

Conclusion

Close the Gap believes that a more effective monitoring and measuring system is needed to assure that appropriate progress is being made. Currently the American College of Cardiology does not allow industry-based disparities efforts to track progress below a national level. We support legislation to allow measurement by Metropolitan Statistical Area as we seek to assess progress in this area.

Statement for the Record

Submitted to the Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives

Kaiser Permanente Medical Care Program

June 24, 2008

Kaiser Permanente (KP) applauds the subcommittee for bringing attention to the critical issue of health equity through discussion of H.R. 3014, the Health Equity and Accountability Act of 2007.

In particular, we commend the vital leadership of Congresswoman Hilda Solis, who as chair of the Congressional Hispanic Caucus's Task Force on Health, has spearheaded annual summits across the country to inform the public about racial and ethnic health disparities and efforts to eliminate them.

The existence of racial and ethnic differences in health status and health care access and quality in the United States is well documented. Researchers, think tanks, government entities, and advocacy organizations have worked to summarize many of the root causes, environmental and behavioral influences, and health system factors that play a role. Yet sustained and significant change has been elusive.

America's goals for the health status of its people and the quality of its health care systems cannot be achieved without addressing health disparities. As the nation's largest non-profit health plan and largest non-governmental integrated health system, Kaiser Permanente is committed to improving health equity and reducing disparities among our members and the communities we serve. As part of that commitment, we have initiated a number of programs around cultural competency, workforce diversity, research, and community benefit.

Cultural competency. As H.R. 3014 recognizes, cultural and linguistic competency must be addressed if we are to truly meet the needs of patients from diverse backgrounds and cultures. KP's National Linguistic and Cultural Programs provide expert consultation and leadership in developing linguistically and culturally competent care programs for our diverse multilingual and multicultural staff, members, and communities. This includes building capabilities to serve people with limited English proficiency by, for example, training and certifying professional health care interpreters, identifying qualified bilingual staff and physicians, and developing a standardized document translation infrastructure.

Kaiser Permanente's Institute for Culturally Competent Care helps clinicians integrate the principles of culturally competent care into their practice, through resources, training, and nine clinical Centers of Excellence in Culturally Competent Care. The Institute also

develops handbooks that offer an overview of diverse population groups within Kaiser Permanente's membership. In high demand since the first editions, the Provider Health Series feature information for the African American population, the Asian and Pacific Islander populations, Individuals with Disabilities, the Latino population, and the Lesbian, Gay, Bisexual, and Transgender populations. Each handbook details characteristics that may affect the health status and health care utilization of culturally diverse populations, including demographic information, risk factors, major diseases and conditions, health behaviors and beliefs, and special clinical areas of focus.

Workforce diversity. H.R. 3014 also aims to provide for health care workforce diversity. African Americans, Hispanics, and Native Americans make up over 25 percent of the U.S. population but represent only 9 percent of nurses, 6 percent of physicians, and 5 percent of dentists. Studies have found an association between patient/physician racial concordance and patient reports of greater participation in medical decisions and higher levels of satisfaction, suggesting that one imperative in improving overall health care quality is to increase the opportunities for training health care providers from diverse backgrounds.

Kaiser Permanente has a long, proud history of cultivating and celebrating diversity and striving to achieve health equity. We have established a robust infrastructure for diversity initiatives throughout our organization, including national and regional diversity councils, a full staff in our corporate headquarters devoted exclusively to issues of diversity, and several very active multicultural staff associations.

Kaiser Permanente has developed and disseminated these and other strategies to improve health equity through annual National Diversity Conferences for the past 30 years. The longevity and quality of these conferences exemplifies our commitment to education, and how we disseminate best practices, celebrate accomplishments, and identify new strategies for leveraging diversity to reduce disparities in health and health care and improve health equity.

Research. As an integrated health care delivery system, Kaiser Permanente has the ability to impact the care experience, health care processes, and health outcomes of our members across the continuum of care. Kaiser Permanente HealthConnect™, the comprehensive health information system and electronic medical record that we are putting in place, is improving our ability to collect information on the race, ethnicity, and preferred language of our members and to manage the full spectrum of health data to identify gaps and implement solutions. One of our information technology initiatives, the Information Hub (IHUB), will consolidate information from the electronic medical record and our other administrative data systems into a unified analytical database. The IHUB promises to transform our understanding of health and health care.

In 2007, Kaiser Permanente's Northern California Division of Research launched one of the largest research projects in the world to examine the genetic, environmental, and behavioral factors influencing health: the Research Program on Genes, Environment, and

Health (RPGEH). This research examines the genetic and environmental factors that influence common diseases known to be linked to heredity. RPGEH seeks to gain a deeper understanding of the combinations of genes, behavior, and environmental factors that affect disease prevalence, severity, and outcomes

Community benefit. As part of Kaiser Permanente's mission to improve the health of our members and the communities we serve, we are engaged in a broad set of activities focused on care and coverage for vulnerable populations. Community Health Initiatives focus on healthy eating and active living, health care safety net partnerships, and developing and disseminating health knowledge. The goal of improving health equity and reducing racial and ethnic health disparities underpins these activities.

We have also sought to engage other organizations. The Kaiser Permanente Institute for Health Policy has synthesized the literature on disparities and identified a framework for considering the issue to spur thinking and discussion among those who inform, influence, and make public and private policy impacting health. This work aims to equip people and organizations in health care and other sectors with a shared language and model to consider the problem and potential solutions, and to provide a basis for dialogue, development of strategies, and action. The summary version of this synthesis is attached; the full analysis is available at http://www.kpihp.org/publications/docs/disparities.pdf

Thank you for your thoughtful consideration of the Health Equity and Accountability Act of 2007. Kaiser Permanente's experience in and commitment to the issues of diversity and health equity give us great interest in policy progress in these areas, and we appreciate your vision and leadership.

The Times-Picayune

THURSDAY, JUNE 5, 2008

Health care is high on mayors' agenda

GEORGE L. GRACE
AND GERALD HUDSON

Point of View

Black mayors gathering in New Orleans this week represent large cities like Philadelphia and tiny rural towns like St. Gabriel, La. But all are looking for ways to make our communities stronger, healthier and more prosperous.

Health care reform, a recurring theme of the presidential primary election season, will be on the agenda during the National Conference of Black Mayors' 34th convention. It's also the centerpiece of a new initiative with the Service Employees International Union, the nation's largest health care workers union. This initiative sounds a clarion call to move our country to health equity.

Both the mayors' conference and the service employees' union, with tens of thousands of black and brown workers, know first-hand the terrible impact of inequality in health care services, access, quality and outcomes. This inequality is reflected in chronic diseases and lower life expectancy.

It's a painful fact: African-Americans live sicker and die quicker, from the premature cradle to the early grave.

Mortality stemming from problems such as preterm birth, heart disease and diabetes is dramatically higher among African-Americans. The Big City Health Index released by the National Association of City and County Health Officers shows that black mayors govern in 10 of the 15 cities with the highest rates of preterm births — babies born too small or too soon. New Orleans and Detroit tied for first place, and Baltimore was slightly below in third place. All three cities are headed by black mayors.

These health risks affect all citizens, white and black, of these municipalities. But it's no coincidence that these cities have majority black populations. Nor is it happenstance that half of the members of the black mayors' conference govern cities and towns in the Delta region of Louisiana, Florida, Alabama, Mississippi, Arkansas and Georgia, the area of the nation with the highest rates of uninsured citizens.

Nationally, about 18 percent of the population is uninsured. But in Florida and Louisiana the number of uninsured is a whopping 24 and 20 percent, respectively. And in both states, 27 percent of black people are uninsured.

Being uninsured doesn't just make life difficult. It can make it difficult to live. The Urban Institute estimates that 22,000 people die prematurely each year because they lack health insurance and cannot get the care they need. In New Orleans, despite the efforts of Mayor Ray Nagin and his health officers, residents have been woefully underserved, even prior to Katrina. New Orleans ranks first among big cities in death by diabetes, according to the health officers' data.

While those denied health coverage suffer the most, everybody pays. The lack of health insurance costs the nation between $65 billion and $130 billion annually. The nation loses nearly $1 trillion a year in productivity due to illness.

The disparities that black mayors of many cities confront are symptoms of broader structural inequality. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities that have historically suffered from a lack of health care investment.

In New Orleans, health care workers and local mayors will announce an important initiative. Mayors will commit to holding town hall meetings to allow citizens across the country to talk about their experiences with the health care system. Meanwhile, health care workers will begin collecting hard data on the problems of disparity in medical services.

It's a painful fact: African-Americans live sicker and die quicker, from the premature cradle to the early grave.

The goal is to change health care policy. But it's impossible to do it alone. We need national leadership, especially from our next president.

The solution is a new health care system that is universally accessible, comprehensive and equitable.

Understanding and halting racial disparity is the path to better health for everyone.

