ADDRESSING DISPARITIES IN HEALTH AND HEALTHCARE: ISSUES OF REFORM

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

JUNE 10, 2008

Serial No. 110–86

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PRINTING OFFICE

47–453 WASHINGTON : 2009

For sale by the Superintendent of Documents, U.S. Government Printing Office
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ADDRESSING DISPARITIES IN HEALTH AND HEALTHCARE: ISSUES OF REFORM

TUESDAY, JUNE 10, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:07 a.m., in room 1100, Longworth House Office Building, Hon. Fortney Pete Stark [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 03, 2008
HL–26

CONTACT: (202) 225–3943

Addressing Disparities in Health and Healthcare: Issues for Reform

House Ways and Means Health Subcommittee Chairman Pete Stark (D–CA) announced today that the Subcommittee on Health will hold a hearing on disparities in health and access to care as part of the on-going health reform hearing series. The hearing will take place at 10:00 a.m. on Tuesday, June 10, 2008, in the main committee hearing room, 1100 Longworth House Office Building.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Over the years, numerous studies and reports have documented the disparities that exist in health and access to healthcare for women and racial and ethnic minorities in the United States. Despite research on the causes of these differences, disparities persist in access to care, quality of care, health outcomes, and prevalence of certain diseases for particular subpopulations. A host of socioeconomic factors such as place of residence, income, education, and insurance status contribute to this troubling problem.

Though isolating the precise impact of gender, race, and ethnicity is difficult, lack of health insurance coverage is undeniably one of the most important barriers affecting access to care and the resulting disparities that exist today. A 2007 report published by the Agency for Healthcare Research and Quality (AHRQ) found that uninsured individuals were six times more likely than insured individuals to be without a usual source of care and nearly four times as likely to be without a usual source of care for financial reasons[1]

However, even when people have insurance coverage, both public and private, disparities remain. The House-passed CHAMP Act, H.R. 3162, attempted to improve the understanding of and address some root causes of the persistent disparities in the Medicare population by improving data collection across the program, increasing access to culturally and linguistically appropriate care, and instituting several demonstration projects to address issues affecting vulnerable beneficiary subgroups.

In announcing the hearing Chairman Stark said, **"While we can make a big dent in addressing disparities by getting everyone covered, we must recognize that these issues transcend access to coverage. We must pay special attention to ensure access to care and good outcomes for everyone, regardless of race, gender, or ethnicity."**

[1] *http://www.ahrq.gov/qual/nhdr07/nhdr07.pdf*

FOCUS OF THE HEARING:

The hearing will focus on issues related to health disparities and disparities in access to care, as well as possible solutions to address these issues.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov/*, select "110th Congress" from the menu entitled, "Committee Hearings" (*http://waysandmeans.house.gov/Hearings.asp?congress=18*). Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Follow the online instructions, completing all informational forms and clicking "submit". Attach your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business **Tuesday, June 24, 2008**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov/*.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairman STARK. If our guests can find seats, we will commence the hearing, the third in the series dealing with issues that we may face in healthcare reform in the next Congress; and I welcome our colleagues from the Congressional Black Caucus, the Hispanic Caucus, the Asian Pacific American Caucus and the Rural Caucus, I presume.

The purpose of the hearing is to learn more about healthcare disparities, and there are still some people that question whether

these disparities exist. Hurricane Katrina established that we have a two-tiered healthcare system, if anybody else didn't believe that, one for those who are healthy and well-insured and have money and one for everybody else. Without Katrina, it is clear on a daily basis that minority populations are disproportionately represented in the second tier of everyone else.

We could do better; and, as we gear up for health reform, we should try and craft solutions that reduce and hopefully eliminate healthcare disparities. We must do more than simply cover everyone. We should ensure access and the receipt of healthcare to be determined by one's healthcare needs and not their ability to pay, their place of residence or their skin color.

We have to look at the role that Medicare has played in reducing disparities among the elderly and the general population and know that universal coverage is a necessary step toward eliminating health disparities.

Before Medicare, minorities age 75 or over had an average of 4.8 doctor visits a year compared to 7.5 for their white counterparts. By 71, minority beneficiaries saw doctors at a rate comparable to the rest of the United States, and Medicare helped integrate the healthcare system as a whole which was previously segregated, thereby improving access.