•••••••

George L. Grace, the mayor of St. Gabriel, is president of the National Conference of Black Mayors. Gerald Hudson is the executive vice president of the Service Employees International Union.

LIFELINE TO HEALTH EQUITY: POLICIES FOR REAL HEALTH CARE REFORM

A briefing paper by Brian Smedley for the Service Employees International Union and the National Conference of Black Mayors.

June 2008

About the Author

Brian D. Smedley is Research Director for the Opportunity Agenda. He served most recently as a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM) where he was Study Director for the IOM report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care."

About the Service Employees International Union

SEIU represents nearly 1 million health care workers, including nurses, physicians, home health care aides, and nursing home workers. It is the largest union of health care workers in North America. SEIU is also the nation's most diverse union. SEIU has been a leader in the health care debate, and has sought to bring together businesses, providers, health care workers, and elected officials to tackle the health care crisis.

About the National Conference of Black Mayors

The National Conference of Black Mayors represents 647 black mayors nationwide who represent more than 40 million citizens.

Acknowledgements

We would like to thank the staff of Economic Policy Institute's Institute Agenda for Shared Prosperity for their help in shaping and editing this policy brief. EPI's Agenda for Shared Prosperity is enlisting the efforts, expertise and intellectual energy of some of the most imaginative and innovative thinkers to develop policy analyses that address the growing gap between Americans promise and its problems.

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RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

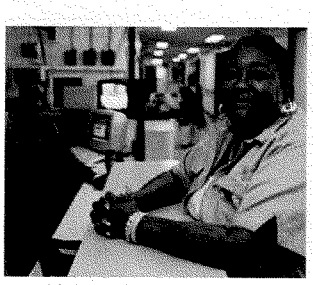
Health care reform is emerging as a key issue in the 2008 presidential campaign, and over two dozen state legislatures and governors are examining proposals to significantly expand health insurance coverage. These health care reform discussions are being triggered by concerns about rapidly escalating health care costs, rising ranks of the uninsured, and the uneven quality of health care. But few of these discussions have focused on the problem of health care disparities, that is, differences in access to and the quality of health care, relative to more advantaged groups, experienced by racial and ethnic minorities, immigrants, those who are not proficient in English, and others.

Health care disparities take many forms and derive from a variety of causes:

- Across a range of measures of health care access and quality, communities of color receive a lower quality and intensity of care than white patients, even when they have similar insurance and incomes and present with the same types of health problems.
- Racial and ethnic minority and immigrant communities are disproportionately uninsured. While about 21% of white Americans were uninsured at any point in 2002, the share was 28% among African Americans and 44% among Hispanics.

- Economic and geographic segregation has created a system of separate and unequal care for low-income and minority patients. Institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than those serving non-minority communities.
- African Americans, Hispanics, and the poor and near poor are more likely than white non-poor groups to face barriers to having a regular source of health care, an important resource for maintaining good health or managing chronic illness.

Left unaddressed, these disparities have the potential to unravel even the best efforts to contain health care costs and improve the overall quality of care. In addition, their persistence leaves U.S. health care systems poorly prepared to address the needs of some of the fastest-growing segments of the population. This paper will examine the causes and consequences of health care disparities, and offer a policy framework for their elimination.



Health care disparities: The U.S. context

Health care disparities are not new—they are a persistent relic of segregation and inadequate health care for communities of color. Like access to other opportunities, health care for minorities suffered from government inattention (and, in some cases, an explicit blessing by the government of inequality) for over 100 years after the end of the Civil War. Even less than 40 years ago, minorities routinely received inequitable care in segregated settings, if care was received at all (Smith 1999). The nation's nascent civil rights laws had yet to make a significant dent in practices such as medical redlining and de facto segregation of health care facilities. Today, these problems are largely ameliorated, but the contemporary health care context remains shaped by this history.

Access to high-quality health care is particularly important for communities of color because deep gaps in health status persist among U.S. racial and ethnic groups. While the nation has made progress in lengthening and improving the quality of life, racial and ethnic health disparities begin early in the lifespan and exact a significant human and economic toll. For example:

- The prevalence of diabetes among American Indians and Alaska Natives is more than twice that for all adults in the United States (U.S. Department of Health and Human Services (DHHS) 2007).
- Among African Americans, the age-adjusted death rate for cancer is approximately 25% higher than for white Americans (DHHS 2007).
- Although infant mortality decreased among all races during the 1980-2000 period, the black-white gap in infant mortality widened (DHHS 2007).
- While the life expectancy gap between African Americans and whites has narrowed slightly (Harper et al. 2007), African Americans still can expect to live 6-10 fewer years than whites and face higher rates of illness and mortality (DHHS 2007).

In terms of lives, this gap is staggering. A recent analysis of 1991-2000 mortality data concluded that, had mortality rates of African Americans been equivalent to those of whites in this period, over 880,000 deaths would have been averted (Woolf et al. 2004).

Despite these health gaps, communities of color experience significant disadvantages relative to whites in both access to care and in the quality of care received. The 2006 National Healthcare Disparities Report (NHDR), prepared and released annually by the U.S. Agency for Healthcare Research

and Quality, is an authoritative source for the documentation of access and quality gaps. Summarizing a range of measures of health care access, the report found that access for some groups, such as African Americans and American Indians, was worse than for whites in the preponderance of the study's measures. Latinos experienced the greatest access problems of all ethnic groups; they received equivalent care as whites in only 17% of the measures, while the remaining access measures (83%) were overwhelmingly poorer for Latinos (Agency for Healthcare Research and Quality 2006). With regard to health care quality, minority groups again faired poorly relative to whites: African Americans and Latinos receive poorer quality care than whites on 73% and 77% of measures, respectively, and Asian Americans and American Indians received poorer care on 32% and 41% of measures, respectively. These growing access and quality gaps are not trivial. For example, from 1999 to 2004 the proportion of adults age 65 and over who received a pneumonia vaccine increased for whites (from 52% to 59%) but decreased for Asians (from 41% to 35%), and from 2000 to 2003 colorectal cancer screening rates increased for whites while falling off sharply for American Indians and Alaska Natives (Agency for Healthcare Research and Quality 2006). These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in non-minority communities.

The NHDR provides a window into the health care experiences of a diverse patient population, but it does not disentangle the influences of race, income, and insurance on health care. A substantial body of evidence demonstrates that racial and ethnic minorities receive a lower quality and intensity of health care than white patients, even when they are insured at the same levels, have similar incomes, and present with the same types of health problems (Institute of Medicine 2003b). Below are a few examples from the research literature:

- Insured African American patients are less likely than insured whites to receive many potentially life-saving or life-extending procedures, particularly high-tech care, such as cardiac catheterization, bypass graft surgery (Henry J. Kaiser Family Foundation 2002), or kidney transplantation (Klassen et al. 2002).
- Black cancer patients fail to get the same combinations of surgical and chemotherapy treatments that white patients with the same disease presentation receive (Institute of Medicine 2003b).
- African American heart patients are less likely than white patients to receive diagnostic procedures, revascularization procedures, and thrombolytic therapy, even when they have similar incomes, insurance,

and other patient characteristics (Henry J. Kaiser Family Foundation 2002).

- Even routine care suffers. Black and Latino patients are less likely than whites to receive aspirin upon discharge following a heart attack, to receive appropriate care for pneumonia, and to have pain—such as the kind resulting from broken bones—appropriately treated (Institute of Medicine 2003b).
- Minorities are more likely to receive undesirable treatment, such as limb amputation for diabetes, than whites (Institute of Medicine 2003b).

Of these health care disparities, inequality in long-term care services is among the most troubling. Population trends show that people of color are the fastest-growing segments of the U.S. population. Racial and ethnic minorities are also burdened with a higher prevalence of chronic diseases. These realities require long-term care policies and funding streams that address the needs of minority patients, their families, and their communities (Akhter and Levinson 2003). Yet people of color requiring long-term care are less likely to be treated in such a system. Despite the increasing supply of nursing home beds and the emergence of assisted living facilities, African Americans are less likely than similarly situated whites to be placed in a nursing home (Akamigbo and Wolinsky 2007). Studies also show that nursing home care remains largely separate and unequal. Most African American nursing home residents tended to be concentrated in a few predominantly African American facilities, and the vast majority of white nursing home residents live in predominantly white facilities. Facilities housing African Americans tend to admit individuals with mental retardation and difficulty in ambulating, and to have lower ratings of cleanliness/maintenance and lighting (Howard et al. 2002). The nearly 15% of U.S. nursing homes that serve African American residents predominantly have fewer nurses, lower occupancy rates, and more health-related deficiencies. They are more likely to be terminated from the Medicaid/Medicare program, are disproportionately located in the poorest counties, and are more likely to serve Medicaid patients than are other facilities (Mor et al. 2004). Other studies document a strong relationship between nursing home or long-term care facility racial concentration and quality. For example, controlling for individual, facility, and market characteristics, blacks were found to be admitted to nursing homes with 32% higher rates of deficiency (defined as evaluations of poor quality made by state surveyors under the federal nursing home certification regulation) (Grabowski 2004).

What are the factors that contribute to health care disparities?

Many of the same problems associated with racial and ethnic inequality in education, employment, housing, and criminal justice are implicated in health care disparities. One of the most pressing fundamental causes of these disparities is residential segregation. Racial and ethnic minorities are more likely to live in segregated, high-poverty communities, communities that have historically suffered from a lack of health care investment. The result too often is that the geographic distribution of health care resources within and across communities results in racially disparate health care: institutions that serve communities of color are more likely to experience quality problems and have fewer resources for patient care than institutions serving non-minority communities.

Racial and ethnic segregation and inequality therefore set the stage for inequitable health care in the United States. But many other causal factors—such as policies and practices of health care systems, the legal and regulatory context in which they operate, and the behavior of people who work in them—are also involved (Grabowski 2004). Some of these causal factors include: (1) differences in insurance coverage and sources of coverage, (2) the inequitable distribution of health care resources, and (3) aspects of the clinical encounter, including cultural and linguistic barriers in health care systems and the interaction of patients and providers. These examples are explored in greater detail below.

Sources of insurance coverage

In its landmark series on the causes and consequences of uninsurance, the Institute of Medicine concluded that the availability and quality of health care in the United States suffers when large segments of the population lack health insurance (Institute of Medicine 2003a). Racial and ethnic minority and immigrant communities are disproportionately uninsured (see **Figure A**), making them especially vulnerable to health crises.[1] For example:

- While about 21% of white Americans were uninsured at any point in 2002, the share among communities of color were higher (28% of African Americans, 44% of Hispanic Americans, 24% of Asian Americans and Pacific Islanders, and 33% of American Indians and Alaska Natives), and these communities are more likely to be dependant upon public sources of health insurance (DHHS 2006).
- While Hispanic children constitute less than one-fifth of children in the United States, they represent over one-third of uninsured children

Nonelderly uninsured by race/ethnicity, 2005

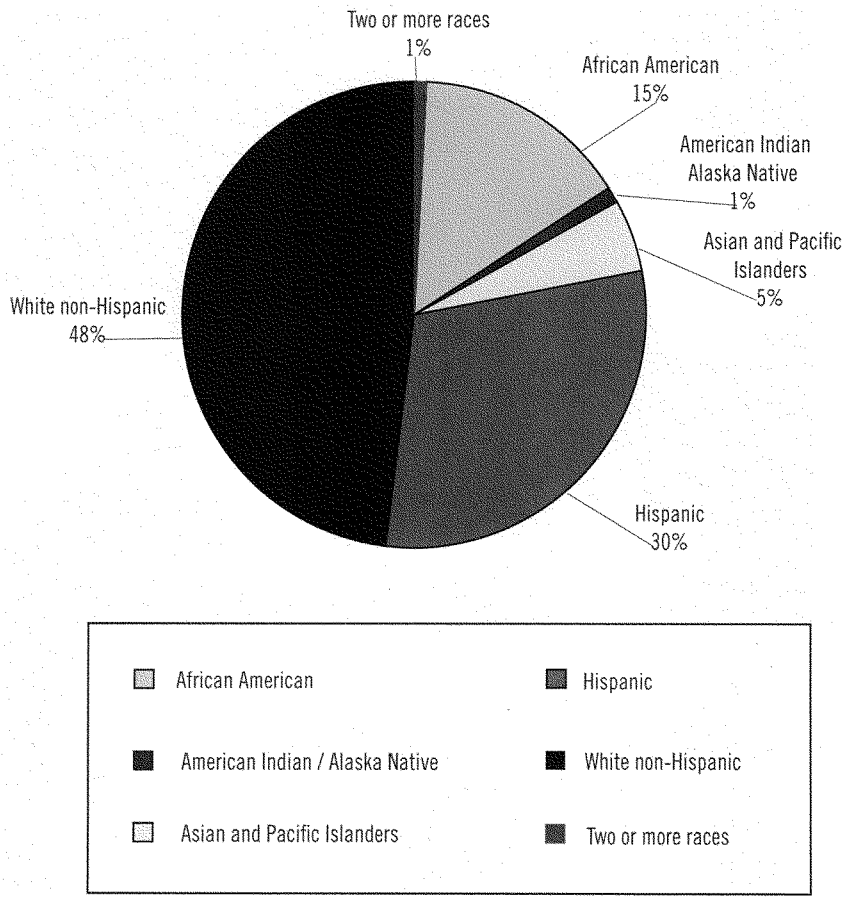
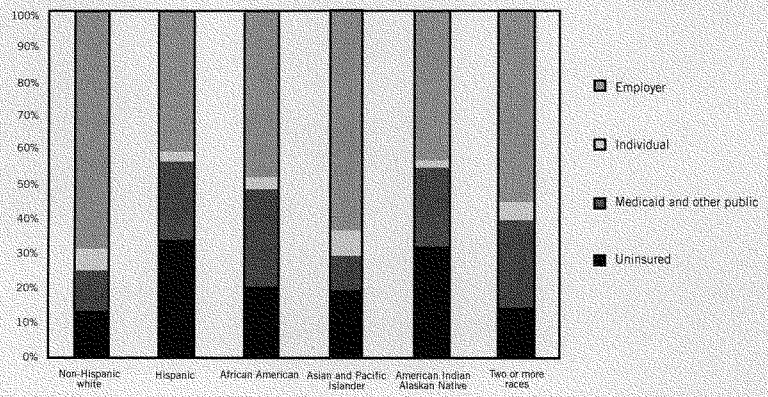


FIGURE 1

Health insurance coverage of the nonelderly by race / ethnicity, 2005



Source: Kaiser Family Foundation (2007).

(Robert Wood Johnson Foundation 2005). And among children in fair or poor health who lack insurance (nearly 570,000 children in 2002), over two-thirds are Hispanic (Urban Institute 2005).

- More than 11 million immigrants were uninsured in 2003, contributing to one-quarter of the U.S. uninsured.[2] Between 1998 and 2003 immigrants accounted for 86% of the growth in the uninsured population (Employee Benefit Research Institute 2005).
- Foreign-born people are 2.5 times more likely than the native-born to lack health insurance, a gap that remains unchanged since 1993 (U.S. Census Bureau 2005).

The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs—jobs disproportionately occupied by people of color—tend to offer only limited health benefits, if they offer benefits at all, that are often accompanied by relatively expensive cost-sharing arrangements with employees. Moreover, as noted above, racial and ethnic minorities are disproportionately dependent on public insurance sources, such as Medicaid (see **Figure B**). While Medicaid has been vital for expanding access to health insurance, its limited benefit package and low reimbursement rates have a dampening effect on health care access and quality among its beneficiaries.

The distribution of health care resources

These economic pressures can sustain a form of "medical apartheid"—that is, separate and unequal care for low-income and minority patients (Bronx Health Reach 2005). For example, physicians who serve predominantly racial and ethnic minority patients are less likely to possess board certification, and have greater difficulties accessing high-quality specialists, diagnostic imaging, and non-emergency hospital admissions for their patients than physicians who serve predominantly non-minority patients (Bach et al. 2004). A recent study of over 300,000 patients treated at 123 hospitals across the country found that minorities were disproportionately likely to receive care in lower-quality hospitals, a problem that explained the largest share of health care quality disparities (Hasnain-Wynia et al. 2007). The geographic mal-distribution of services likely contributes to the problem. For example, a study of the availability of pain medication revealed that only one in four pharmacies located

in predominantly non-white neighborhoods carried adequate supplies, compared to 72% of pharmacies in predominantly white neighborhoods (Morrison et al. 2000). Nearly one in five Latinas (18%) and one in 10 African American women reported not seeking needed health care in the last year due to transportation problems, compared to 5% of white women (Henry J. Kaiser Family Foundation 2004). These problems are the by-product of residential segregation and economic pressures that reward the concentration of services in outer suburbs and wealthier communities, and create disincentives for practice in urban centers (Smith 2005).