Just as a sidebar, there is absolutely no mention in Medicare, either when you sign up for it or in the records we keep, that deals with race and ethnicity. That may be a problem. But it is an absolutely color, race, religion-blind system that basically everyone over 65, I would say, participate. Interesting to study that.

There are other economic factors that drive disparities. Good health insurance is the single-most-important variable, one affecting access; and the most important thing we can do to reduce disparities is to get everyone covered. However, we shouldn't stop there. Data from public and private programs show that disparities persist even when coverage is available, which is a reasonable doubt—I have lost my pages here.

Just last week, the Robert Wood Johnson Foundation released new research showing that the quality of care and health outcomes does vary dramatically depending on race; and that is not acceptable. Last year's CHAMP Act included a number of provisions to combat these problems in Medicare, and I am pleased to see that Chairman Bachus may have included some of these provisions in the legislation that will be before the Senate this week.

But there is more to be done. We will hear from our colleagues, from the Congressional Black Caucus, the Congressional Hispanic Caucus, the Asian Pacific Caucus; and we will discuss these issues generally with a mention of the provisions of H.R. 3014, the Health Equity and Accountability Act, that are, at least those provisions, under our jurisdiction and a discussion of the CHAMP Act's disparity provisions, which are still pending in the Senate.

The witnesses on the second panel will give us a broad overview of health and healthcare disparities and offer promising approaches to address them. The panel includes health services research experts and those with firsthand experience as physicians and administrators. Again, I want to thank the witnesses today.

And I want to add one other comment for this panel and the subsequent panels, and the Members of this Subcommittee I think have heard me suggest this often. We don't—and I don't—let's just say as a matter of my policy, to the extent that I can direct the policy on this Committee—try to make decisions in this Committee that will affect various procedures, drugs or dollar payments for specific procedures.

We have MedPAC. We have CMS with experts. We aren't expert. Most of the procedures and drugs we can't pronounce or spell, and we don't have any idea what they do. And if we once started to say, okay, Doc, we are going to pay X dollars for this procedure, the line outside our office doors would go around the block three times for other doctors wanting to get the price of their procedures raised or manufacturers of exotic new equipment wanting us to include it in Medicare. I think you, our colleagues in the House and the public are better served by our defaulting to professionals to advise us and for us to deal with broader payment structures to the providers.

Because there will be discussions of—for example, I think it is known that African Americans have a higher rate of diabetes. I am not sure this Committee should get into the issue of whether we should pay more for certain diabetic procedures or not. I think the fact that we—if we recognize that and can ask the public insurance companies, who are the only ones we have any control over, to take that into account and ask for studies, that is about as far as we go. And I just wanted to add that as kind of a limitation that I think we have in our jurisdiction.

Mr. Camp, would you like to address the panel?

Mr. CAMP. Yes. Thank you, Mr. Chairman; and I also want to welcome all of our witnesses and thank them for coming. I look forward to hearing your testimony today.

It is an unfortunate fact in this country that some people don't have health insurance, and in previous hearings we have talked about who these people are. And today we will hear testimony about why some people have better access to quality care than others, and we will find discrepancies and treatments and outcomes do exist amongst certain populations. This morning, several factors will be dissected and their role in contributing to health disparities will be discussed.

The Robert Wood Johnson Foundation released a study last week that examined geographical and racial disparities within the Medicare Program. This study found that, on a variety of quality indices, African Americans are less likely to receive recommended care than whites within a given region. However, the most striking disparities are found when comparing results across States.

For example, 72 percent of African American women in Medicare in Massachusetts received mammograms, while just 48 percent received them in California. Also, in all but two States, African American diabetics are less likely than whites to receive annual hemoglobin testing. But 88 percent of African Americans in Massachusetts received the screening, compared to just 66 percent of those living in Colorado.

It is clear having health insurance, even Medicare, will not solve the disparities that exist within the healthcare system.

We also need to address the variations in medical practice and spending. In the time remaining, I do want to emphasize one contributor that I believe should not be overlooked, and that is a person's geographic location. I want to highlight this area because I represent a large rural district. I routinely hear from constituents with difficulty obtaining needed healthcare because of a dwindling number of healthcare providers in their communities. For those with chronic conditions, it can be an incredible burden to follow prescribed treatment plans when specialists are not local or are unable to travel to see their patient in their home. Health disparities as they relate to race and ethnicity are very important, and I wanted to bring attention to the fact that disparities exist across rural areas as well.

I thank the chairman for calling this important hearing, and I look forward to working with him in a bipartisan manner to address these critical issues.

Thank you. I yield back.

Mrs. JONES. Mr. Chairman?

Chairman STARK. Yes, Mrs. Tubbs-Jones.

Mrs. JONES. I would like unanimous consent to make a statement, please.

Chairman STARK. Absolutely. Who would dare object to that request?

Mrs. JONES. I don't know, Mr. Chairman. I knew you wouldn't, though. That is why I love you.

Thank you. Mr. Chairman——

Mr. CAMP. Me neither.

Mrs. JONES. A short one.

I just want to, first of all, thank you for hosting this hearing. Throughout the time that I have been on this Committee, it has been an issue that has been very, very important to me and more important to—as important to my predecessor, Honorable Congressman Louis Stokes. I stand on his shoulders trying to make sure that we continue to address the issue of health disparities.

I won't try to go into a diatribe or anything like that. There are a lot of issues that we must focus on in order for us to assure that people, regardless of their race, color, sex, religion, et cetera, et cetera, have access to healthcare. And it is clear with all the studies that have been presented that, even with the same kind of healthcare coverage, there is a disparity in the access to that care, no matter where you compare throughout the country; and we have to be careful to compare Massachusetts with the rest of the world in terms of the delivery of healthcare.

I thank you so very much for focusing on this issue, and I appreciate the opportunity for my colleagues who have a lot of experience and background in the area to be able to address you. Thank you very much, Mr. Chairman.

Chairman STARK. If there are no other statements, I am going to recognize the four Members before us and from left to right. The first will be the Honorable Donna M. Christensen, a delegate to the Congress from the United States Virgin Islands, a physician and a Member. She will be followed by the Honorable Hilda Solis from the wonderful State of California; Madeleine Bordallo, a delegate from Guam; and Jerry Moran, a representative from the State of

Kansas, who seemed to have avoided tornadoes in this last week and everybody else got them. Right?

So, Donna, if you would like to lead off, and we will just go down the line. The light will go on for 5 minutes. Without objection, your prepared testimony will appear in the record in its entirety; and we will get a chance after—you want to summarize your statements or expand on them—to find out more from you during the inquiry period.

Donna, proceed.

STATEMENT OF THE HON. DONNA M. CHRISTENSEN, A DELEGATE TO CONGRESS FROM THE TERRITORY OF THE VIRGIN ISLANDS

Mrs. Christensen. Thank you. Good morning, Chairman Stark, Ranking Member and Members of the Subcommittee.

This is a historic and very important hearing on an issue of grave concern; and on behalf of my colleagues in the TriCaucus, some of whom you will hear from this morning, who have been seeking a hearing on this issue for a long time and the millions of racial and ethnic minorities who are in poorer health because of these disparities, I sincerely thank and applaud you for this hearing. And I also want to thank my colleague, Congresswoman Stephanie Tubbs-Jones, for her leadership as well.

The central core of my testimony today, which is very much abbreviated, is that health disparity elimination must be an integral component of healthcare reform. And I also wanted to make sure that the Subcommittee understands that the poor health outcomes of minorities adversely impacts not just ours but the health of everyone else in this country. It is also the racial and ethnic health disparities, infant and maternal mortality, to name just two, in African Americans, that are responsible for our embarrassingly dismally national health indicators compared to other countries in the world. Closing these and other gaps will improve healthcare for everyone in the country, improve our world standing and also reduce the cost of healthcare. We therefore owe it to our fellow Americans, all of them, to eliminate the racial, ethnic, rural and gender health disparities that have plagued this country for too long.

This hearing is a good first step. Passing the disparities provisions of CHAMP would be another. And while the great success achieved with the passage of CHAMP in the House was unfortunately short-lived, it nonetheless started a process that brought us here today where racial and ethnic health disparities are front and center in the work of this very important Subcommittee.

And before I turn to the three provisions of H.R. 3014, it is also important to underscore that health or the lack of it does not occur in a vacuum and to recognize the important roles that the lack of universal coverage and the social determinants of health play.

This bill, the healthcare Equity and Accountability Act which the TriCaucus has introduced in the last three Congresses, was developed with broad input both on and off the Hill and with a comprehensive approach. Additionally, it tracks key recommendations of the Institute of Medicine report on equal treatment.