Regular source of health care

Having a regular source of health care—a local physician, clinic, or health center that patients can consider their "medical home"—is important, particularly for individuals who face or are at risk for chronic illness. When patients are able see a health care provider consistently, they are better able to build trusting relationships, ask questions, and give and receive information. Patients who lack a regular source of health care often report miscommunication, misdiagnoses, and greater frustration about their ability to receive needed care (Henry J. Kaiser Family Foundation 2003). The uninsured and underinsured, many racial and ethnic minorities, people who are not proficient in English, those who live in rural communities, and those who have low incomes are more likely to report not having a regular source of health care (Henry J. Kaiser Family Foundation 2003). Yet the regular-source-of-health-care gap among racial/ethnic and income groups is growing:

- African Americans, Hispanics, and the poor and near poor (of all racial and ethnic groups) are more likely than white non-poor groups to face barriers to having a regular source of health care. These gaps have increased since 2000. Over 42% of Hispanic poor and 37% of Hispanic non-poor people lacked a regular source of health care in 2001 and 2002, an increase of more than 30% and 18%, respectively, since 1995 and 1996 (Henry J. Kaiser Family Foundation 2003).
- During this same period, the percentage of poor and near-poor African Americans and whites without a regular source of health care went largely unchanged. But these groups were up to 75% more likely than non-poor African Americans and whites to lack a regular source of health care in 2001 and 2002 (Henry J. Kaiser Family Foundation 2003).

- The percentage of Hispanics from all income groups who lacked a regular source of health care increased between 1993 and 2002, despite a 15% decline over the same period in the ranks of white poor individuals who lacked a regular source of health care (Henry J. Kaiser Family Foundation 2003).
- African American and Hispanic patients are nearly twice as likely as whites to report having a "non-mainstream" usual source of care, e.g., a hospital-based provider, rather than a private physician (Lillie-Blanton et al. 2001).

Language barriers

More than 46 million people in the United States speak a language other than English. Of those, more than 35 million speak English "well" or "very well," but over 10 million speak the language "not well" or "not at all" (U.S. Census Bureau 2006). Individuals with limited English proficiency are less likely than those with strong English language skills to have a regular source of primary care or to receive preventive care. Moreover, they tend to be less satisfied with the care they receive, are more likely to report overall problems with care, and may be at increased risk of experiencing medical errors (Institute of Medicine. 2003b). The quality of their health care therefore depends on the ability of medical professionals to effectively communicate. But many health care organizations do not provide adequate interpretation services:

- Nearly half of Latinos who are primary speakers of Spanish report having difficulty communicating with doctors or other health care providers because of language barriers (Pew Hispanic Center 2004).
- Over one in five non-English-speaking patients avoid seeking medical help altogether because of language barriers (Pew Hispanic Center 2004).

The clinical encounter

Aspects of the clinical encounter—the interaction between patients, their providers, and the health systems in which care is delivered—can play a powerful role in contributing to health care inequality. Patients and providers bring a range of expectations, preferences, and biases to the clinical encounter that can be expressed both directly and indirectly. For example, at least part of the disparity results from biases and stereotypes that health care providers may carry about racial and ethnic minorities. Experimental studies confirm that physicians can hold a host of negative beliefs about minority patients. They are presumed to be more likely to abuse drugs or

alcohol and to be less educated. They are not expected to comply with physicians' instructions, to want an active lifestyle, or to participate in rehabilitation if prescribed. Doctors are likely to consider white patients more "pleasant" and "rational" than black patients, and to prefer white patients as "the kind of person I could see myself being friends with." These kinds of stereotypes and biases are often unconscious, but nonetheless can influence physicians' decisions regarding when and what treatments to offer (Institute of Medicine 2003b).

More recent research confirms that implicit biases (that is, unconscious biases that may reflect racial socialization) influence medical professionals' decision making. For example, Green and colleagues assessed the relationship between implicit biases (as measured by a widely accepted computer-based test of the speed with which individuals make associations between people and concepts) and physicians' decisions regarding the use of thrombolysis (i.e., clot-busting medications) among hypothetical patients in the midst of a heart attack. While physicians reported no explicit preference for white versus black patients or differences in perceived cooperativeness, scores on implicit association tests revealed a preference favoring white Americans and implicit stereotypes of black Americans as less cooperative with medical procedures, and less cooperative generally. More importantly, physicians' level of pro-white implicit bias significantly predicted their likelihood of treating white patients and not treating black patients with thrombolysis. That is, physicians who harbored the highest level of implicit racial bias were less likely to treat black heart attack patients with a potentially life-saving treatment (Green et al. 2007).

Eliminating health care inequality

Health care disparities are a complex problem rooted in systemic racial and ethnic inequality and are embedded in multiple institutions. Their elimination will require a long-term commitment and investment to address multiple problems, involving many public and private stakeholders.

Table 1 presents a framework for policy steps that can be adopted by federal, state, and local governments to improve access to and equalize the quality of health care for all, with particular attention to the needs of communities of color. These include strategies to:

1. ***Expand access to health insurance.*** The most important step toward eliminating racial and ethnic health care disparities is to achieve universal health insurance coverage. Benefits should be comprehensive, and should include services that many communities

TABLE 1

Achieving health care equity: A policy framework

Expand access to health insurance	***Improve access to providers and services***	***Promote equally high health care access and quality***	***Empower patients and communities***
Strive for universal insurance coverage	Increase provider diversity	Collect and monitor data on disparities	Promote patient education and health literacy
Promote fair sharing of costs	Support safety net institutions	Publicly report data	Promote the use of lay health navigators
Promote comprehensive benefits	Provide incentives to providers for the undeserved	Adopt cultural and linguistic standards	Promote community-based health care planning
Target and evaluate outreach efforts to underserved	Address geographic imbalance of health care resources	Encourage attention to disparities in quality improvement	Strengthen community benefits obligations

of color need to access appropriate care, such as interpretation services.

2. ***Improve access to health care providers.*** Even if the United States achieved universal health insurance coverage, because of residential segregation and the dearth of health care providers and resources in communities of color, special efforts must be made to ensure that health care resources are better aligned with these communities' needs.
3. ***Promote equally high health care access and quality.*** As the studies noted above demonstrate, health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high-quality health care. Several policies offer mechanisms to elevate and promote equitable care for all.
4. ***Empower patients and communities.*** To ensure that health care meets their needs, patients and communities should be empowered to participate in treatment decisions and to inform policies regarding the distribution of health care resources at the community level.

While health care disparities are most effectively addressed at multiple levels of government, some jurisdictions are assuming a leadership role in developing and implementing strategies on their own. Several cities and counties, for example, have made the elimination of health and health care inequality a priority, and have developed strategies to address them. (See the box, "**Local jurisdictions take action to eliminate health disparities.**")

Expand access to health insurance

The dearth of insurance coverage—specifically, the high rates of uninsurance and underinsurance among people of color—is the foremost problem to solve to eliminate health care inequality. The United States is the only modern, industrialized nation without a universal health care program. Health insurance coverage is primarily provided by employers, but as benefit costs rise employers are declining to offer coverage or are purchasing plans that require greater employer cost sharing. These economic pressures contribute to growing inequality in insurance coverage. Health insurance coverage is increasingly unequal, disproportionately hurting those who need health care the most—particularly racial and ethnic minorities, children, and lower-income women and their families. For example, less than half of low-wage workers have employer-provided health insurance from their own employer or a family member's employer, and female low-wage workers

are half as likely as male low-wage workers to receive health insurance from their employer (Boushey and Diaz 2004).

Strive for universal insurance coverage. Health care access inequality must be tackled by state and federal efforts to develop a universally accessible, comprehensive, and equitable health care system. The most cost-effective way to achieve this goal is by pooling risk as broadly as possible in a common, comprehensive health insurance system—a national, single-payer health insurance plan. Such an approach allows patients to choose their health care provider, and insures that the delivery of care remains in public and private systems while allocating health care resources more fairly. For example, by allowing employers and individuals to buy into Medicare, policy makers can create a "Medicare for all" national single-payer plan. Medicare is more efficient than private plans because of its low administrative costs (about 2%, or one-seventh most estimates of administrative costs in private health plans). And because Medicare is a federal program, subject to the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, ethnicity, language status, and other factors, it contains mechanisms of accountability that can be expanded and enhanced to ensure that any instances of discriminatory health care are thoroughly investigated and prosecuted.

In the United States, however, such an approach meets often strong resistance. It is therefore often more politically pragmatic to craft policy solutions that build on the most popular elements of the present structure. Hacker, for example, proposes a plan ("Health Care for America") that would create a new national public insurance pool modeled after Medicare that enjoys the program's flexibility, comprehensiveness, and administrative efficiency while allowing employers to either continue to offer private health insurance benefits or pay into the new public insurance pool ("pay or play") (Hacker 2007). Such a plan shares many key elements of a universal health insurance strategy, such as pooling risk as broadly as possible, while preserving the private insurance market. Moreover, Health Care for America would address equity issues by (1) providing near-universal health insurance coverage, which will disproportionately benefit communities of color; (2) encouraging fair cost-sharing and minimizing out-of-pocket costs (both of which can increase access to health insurance among low-income populations, as discussed below); and (3) ensuring that all public and private plans provide comprehensive benefits, thereby addressing the "fragmentation" of the health insurance market (also discussed below).

Local jurisdictions take action to eliminate health disparities

Local jurisdictions are increasingly making the elimina-tion of health and health care disparities a high priority. Spurred by a large body of evidence documenting the persistence of health inequality and a paucity of action to address these problems at the federal level, several major U.S. cities and counties have developed innovative pro-grams to improve access to high-quality health care for people of color, as well as community-based strategies to improve living conditions and opportunities for good health.

Led by Mayor Sheila Dixon, congressman Elijah E. Cummings, and Maryland State Delegate Shirley Nathan-Pulliam, Baltimore City and Baltimore County are partnering in a major public health initiative to reduce cardiovascular disease and diabetes and to re-duce racial and ethnic disparities in the incidence and toll of these diseases. Initiatives are planned to:

- Increase community-based smoking cessation programs, including targeted outreach and education programs to communities of color, coupled with telephone counseling and nicotine replacement therapy;
- Expand community health worker programs, which help patients to navigate interactions with the health care system and address com-munication difficulties;
- Expand health screening in barber shops and beauty salons, building on successful programs that provide programs such as blood pressure monitoring and counseling regarding diet, physical activity, and other health-enhancing behaviors;
- Increase partnerships with faith-based organizations to provide services such as blood pressure and cholesterol screening, diet and nutrition workshops, smoking cessation, and exercise programs; and,
- Launch a task force on reducing sodium intake, to develop recommendations for a range of stakeholders such as the food industry, grocers' associations, medical organizations, nonprofit organizations, political leaders, and government health agencies.

The Alameda County Public Health Department, under the leadership of Dr. Tony Iton, has released a report, "Life and Death from Unnatural Causes: Health and Social In-equity in Alameda County," which explores how social and economic inequality and where people live and work affect their health.

To address issues raised in the report, the county is mobilizing community partnerships and developing policies that support individual and commu-nity health. Similarly, King County is Washington State, under the leadership of county executive Ron Sims, has launched an Equity and Social Justice Initiative, which aims to end persistent local inequities and injustices that result in higher rates of disease among low-income populations and disproportionate rates of young black men in jail.

Since 2003, the city of Boston has prioritized the elimination of health disparities and has undertaken a series of steps—often in concert with the Commonwealth's sweeping 2006 legislation to achieve universal health insurance coverage—to improve data collection, health care workforce training, and patient education, among other strategies. The city's "Disparities Project: Action Plan for Addressing Racial and Ethnic Health Disparities" is an effort led by the mayor's office and the boston Public Health commission (BPHC) to eliminate racial and ethnic health disparities, which the city identified as its primary pubic health concern in 2003. To date, the Disparities Project has released three reports:

- The Mayor's Hospital Working Group issued hospital-based recommendations around the collection and reporting of disparities data, diversifying the health care workforce, and im-proving institutional cultural competency efforts.
- The Mayor's Blue Ribbon Task Force (TF) issued a blueprint with strategies to eliminate health disparities.
- Through the BPHC, the city issued a data report that provides a comprehensive profile of health disparities in Boston.

The "Mayor's Task Force Blueprint: A Plan to Eliminate Racial and Ethnic Disparities in Health, sought to coordinate the city's resources to address health disparities. Released in June 2005, the blueprint made several recommendations, coupled with short-term and intermediate action steps, to eliminate disparities. Among its 12 recommendations, it urged the city to promote universal health insurance coverage; require that all health care organizations and in-surers collect uniform data on the race, ethnicity, primary language, and socioeconomic status of patients; expand and develop cultural competence training programs; and identify promising workforce development strategies to expand access to medical education for low-income and minority students. Consistent with the report's recom-mendations, in May 2006, The Boston Public Health Commission approved regulations requiring the city's 10 acute care hospitals and eventually all Boston hospitals and community health centers to collect data on patient race, ethnicity, education, and preferred language.

Promote fair sharing of costs. Many state health care expansion proposals are weighing new cost-sharing arrangements that are intended to make costs more transparent and promote cost-conscious consumer behavior. But several studies demonstrate that low-income communities are less likely to access health care as out-of-pocket costs rise (see, for example, Doty and Holmgren 2006; Hargraves and Hadley 2003; Lillie-Blanton and Hoffman 2005; and Weinick et al. 2005). Equitable cost-sharing takes into account and attempts to minimize the disproportionate impact that cost-sharing arrangements can have on health care access and utilization among currently underserved groups. These efforts include public subsidies for those with low incomes to purchase health insurance; sliding fee scales for premiums, co-payments, and out-of-pocket costs; and studies of and responses to potential unintended effects of cost-sharing on utilization.

Promote comprehensive benefits. As noted above, many in communities of color require services such as professional interpretation and translation. In addition, because these communities are less likely to access other needed services, such as dental and mental health services, comprehensive benefit packages should cover these services. Equalizing access to the same kinds of health care products and services regardless of insurance source will also help to reduce fragmentation of the health insurance market. A potentially significant source of racial and ethnic health care disparities among insured populations lies in the fact that minorities are likely to be disproportionately enrolled in "lower-tier" health insurance plans. Such plans tend to limit services, offer fewer covered benefits, and have relative small provider networks. These limits can harm access to quality care (Institute of Medicine 2003b). Given that several states are examining strategies to expand health insurance coverage, it is important that these coverage expansion proposals improve access to the same health care products and services, regardless of coverage source.

Target and evaluate outreach efforts to the underserved. Racial and ethnic minorities and immigrants are underrepresented, relative to eligibility rates, in public health insurance programs. States that have achieved greater success in increasing minority participation in public programs have developed and sustained aggressive outreach programs and have taken steps to improve and streamline enrollment, with particular attention to the needs of cultural- and language-minority groups. Moreover, because state health insurance expansions may not reach communities of color equally, states should consistently evaluate outreach to and enrollment of underserved groups in public health insurance programs. Measurement of public insurance take-up rates in low-income communities and communities of color is an important step to ensure

that health care expansion efforts reach underserved groups. States that regularly conduct such evaluations can be expected to see improved coverage rates among eligible populations.

Improve access to health care providers and services

Universal health insurance coverage is an important step toward improving the geographic distribution of health care providers and resources, but federal, state, and local governments must take steps to improve underserved patients' access to providers. Several jurisdictions have adopted strategies that improve community-level access to providers and services with particular attention to the needs of communities of color.

Improve provider diversity. State and federal governments must also take steps to strengthen the health professions' ability to serve the nation's increasingly diverse population. By the middle of this century, nearly half of all who live in the United States will be members of racial or ethnic minority groups, and four states—California, Hawaii, New Mexico, and Texas—are already "majority minority." Racial and ethnic minority patients are more likely than majority-group patients to experience cultural and linguistic barriers when attempting to get the health care they need, and they often express greater satisfaction when they receive care from a provider of the same background (Institute of Medicine 2004). In addition, several studies demonstrate that racial and ethnic minority health care providers are more likely to express interest in and work in medically underserved communities (Institute of Medicine 2004). To help health care systems address the needs of an increasingly diverse patient population, state and federal governments should take steps to increase the racial and ethnic diversity of health care providers by reducing or eliminating financial barriers to health professions education for low-income students, strengthening magnet science programs in urban high schools, and, consistent with the U.S. Supreme Court's ruling in the 2004 Gutter v. Bollinger decision, supporting the consideration of applicants' race or ethnicity as one of many relevant factors in higher education admissions decisions.

Support safety net institutions. People of color and low-income individuals are more likely to access health care in "safety net" institutions, such as public hospitals and community health centers. In many cases, these institutions face financial vulnerability because of low Medicaid reimbursement rates and/or the costs of providing uncompensated care to uninsured individuals. These institutions may fare better in states where near-universal health insurance coverage proposals are enacted and where health insurance expansions are realized, but they will likely

continue to face financial vulnerability until truly universal coverage is achieved. States vary widely, however, in their support for safety net institutions. California, for example, has assumed much of the cost of hospital indigent care, Maryland and Massachusetts have established statewide uncompensated care funds, but many other states fail to assist institutions that serve low-income and uninsured populations.

Provide incentives to providers for the underserved. Creating and/or enhancing incentives—such as education loan repayment or debt forgiveness—to encourage health care professionals to establish practices in underserved communities can be an important strategy to balance the distribution of health care providers, particularly primary care providers. Low-income and minority communities often have the most pressing need for health care services, but they are served by a dwindling number of providers and institutions that lack resources to expand and improve services. State and federal governments have attempted to address this imbalance by providing incentives such as funds for graduate medical education programs that focus on underserved populations, and tuition reimbursement and loan forgiveness programs that require service in health professional shortage areas (Institute of Medicine 2004).