It is our position that H.R. 3014, introduced by my colleague Congresswoman Solis, even though many of the provisions are not

under the purview of the Subcommittee, should be the foundation upon which healthcare reform meets the health and healthcare challenges of millions of racial and ethnic minorities, women and rural populations.

The first issue I want to raise from the bill is the need for health workforce diversity. At the outset, let me say that the only way to truly achieve cultural and linguistic competency in healthcare is to increase and dramatically so the number of minority health providers at all levels.

Studies indicate that racial and ethnic minority healthcare providers are more likely to serve racial and ethnic minorities and other underserved communities. Additionally, providers of the same background are more likely to be able to bridge the gaps and the dynamics of the patient-provider relationship, which translates into more trust and better outcomes.

Because of poor policy and budget priorities, racial and ethnic minority providers are grossly underrepresented across all aspects of the U.S. healthcare system. Together, African Americans, Hispanic Americans, Asians and American Indians make up only 9 percent of our nurses, 6 percent of our physicians and 5 percent of our dentists; and racial and ethnic minorities make up less than 10 percent of baccalaureate nursing, 8.6 percent of dental school and only 4.2 percent of medical school faculties.

So the larger healthcare reform dialog must address these severe deficiencies. Without diversity within our Nation's healthcare system, millions of innocent, hard-working Americans will continue to suffer poorer health outcomes and a lower quality of life and be at risk for premature, preventible death. Hopefully, in the next panel or in the question period, the issue of disparate treatment of providers in communities of color by CMS will be raised as well as the need for incentives to providers serving in high-health-disparity communities.

The next issue is accountability. Critical to the health disparity elimination and also to healthcare reform is establishing accountability and evaluation as well as coordination of effort in the elimination of health disparities. The Health Equity and Accountability Act in that bill would not only work to strengthen and expand 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 Research at NIH, but we also propose the creation of offices of minority health within CMS and FDA and to create an Office of Health Disparities in the Office of Civil Rights at the Department. These offices would help to ensure that Federal efforts and Federal resources are better coordinated and more effective.

Third, I want to address the need for community centered and comprehensive approaches to eliminating health disparities. Our proposal for health empowerment zones, which enjoyed broad and strong support in the health advocacy community, should resonate in this Committee which created health economic empowerment zones. They are included in H.R. 3014 as well as in a stand-alone bill. These zones leverage expertise at the community level as well as existing resources across all Federal agencies to implement health disparity elimination plans developed by the impacted com-

munities with technical assistance provided by the Department. Fully engaging the community is essential. Not doing so is what I believe the chief reason that prior efforts have been unsuccessful.

In closing, no discussion on health disparities before this Subcommittee would be complete without including health disparity elimination within the Medicare population, including the health and quality of healthcare for those with end-stage renal disease, a disease that has a disproportionate impact on African Americans.

Additionally, while my position agrees with that stated by the chairman earlier and remains that it is not good policy to legislate medical practice, as the Subcommittee and the Committee decides to move forward with proposed legislation I urge doing so with provisions that acknowledge the differences between small and large dialysis facilities and that factors like race, ethnicity and geography affect the needs of many patients.

In this case, one size does not fit all; and so we hope that whatever approach you take would allow for the case-by-case adjustments necessary to preserve the health and wellness of the millions of Americans, a disproportionate number of which are African American as well as other racial and ethnic minorities and members of rural communities.

In closing, I want to again thank Chairman Rangel, Mr. Stark, Ranking Member Camp and everyone else who made this hearing possible.

Chairman STARK. Donna, thank you very much.

[The prepared statement of Mrs. Christensen follows:]

Statement of The Honorable Donna M. Christensen, Delegate to Congress from the United States Virgin Islands

DONNA M. CHRISTENSEN
Delegate, Virgin Islands

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Testimony to the Subcommittee on Health in the House Ways and Means Committee on
Addressing Disparities in Health and Healthcare:
Issues for Reform

By Congresswoman Donna Christensen
Tuesday, June 10, 2008

Thank you very much, Chairman Rangel and Mr. Stark, and ranking member Mr. Camp for holding this historic and critically important hearing on an issue of grave concern. I also want to thank my colleague, Congresswoman Stephanie Tubbs Jones, for her leadership – as a member of this subcommittee – on health disparity elimination.