Address geographic imbalance of health care resources. State and local governments are increasingly returning to Certificate of Need (CoN) assessments as a tool to reduce geographic disparities and reduce the fragmentation of the health insurance market. Historically, the purpose of the CoN process has been to control health care costs and ensure that capital and technology investments in the health care industry reflect community needs. In most states that employ CoN, the process has required hospitals or other health care institutions that seek to establish or expand services to submit proposals to state boards; the boards in turn evaluate projects to eliminate unnecessary duplication of services and ensure that investments strategically address health care needs. But the process has met significant resistance and criticism for its failure as a cost-containment measure. The CoN process, however, has great potential to encourage a better distribution of health care resources to reflect community and statewide need. States should re-evaluate and in some cases reinvigorate CoN through new policies that ensure accountability for the use of public funds (Smith 2005).

Promote equally high health care access and quality

As the studies noted above demonstrate, universal health insurance coverage by itself is insufficient to ensure that communities of color have access to and receive high-quality health care. Federal, state, and

local governments are increasingly examining mechanisms to promote "equality of health care quality." These strategies have the potential to improve the accountability of health care systems to patients and employers, and reduce health care costs and improve quality for all patients by encouraging greater use of evidence-based guidelines and by rewarding the provision of cost-effective primary care.

Collect and monitor data on disparities. State and federal contracts and policies are increasingly requiring all public and private health systems to collect data on patients' race, ethnicity, gender, primary language, and educational level, and to monitor for inequality in access to needed services and in the quality of care received. Currently, federal and state data collection efforts with regard to health care disparities are uneven. Some states require recipients of state funding (e.g., Medicaid managed care organizations) to collect and report health care access and quality data by patient demographic factors, but many others fail to use their leverage as regulators, payers, and plan purchasers to encourage all health systems to collect and report data using consistent standards. And given that federal and some state non-discrimination laws apply to health care settings and require diligence to enforce, federal and state requirements to collect and report standardized data are an important benchmark for efforts to reduce health care inequality.

Publicly report data. Publicly reporting health care access and quality disparities at the institutional (e.g., hospital or health clinic) level is important to ensure that the public and policy makers are aware of when and where health care inequality occurs. Once state and federal governments have obtained health care access and quality data by patient demographic factors, this information should be publicly reported at the smallest possible level (e.g., hospitals and health centers) to promote greater public accountability, to allow consumers to make more informed decisions about where to seek care, and to assist efforts to monitor disparities and take appropriate action to investigate potential violations of law.

Adopt cultural and linguistic standards. To ensure truly accessible health care, health care systems must also be responsive to patients' cultural and linguistic needs. State and federal policies can expand access for disparity populations by promoting cultural and linguistic competence in health care settings and diversity among health care professionals. The federal Cultural and Linguistic Access Standards (CLAS) identify over a dozen benchmarks that have been widely accepted and increasingly adopted by health systems and providers. And despite the fact that federally funded health care organizations are mandated to meet four of

the standards, few states have taken steps to encourage more widespread adoption of the guidelines and recommended standards. Such programs improve the cultural competence of health systems and increase the likelihood that patients of color will access and be satisfied with the health care they receive. In addition, some jurisdictions are requiring cultural competency training for all health care professionals as a condition of licensure. As of 2005, for example, New Jersey required that all physicians practicing in the state must attain minimal cultural competency training before receiving a license.

Encourage attention to disparities in quality improvement. State and local jurisdictions are also increasingly extending financial incentives to health systems that adhere to evidence-based clinical guidelines as a means of promoting the highest standards of health care for all patients. Health care quality improvement efforts, such as pay-for-performance or performance measurement, are gaining increasing attention. But they can unintentionally deepen health care access and quality gaps. Because underserved communities are typically sicker and face greater barriers to treatment compliance, performance measurement can inadvertently dampen provider enthusiasm for treating low-income communities or communities of color. Quality improvement efforts should take into account the challenges and needs of underserved communities and reward efforts that reduce disparities and improve patient outcomes relative to baseline measures. Some quality improvement measures adjust for patient case mix or emphasize efforts to reduce disparities in order to avoid unfairly penalizing providers while holding them and health systems accountable for improvements in health outcomes.

Empower patients and communities

Too often in American health care, patients are expected to make sound health care decisions and advocate for their needs absent the knowledge and power necessary to do so. Such an approach can be particularly problematic for communities of color, who face lower levels of health literacy and who often—because of historical and cultural reasons—feel less empowered to aggressively advocate for their health care needs than do more socially and educationally advantaged groups. Moreover, governments have the power to lessen the impact of a market-driven health care industry that has tended to overlook the needs of low-income communities and communities of color in favor of wealthier communities that promise lower financial risks and greater financial reward. State and federal governments should give all communities the power to make recommendations and weigh in on decisions regarding health care policies that affect them.

Promote patient education and health literacy. Several jurisdictions are developing and assessing the efficacy of patient education programs, such as health literacy and navigation programs, and are replicating effective strategies. Patient education programs commonly seek to help patients understand how to best access health care services and participate fully in treatment plans. Successful programs are well-researched and are tailored to the need of underserved communities. Such efforts to empower patients can help reduce health care disparities by providing patients with skills to effectively navigate health care systems and ensure that their needs and preferences are met. Patient education programs are most effective when designed in partnership with target populations and when language, culture, and other concerns faced by communities of color are fully addressed.

Promote the use of lay health navigators. Health departments can support the training of and reimbursement for community health workers, sometimes also known as "lay health navigators" or promotores, who can serve as a liaison between health care institutions and their patients. Community health workers are trained members of medically underserved communities who work to improve community health outcomes. Several community health worker models train individuals to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources. In health care contexts, they serve as a liaison between patients and health systems. Community health worker models are rapidly spreading, as research and practice indicates that such services can improve patients' ability to access care and understand how to manage illness. State and federal governments can stimulate these programs by providing grants, seed funding, or other resources.

Promote community-based health care planning. States can promote and/or (in most cases) reinvigorate community health planning, in which members of the community identify their needs and assist policy makers in planning, implementing, and evaluating the effectiveness of public health care systems. Community health planning has a long history, but its promise as a tool to reduce health care disparities has yet to be fully realized. Community health planning seeks to strengthen communities to play a greater role in their own health, actively involving residents in the planning, evaluation, and implementation of health activities in their communities. The 1974 National Health Planning Law sought to create and support a network of community Health Services Agencies (HSAs), but a lack of funding and effective mechanisms for community input to shape health policy has led to a decline in HSA power and influence. Some states, such as New York, are examining strategies to reinvigorate

HSAs and to include disparities-reduction efforts as part of the mission of these planning agencies.

Strengthen community benefits obligations. Nonprofit and tax-exempt health care institutions attain their special status as a result of contributions they make to the broader public good. By far, most tax-exempt institutions allocate their charitable resources to the costs of care (particularly emergency room services) for the uninsured. But policy makers are increasingly seeking a more in-depth understanding of the potential charitable contributions of nonprofit hospitals and health systems. These can include comprehensive approaches such as strategies to encourage healthy behaviors and improve social and physical conditions in communities. If successful, these efforts meet both the community's and the hospital's goals of improving health status and reducing the demand for high-cost emergency room and inpatient care. Such strategies centralize the importance of improving community health, empower community members to voice concerns, and increase nonprofits' public accountability for their tax-exempt status (Public Health Institute 2004).

Social and community-level influences on health disparities

The policy strategies outlined above are directed at improving the ability of health care systems to respond to the needs of communities of color. As discussed, however, improving the health status of many racial and ethnic minority groups will require policy strategies focused outside of the health care arena. These include efforts to improve housing and community living conditions, improve food resources and nutrition options, improve conditions for exercise and recreation, and ultimately, reduce economic and educational gaps. These social and community-level strategies—along with examples of state and local efforts to implement them—are discussed in the accompanying box, "**Addressing social and community-level determinants of health**."

The role of organized labor

The labor movement has historically been at the forefront of efforts to advocate for equitable, high-quality health care for all who live in the United States. Labor unions must continue to exert pressure on political leaders to make health equity a key policy goal of any health care reform effort. The Service Employees International Union (SEIU), for example, has released a new plan to promote quality health care for all, and has demanded from every presidential candidate a health care plan for universal coverage that promotes quality, prevention, and patient choice, and is

financed fairly by employers, government, and individuals. SEIU is also advocating to improve conditions and training for health care workers, and has led the Partnership for Quality Care, a unique coalition that brings together SEIU and some of the nation's largest health care providers to press for the reform and improvement of the U.S. health care system. In addition, SEIU is working to raise awareness of how social and economic inequality and the conditions in which people live and work affect health. These and other efforts contribute to a historic opportunity to charge the way health care is financed and delivered in the United States, as well as how policies in other areas—such as education, employment, and housing—affect health.

Conclusion

Health care access and quality is more often compromised for racial and ethnic minorities than for whites, for those who do not speak English well relative to those who are English-proficient, and for immigrants relative to U.S. natives. These disparities have a long history in the United States and are both a symptom of broader structural inequality and a mechanism by which disadvantage persists. Moreover, they carry a significant human and economic toll. The Institute of Medicine estimates that 18,000 people die prematurely each year because they lack health insurance, and that the annual cost to the nation of the poorer health and shortened life spans attributable to uninsurance is between $65 billion and $130 billion (Institute of Medicine 2003a). Because people of color are disproportionately among the uninsured, these numbers carry a greater burden in minority communities.