My colleagues and I in the TriCaucus have been seeking a hearing on this issue for a long, long time, and our expectations were heightened when Democrats came back into the majority. Today this important Subcommittee has answered our call and the call of millions of people of color, those in rural America and the territories who bear a disproportionate burden of disease.

Issues of heath disparities have loosely come up during past hearings held by this committee, but to the best of my knowledge, this is the first Health Subcommittee hearing focusing solely on health disparities.

On behalf of my colleagues in the Congressional Black Caucus and joining those in the TriCaucus and the millions of racial and ethnic minorities who are in poorer health and have worse health care because of these disparities, I sincerely thank and applaud you!

As a physician and as the Chair of the Congressional Black Caucus Health Braintrust, I am encouraged by the fact that lawmakers, on both sides of the aisle and in both chambers, are engaging in thoughtful discussions about health care reform and widely recognize the need for it. In this regard, the most pressing point I want to leave

with this Subcommittee today is that health disparity elimination must be an integral component of – and **not** an accessory to – the dialogue and resulting legislative solutions.

Contrary to the belief of many who resist the ideas of addressing anything that has to do with racial and ethnic health disparities, their elimination is not only about improving the health of these groups. Because our health and the kinds of health care we often have to seek late in illnesses for which we often have no coverage or ability to pay, health disparities affect the quality of healthcare of everyone else, as was clearly demonstrated in a series of reports from the Institute of Medicine a few years ago.

The elimination of health disparities would also finally raise the shameful health standing of this rich and technologically advanced country vis a vis the other nations of the world. In fact, we rank 41st in the world in terms of maternal mortality and despite having more neonatologists and neonatal intensive care beds per person than Australia, Canada and the United Kingdom, our infant mortality rate is higher than any of those countries and that of some others considered undeveloped.

A major factor leading to our lower health rankings is our failure to close the gaps in health care and health outcomes that have a disproportionate and detrimental impact on African Americans and other racial and ethnic minorities, as well as on rural populations. For example:

- the African-American infant mortality rate is more than twice that of whites, even when comparing women of similar socioeconomic status; and
- African-American women are nearly four times more likely than white women to die during childbirth or from pregnancy complications.

This and other similarly alarming statistics have existed for far too long and this Democratic-led Congress needs to take steps now to end these tragic gaps once and for all. This hearing is a good first step; passing the disparity provisions of CHAMP would be another.

Health or the lack of it does not exist in a vacuum. The lack of universal coverage 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, the built and natural environment, education, discrimination and others which numerous studies confirm have a direct and indirect impact on the health and well being of millions of Americans. Therefore, reforming the healthcare system is not enough. We must also fix the social and physical environments which fuel and support their continued existence.

And because this is also clearly a justice issue, we must also 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 and the differences in insurance status – which, are at the root of health inequity.

We are pleased that issues of health disparities were addressed during the development and successful passage in the House of H.R. 3162 – the CHAMP Act – which included sound provisions which bolstered data collection across the Medicare program, expanded access to culturally and linguistically appropriate care, and instituted several demonstration projects to address the root causes of health disparities within the Medicare population.

While that great success unfortunately was short-lived, it nonetheless was a victory that laid yet another row of bricks on the path to health equity that my colleagues in the TriCaucus and I have been building for the past four congresses through the introduction of our health disparity elimination bills.

H.R. 3014, is the latest bill which was introduced in the first session of 110th Congress by Congresswoman Solis and attempts to hone in on the root causes of *all* health disparities, not just racial and ethnic, but also gender and rural disparities. When we developed this bill, we did so with broad input, both on and off the Hill, and intentionally thought about health disparity elimination in a comprehensive manner.

Additionally, we developed the bill with respect to and following the key recommendations that came out of the groundbreaking 2003 Institute of Medicine (IOM) "Unequal Treatment" report. As such, we have a bill that is and should continue to be championed as a foundation upon which health care reform – the type of reform that is cognizant of and thus meets the health and health care challenges of millions of racial and ethnic minorities, women and rural populations – exists and occurs.

The Health Equity and Accountability Act includes provisions – some which fall under the jurisdiction of this subcommittee – to 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.

Because we recognize the pivotal role that the issues addressed in the provisions in H.R. 3014 – provisions that not only complement, but expand upon those in the CHAMP Act –must continue to play in health care reform efforts, my colleagues from the TriCaucus and I are addressing these issues here today, despite the fact that not every provision falls under your jurisdiction, because they are necessary to raise in a forum focusing on both health care reform and health disparities as a needed component of that reform.

That said, we will address a handful of issues addressed in our bill in an effort to continue to impress their importance not only in efforts to eliminate health disparities, but also to truly achieve health care reform in a manner that resonates with all Americans.

I am not providing statistics in my presentation. 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 – save one who continues to insist that race plays no role in the face of a mountain of information to the contrary – 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. We in the first panel will highlight several key provisions of HR. 3014.

The first issue I want to raise is the need for health workforce diversity.

At the outset, let me say that the only way to truly achieve cultural and linguistic competency in health care is to increase – and dramatically so – the number of health providers at all levels. Health workforce diversity does and will play a crucial role in health disparity elimination.

Studies indicate that racial and ethnic minority health care providers – all providers, including physicians, nurses, dentists, pharmacists, hospice care providers, community health workers, ophthalmologists and social workers, as well as health care executives – are more likely than their white counterparts to serve 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 cannot be adequately taught from a textbook. Yet 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.

The sad fact is that 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.

The larger health care reform dialogue, therefore, must include discussions and solutions to ensure that these important programs and institutions receive the funding that they need to meaningfully contribute to the needed health reform by ensuring that

our nation's health care workforce – on all levels – mirrors our nation's growing racial and ethnic diversity. Not only will greater diversity in the health care workforce boost positive health benefits, but it also will help ensure more prudent spending of precious health care dollars.

Without diversity within our nation's health care system and among our nation's health care executives, researchers and health policy makers, the racial, ethnic, and gender nuances that are known to have a direct and indirect impact on health care decisions and thus health care and health status will remain under-addressed. 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, preventable death during their most productive life years.

Hopefully someone on the next panel or in the question period will raise the issue of disparate CMS reimbursements in different zip codes, as has been alleged by African- American physicians working in minority communities, as well as the need for low-interest loans for start-up practices, loan forgiveness and tax incentives for providers serving in high health disparity communities. Save loan forgiveness programs; they are not addressed in HR.3014, but we anticipate another bill which will address these also important issues.

My next issue is accountability.

Critical to health disparity elimination and also to health care reform is establishing accountability and evaluation as well as on coordination of effort. If we – as a nation – took the necessary steps to ensure that across all federal agencies and offices with health oversight and that issues which 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 surely 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.

Lastly I want to address the need for community centered and comprehensive approaches to eliminating health disparities.

Our proposal for Health Empowerment Zones, which enjoy broad and strong support in the health advocacy community, should resonate in this Committee which created Economic Empowerment Zones in the 90's. They are included in the Health Equity and Accountability Act (H.R. 3014), as well as in a standalone bill – the Health Empowerment Zone Act.

This provision leverages not the expertise at the community level as it pertains to health disparities, but also the all existing resources – across all federal agencies -- 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 – with technical assistance from the Department -- to develop a plan with solutions that mirrors the direction that myriad health disparity elimination studies have recommended. Fully engaging the communities most affected is essential! Not doing so, I believe, is the chief reason prior efforts have been unsuccessful.

As I close my testimony, I want to stress that I – along with my colleagues – fully understand that health disparity elimination, in many ways, is like the final match of any World Cup Final, in that if you keep shooting, you eventually score. So, that is the strategy we have and will continue to employ, because we are here to play for the season and not just the game.

That said, we have another game before us that could guarantee a victory for the season. There is a Medicare package that we all have been discussing and debating for many months. In this package, there are opportunities to reduce health disparities, but what hangs in the balance is our foresight and willingness to allow good politics and sound research to guide us toward great policy. While this package focuses on only a few of the several health disparity elimination issue areas, it is, nonetheless critically important and has an enormous impact in our collective efforts to not only achieve health equity, but to further the health care reform debate. So, as we move forward with this latest round of Medicare legislation, we must do so with an emphasis on strengthening our nation's successful Medicare system.

And, this must include ensuring that health disparity elimination within the Medicare population is at the forefront of our objectives. Doing so means that we must ensure that as the health and quality of health care for those with end-stage renal disease – a disease that has a disproportionate impact on African Americans – are adequately addressed with legislation that reflects the data suggesting that one size does not, in fact, fit all.