Encouragingly, policy makers are increasingly focused on eliminating these disparities. A range of policy strategies are available to federal, state, and local governments, but it is important to recognize that no single policy—such as expanding access to health insurance—will fully address health care inequality. Health care disparities are complex and are rooted in many causal factors that span across a range of levels, including institutional, governmental, and individual. It is therefore important to identify, implement, and evaluate multi-level strategies addressing health care financing, systems, and workforce development. Such strategies should operate together to improve health care access and quality for vulnerable populations. The strategies identified here are only a first step toward creating a more equitable health care system for all.

*—**Brian Smedley** is research director and co-founder of the Opportunity Agenda, a communications, research, and policy organization focusing on social justice issues.*

Addressing social and community-level determinants of health

Social and economic inequality among racial and ethnic groups and other marginalized populations is the most significant underlying factor behind most health status inequality. racial and ethnic discrimination and segregation perpetuate and deepen these gaps. Health care, therefore, cannot eliminate health status gaps between population groups. state efforts should look to a broad range of social and economic policy when crafting strategies to improve and equalize health status for all, and state health agencies should play a leadership role in coordinating these efforts. and states can play a large role in providing incentives for efforts to improve health conditions in a community and more effectively punish acts that weaken community health conditions. these include efforts to:

- Improve the coordination of relevant state and federal agencies that should address determi-nants of health inequality (e.g., in education, housing, employment, and criminal justice). Governments that seek to reduce racial and ethnic social and economic gaps are inherently engaging in health equity work. Almost all as-pects of federal, state, and local policy in edu-cation, transportation, housing, commerce, and criminal justice influence the health of residents, and they can have a disproportionate impact on marginalized communities. governments that have taken steps to coordinate the work of agen-cies that impact health disparities are likely to reduce duplication of effort, increase efficiency, and more effectively address health outcome disparities.
- Create incentives for better food resources and options in underserved communities (e.g., grocery chains, "farmers' markets"). Several local jurisdictions have established public-private partnerships to bring supermarkets to underserved areas. for example, the city of Rochester, N.Y., which experienced an 80% decline in grocery stores in the 1970s and 1980s, used public resources (the Federal Enterprise Community Zone program, the community Development block grant program, and other sources) to attract a major supermarket chain to open stores in the city. more recently, Pennsylvania awarded a $500,000 grant to help establish a supermarket in the Yorktown section of Philadelphia, part of a broader initiative to support the development of supermarkets and other food retailers in urban and rural communities that lack adequate access to supermarkets. state and federal governments can make similar investments.
- Develop community-level interventions for health behavior promotion (e.g., smoking ces-sation, exercise). Federal and state programs to promote healthy behaviors are increasingly recognizing the need to target community-level risk factors and strengths that affect individual health behavior. Such programs are often vital for low-income communities and communities of color, which have fewer community resources for exercise (e.g., safe public parks and recreation centers), effective nutrition, and reduction of individual health risks (e.g., low-income urban communities have more public advertisement of tobacco products and greater availability of alcohol). State and federal agencies can exert legal and regulatory authority to reduce com-munity-level health risk and promote healthy behavior.
- Address environmental racism (e.g., by aggressive monitoring and enforcement of environ-mental degradation laws). Racial and ethnic minority communities are disproportionately hurt by the presence of toxic waste dumps and industrial and occupational hazards. Through legal and regulatory strategies, state and federal agencies can reduce environmental health risks and monitor whether and how communities are affected by governmental or commercial activity.

Endnotes

People of color make up only about 30% of the U.S. population, but over half of the nation's uninsured are racial and ethnic minorities. See DHHS 2007.

The uninsurance rate among immigrants increased dramatically in the late 1990s, following passage of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, which imposed a five-year limit on most new immigrants' ability to participate in public health insurance programs. Prior to and shortly following passage of the act (between 1994 and 1998), immigrants accounted for about one-third of the increase in the number of uninsured individuals.

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SEIU Mission Statement
We are the Service Employees International Union, an organization of more than 2 million members united by the belief in the dignity and worth of workers and the services they provide and dedicated to improving the lives of workers and their families and creating a more just and humane society.

NCBM Mission Statement
The National Conference of Black Mayors (NCBM) was founded in 1974 as a private, nonpolitical, nonpartisan, nonprofit organization that represents African American mayors nationwide. The organization's mission is to enhance the executive management capacity of its members for the purpose of governing viable municipalities.

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August 26, 2008

The Honorable John Dingell
Chairman
House Energy and Commerce Committee
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The Honorable Frank Pallone
Chairman, Health Subcommittee
House Energy and Commerce Committee
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The Honorable Joe Barton
Ranking Member
House Energy and Commerce Committee
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The Honorable Nathan Deal
Ranking Member, Health Subcommittee
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Dear Chairman Dingell, Chairman Pallone and Representatives Barton, and Deal:

I am writing in response to your request for additional information related to the testimony I provided before the House Energy and Commerce Committee Health Subcommittee on June 24th during the hearing entitled "H.R. 3014, Health Equity and Accountability Act of 2007." I was pleased to have the opportunity to provide the Subommittee with information and recommendations regarding racial and ethnic health disparities facing minority children in the U.S.

As President of First Focus, a bipartisan advocacy organization committed to making children and their families a priority in federal policy and budget decisions, I am heartened by your leadership on issues affecting our nation's most vulnerable children, and would like to thank you and members of the Subcommittee for bringing the important voice of children to this discussion.

Along with your questions, I am providing below the additional information you requested in your letter of July 31st.

1. *One of the witnesses on the second panel argued essentially that Congress should not allow States the option to extend Medicaid coverage to pregnant women and children who are legal immigrants because of the "public charge doctrine" – Essentially, that these legally present vulnerable groups are simply using the Government and should take care of their own problems. I would like to get your view on this matter.*

    a. *First, are there legitimate public health arguments for ensuring that children and pregnant women have health coverage? In fact, aren't we likely to improve health outcomes and reduce costly emergency room use by reducing the number of uninsured? What are the consequences of allowing children to remain uninsured?*

Ensuring health coverage for our nation's children is a fundamental issue – children cannot read if they have poor vision, understand their teachers if they cannot hear or learn if they are sick. Just as fundamental, pregnant women must have access to the care they need to deliver strong, healthy babies. The evidence is clear that investments in preventive health, especially prenatal care and children's health, are among the most cost effective investments we can make as a nation. It is well-documented that investments in prenatal care result in improved health outcomes for babies and mothers and reduce the need for costly medical interventions after birth. And, children with a routine source of care receive preventive health services, including vaccines and timely treatment for chronic conditions such as asthma, that avoid more serious illness and costly treatment down the road. All of our nation's children – regardless of immigration status – should have a healthy start in life and access to the care they need to become healthy and productive adults.

The problem of uninsurance is a pervasive one for citizens and non-citizens alike. With more than 9 million uninsured children, the numbers are startling. According to a recent study published by the Robert Wood Johnson Foundation, "A Needed Lifeline: Chronically Ill Children and Public Health Insurance Coverage" [1]:

- Approximately 9% of children are uninsured. About one-third of insured children rely on public insurance and 60% are covered by private insurance.
- More children with insurance visited a doctor (91%) within the last year than did uninsured children (69%). Additionally, 77% of insured children had a "well child" checkup within the last year compared to 45% of uninsured children.
- Of the approximate 10 million chronically ill youth, only 3.6 million had public health insurance and obtained health care services at a similar level as those with private insurance.

And, sadly, the numbers of uninsured children are on the rise. According to the latest data from the U.S. Census Bureau (2006), the percentage and the number of children under 18 years old without health insurance increased to 11.7% and 8.7 million in 2006 (from 10.9% and 8.0 million, respectively, in 2005). With an uninsured rate in 2006 at 19.3%, children in poverty were more likely to be uninsured than all children. In addition, the data reveal that one in five women of childbearing age – 12.6 million – was uninsured in 2006. These women accounted for 27% of all uninsured Americans.[2]

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[1] Robert Wood Johnson Foundation, "Chronically Ill Children and Public Health Insurance Coverage (A State-by-State Analysis)," August 14, 2008. http://www.rwjf.org/pr/product.jsp?id=33671&catid=15

[2] DeNavas-Walt, C.B. Proctor, and J. Smith. Income, Poverty, and Health Insurance Coverage in the United States: 2006. U.S. Census Bureau, August 2007. http://www.census.gov/prod/2007pubs/p60-233.pdf

The statistics are even more alarming when it comes to health care for immigrant children:

- Children of immigrants are three times more likely than children of native-born citizens to lack a usual source of health care.[3]
- In 2005, 48% of low-income immigrant children were uninsured, compared to 15% of citizen children in nativeborn families.[4]

Among the factors contributing to these grim statistics is that current law imposes a five-year waiting period before legal immigrants become eligible for public health coverage programs. This restriction, enacted as part of the 1996 welfare reform legislation, has resulted in a significant decline in enrollment of children in immigrant families from Medicaid because they are no longer eligible for coverage or unclear about current eligibility requirements.

Sadly, as is apparent from the testimony you reference above, there is a long history of confusion related to the eligibility of immigrants for public coverage, including the applicability of the so-called "public charge" doctrine for immigrants seeking federal health care services. Under current law, an individual who is "primarily dependent on the government for subsistence" can be deemed a "public charge" and this determination can be used as grounds for deportation. However, the fact of the matter is that, according to the federal Immigration and Naturalization Service, receipt of Medicaid or SCHIP (with the exception of long-term care) cannot be considered grounds for determining that an immigrant might become a "public charge."

Despite efforts to clarify this policy, the number of immigrants participating in Medicaid has declined markedly since the enactment of welfare reform in 1996, including a reduction in participation by citizen children in immigrant families. Although citizen children of immigrants remain eligible for assistance, it appears that some immigrant families have became confused about the eligibility rules or are afraid to participate because of a belief that their children's use of Medicaid might cause immigration problems for the parents. A host of factors, including welfare reform-era policy changes and public charge-related deportations, among many others, has caused a tragic chilling effect on coverage rates for this vulnerable population.

In an effort to begin to address these concerns, First Focus urges Congress to take immediate action to reauthorize the State Children's Health Insurance Program (SCHIP) program, which is set to expire on March 31, 2009. Since its inception in 1997, SCHIP has reduced the numbers of uninsured children in America by one-third. Currently, one in three low-income children rely on SCHIP or Medicaid for their health coverage. Without a doubt, SCHIP is a true lifeline for low-income children and families. We urge Congress to make SCHIP reauthorization an early priority in 2009.

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[3] Randolph Capps, Michael E. Fix, Jane Reardon-Anderson, "Children of Immigrants Show Slight Reductions in Poverty, Hardship," No. 13 in Series, "Snapshots of America's Families III," the Urban Institute, November 7, 2003. http://www.urban.org/publications/310887.html

[4] L. Ku, "Reducing Disparities in Coverage for Legal Immigrant Children and Pregnant Women," Center on Budget and Policy Priorities, April 2007. http://www.cbpp.org/4-20-07health2.pdf

In addition, First Focus urges Congress to ensure passage of the Legal Immigrant Children's Health Improvement Act (LICHIA) (S. 764 and H.R. 1308), legislation that would give states the flexibility to provide coverage through Medicaid and the SCHIP to legal immigrant children and pregnant women who are barred from such coverage by the 1996 welfare reform law. At present, most legal immigrant children and pregnant women who entered the United States on or after August 22, 1996 (the date the welfare reform law was enacted) are ineligible for health care coverage through Medicaid or SCHIP during their first five years in the U.S. The LICHIA legislation would address any lingering confusion for low-income immigrant families about whether their children are indeed eligible for coverage and ensure that this vulnerable population has appropriate access to cost-effective prenatal care, well-child care, immunizations and other preventive or primary care before they become sick and develop more serious health problems. The current policy is not only arbitrary and unfair, but it also increases racial and ethnic disparities among children and results in preventable and costly adverse health consequences.

First Focus was a leading advocate for the inclusion of LICHIA in the various SCHIP reauthorization bills that were advanced during 2007. We were disappointed that the provision that was included in the House-passed Children's Health and Medicare Protection Act (CHAMP) (H.R. 3162) was dropped during final negotiations. With the SCHIP program set to expire in March 2009, we urge Congress to take quick action in the new session to pass the CHAMP legislation, and to urge leadership to ensure the inclusion of LICHIA in the final bill.

A newborn child, a child with cancer, a child with diabetes, or a child with a raging ear infection cannot wait five years for health care. Half of our nation's states have responded to this inhumane policy by providing coverage to these children with state funding, but no child should be denied coverage for a period up to five years. SCHIP reauthorization provides an obvious opportunity to address this shortcoming in the current federal policy.

2. *Following up on the previous question, one of the other witnesses on the second panel argues that we do not need to extend a coverage option to legal immigrant pregnant women because the Department of Health and Human Services (HHS) already allows states to cover fetuses.*

    a. *Could you please comment on this argument? Does the HHS rule mean coverage for pregnant women is unnecessary?*

While it is true that current HHS regulations permit SCHIP coverage for fetuses, this policy falls far short of providing comprehensive, standard-of-care prenatal and postnatal access to care for pregnant women and new mothers.

After SCHIP was enacted, an irony of the program was quickly apparent. The program provides coverage for eligible low-income babies upon their birth but their mothers, who perhaps earn too much money to qualify for Medicaid, are not able to get access to the prenatal services that would increase the likelihood for their babies to have a healthy beginning. As a result, many children in low-income families – who are eligible for federal health coverage upon birth – are denied the access to the care that would ensure them the most positive birth outcome and a healthy start in life.

Recognizing the importance of early prenatal care, the health-related complications that sometimes result from child birth for moms and babies, and the broad array of postnatal-related health care issues, shortly after SCHIP's enactment, lawmakers on both sides of the aisle recognized the need for a more commonsense approach that would address this noticeable coverage gap. However, legislative efforts along these lines were averted when the Bush Administration, in March 2002, issued a rule that would allow coverage for prenatal care by extending the SCHIP benefit to fetuses. According to this regulation, the Administration allows coverage for fetuses in cases where their uninsured mothers are found to be otherwise ineligible for Medicaid. Along these lines, the regulation permits federal funding for prenatal care for all women – citizens, those lawfully present or undocumented – under the rationale that fetuses do not have an immigration status. However, the regulation only allows coverage for prenatal care and does not cover medical services for the mother if they are not for the direct benefit of the fetus.

In short, postpartum care is not covered under the regulation. This gap in coverage includes a range of critical care for women, including potentially life-saving postpartum care for hemorrhage, pregnancy-induced hypertension, infection, ectopic pregnancy, embolism, episiotomy repair, Cesarean section repair, family planning counseling, postpartum depression, and other complications of pregnancy and childbirth. In fact, according to the National Committee for Quality Assurance (NCQA), "Hemorrhage, pregnancy-induced hypertension, infection, and ectopic pregnancy continue to account for more than half of all maternal deaths (59%)."

According to the Centers for Disease Control and Prevention (CDC), there were 3,193 pregnancy-related deaths in this country between 1991 and 1997 for an overall pregnancy-related mortality ratio (PRMR) of 11.5 per 100,000 live births. Racial disparities are rather dramatic with respect to maternal mortality. African-American women had mortality rates over four times higher than that of non-Hispanic whites over the period. American Indian/Alaska Natives, Asian/Pacific Islanders, and Hispanic women had mortality rates 67%, 55%, and 41%, respectively, higher than non-Hispanic whites.

Those disparities are even more pronounced in some states. For example, in Wisconsin, the maternal mortality rate for African-American women was 4.2 times than of white women between 1987 and 1996. Certainly, this is something that we can all agree should be addressed.

Moreover, for the coverage of infants, the eligibility period for coverage begins running under the regulation during the time of coverage during pregnancy. Thus, for states with six-month eligibility coverage periods, there would be the need to conduct eligibility renewals even during the pregnancy itself – much less during the first year of life. Consequently, the infant could lose critically important coverage for well-baby visits, immunizations, and access to their pediatric caregiver. That would be an outright reduction of coverage for some children after birth.

Current policy is insufficient at best. While it recognizes the importance of providing prenatal care to pregnant women, it fails to provide a straightforward and direct path for women to be guaranteed access to these critical health services and it fails to provide continuous eligibility for coverage of newborns through the first full year of life. Sadly, this is in no way a substitute for the comprehensive coverage that is needed for low-income pregnant women and infants.

In short, we need to pass legislation that ensures coverage for a comprehensive benefits package that treats prenatal care, delivery and postpartum services as a continuum of care and addresses and ensures coverage of newborns through the first full year of life. Maternal and infant mortality are at unacceptably high rates in our nation and that is the primary reason that organizations such as First Focus, the March of Dimes, the National Association of Children's Hospitals, the American Academy of Pediatrics, and the Children's Defense Fund all support this legislative improvement for the health and well-being of mothers and their babies.

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I hope this information is helpful. We are grateful for your leadership and indeed all of your efforts on behalf of children and other vulnerable populations. We welcome the opportunity to work with you in the future on legislation to address the health care needs of our nation's most precious resource, our children.

Sincerely,

Bruce Lesley

Bruce Lesley
President