Additionally, while my position remains that it is bad policy to begin legislating medical practice, which has always been referred to as an art because of the uniqueness of every doctor-patient relationship, regardless of the disease entity, if this

Subcommittee and the Committee decides to move forward with legislation, I urge doing so with provisions that are cognizant of the differences between small and large dialysis facilities, and the fact that myriad factors – including race, ethnicity and geography – directly affect not only the volume of patients served, but the needs of those patients. Further, we hope that you will do so carefully and in a manner that focuses solely on provisions that allow for the case-by-case adjustments necessary to preserve the health and wellness of the millions of Americans – a disproportionate number of who are African American, other racial and ethnic minorities or members of rural communities – who will be most affected.

In closing, I, again, thank Chairman Rangel, Mr. Stark and everyone else who made this hearing possible. I know that the issue of health disparities is a difficult one to address, not because it is not important, but because health disparities are rooted in so many factors – some of which are overtly health and health care related, but others that are rooted in realms that tread in areas that are not well understood and others that bring out personal biases – such as race and ethnicity, gender, geography, education, and geography.

That said, I sincerely applaud your leadership and welcome future discussions as we proceed to bring about health care reform, on how we can work together to ensure that eliminating all racial, ethnic, gender and geographical disparities and achieving health equity are championed as components of our collective goals and objectives for the future.

It is only through proceeding in this comprehensive way that we will not only help all Americans achieve wellness, but also bring reform to a system in crisis and stop the skyrocketing costs of health care.

Thank you!

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Chairman STARK. Hilda Solis.

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

Ms. SOLIS. Thank you, Mr. Chairman and Ranking Member Camp and my colleagues. I want to thank you for inviting me here to present what we believe is one of the most important healthcare access issues of our time.

Chairman Stark, you especially are to be commended for your leadership in bringing the attention here to the Congress to discuss healthcare disparities in communities of color; and I am pleased to be here along the side of two very hard-working Members of Congress that have been working on this issue for a number of years, Donna Christensen and, of course, Ms. Bordallo.

I am proud to serve as Chair of the Congressional Hispanic Caucus Taskforce on Health and the Environment and as a Member of the Energy and Commerce Committee on the Health Subcommittee.

Although there have not been any hearings on healthcare disparity since 2000, we know that communities across the country have worked on these issues for many years. Unfortunately, our most vulnerable underserved populations are left behind in health policy.

Latinos, you know, are the fastest-growing ethnic minority population in the country. We make up 14 percent of the population, more than 42 million people across this country. Thirty-four percent of Latinos are uninsured. According to a study of 2007, the National healthcare Disparities Report, Latinos fared worse than non-Hispanic whites for core measurements on healthcare access and quality.

The growing diversity of our country means that patients encounter barriers to receiving optimal healthcare services. Currently, nearly 52 million people, or more than 19 percent of the U.S. population, speak also a language other than English at home. And in my district in East Los Angeles and the San Gabriel Valley, about 60 percent of the population there are Latino, and approximately 20 percent are Asian Pacific Islander. Sixty-eight percent speak a language other than English at their home.

Cultural and linguistic barriers contribute to reduced quality of care, adverse healthcare outcomes and increased racial and ethnic disparities. Just as an example, limited English proficient individuals are less likely to understand their medication instructions, less likely to use primary and preventive care, and more likely to seek care in an emergency room.

This is also why I support funding for outreach efforts by persons such as community health workers. In our community, they are known as promotoras. Community healthcare workers are known to work and help enroll underserved populations in health insurance programs and engage in health promotion and prevention. Through their efforts, they can help reduce the burden of asthma, diabetes, HIV and AIDS awareness in many communities of color.

Given the existing health inequities of our healthcare system, we produced H.R. 3014, the Health Equity and Accountability Act. Among other things, the legislation would create a Medicare demonstration project examining access to care, costs and health outcomes for all beneficiaries. I am proud that we have the support of more than 100 Members of Congress and more than 300 organizations.

And I would like to ask the Committee if I could submit this letter for the record.

Chairman STARK. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. SOLIS. Several provisions of H.R. 3014 have been referred to this Committee. And I stated in my letter addressed to Chairman Rangel and Ranking Member McCrery on October 23, 2007, I am eager to work with each and every one of you on these provisions. Improving access to health insurance, including Medicare, is a key part of reducing inequities in our healthcare system. However, efforts that only address access to insurance are not the solution for our ills.

The Institute of Medicare found large disparities among Medicare beneficiaries. Spanish speakers, as an example, enrolled in Medicare managed care plans have more difficulties with provided communication and timeliness of care when compared to non-Spanish speakers.

I believe Medicare, as the leading purchaser of healthcare, has the opportunity and responsibility to reduce racial and ethnic health disparities; and I am pleased that some of H.R. 3014's provisions were included in the CHAMP Act of 2007. We worked very hard to try to bridge the gap between these disparities.

I have urged the inclusion of provisions in legislation last fall that would improve low-income Medicare beneficiaries' access to services and reduced disparities within Medicare. And on June 4, 2008, I led a letter from the Congressional Hispanic Caucus asking for inclusion of the same provisions in the Medicare package recently developed by the Senate Finance Committee. I would like to also insert that letter for the record with your permission, Mr. Chairman.

Chairman STARK. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Ms. SOLIS. I strongly support the Medicare demonstration project to improve communication between providers and limited English proficient seniors, a study on Medicare patients for language services, an Institute of Medicine report on the impact of language services on the health of limited English proficient beneficiaries and a report on Medicare compliance with national standards on culturally and linguistically appropriate services.

I also believe all the culturally and linguistically appropriate standards should be adopted by Medicare and other healthcare organizations, and I am pleased that Senator Baucus recently introduced a Medicare package which includes some of those provisions which are necessary to reduce these healthcare disparities.

In closing, I would like to take the opportunity to note that our health is the product of our social determinants of health, including income, race, education, environment and geography. It is my hope that the Congress and future leaders will consider how policies impact our health particularly the health of vulnerable communities of color, and we will be able to hopefully implement such measures as H.R. 3014 to improve the quality of healthcare and decrease those inequities that exist in this disparate treatment.

I thank you again for having this hearing, and I commend the Members of this Subcommittee.

I yield back the balance of my time.

Chairman STARK. Thank you very much.

[The prepared statement of Ms. Solis follows:]

Prepared Statement of The Honorable Hilda L. Solis, Representative in Congress from the State of California

Chairman Stark, Ranking Member Camp, and my colleagues, thank you for inviting me to testify about the inequities of our healthcare system. Chairman Stark, I would especially like to commend you for your leadership in bringing attention to disparities in health for communities of color.

I am pleased to be here today with Representatives Christensen and Bordallo. We represent the Congressional Hispanic, Black, and Asian Pacific American Caucuses, known collectively as the TriCaucus.

As the Chair of the Congressional Hispanic Caucus Task Force on Health and the Environment and as a Member of the Energy and Commerce Subcommittee on Health, I am working to improve the health of *all* individuals, particular communities of color. Latinos are the fastest-growing racial/ethnic group in the United States. We make up 14 percent of the population, which is more than 42 million people across the nation, yet we also suffer from the highest uninsured rates in the country. According to data released by the Census Bureau in 2007, 34.1 percent of Latinos (more than 15 million) are uninsured, compared with 20.5 percent of African Americans, 15.5 percent of Asian/Pacific Islanders, and 10.8 percent of non-Hispanic Whites.

As we move forward toward national health reform, we must not leave behind our most vulnerable and underserved populations. Unfortunately, current programs do leave behind our most vulnerable and underserved populations.

Communities of color often suffer from higher rates of death and disease. The Agency for Healthcare Research and Quality's *2007 National Healthcare Disparities Report* (NHDR) finds that "Overall, disparities in quality and access for minority groups and poor populaitons have not been reduced since the first NHDR." According to the 2007 NHDR, Latinos fared worse than non-Hispanic Whites for seven of eight core measurements of healthcare access and for 23 or 38 core report measures of quality.

The growing diversity of our country means that many patients encounter barriers to receiving optimal healthcare. By 2050, it is projected that members of racial or ethnic "minority" groups will together account for almost half of the U.S. population. Currently, nearly 52 million people, or more than 19 percent of the U.S. population, speak a language other than English at home. There are also a substantial number of individuals who are not proficient in the English language. According to the 2006 American Community Survey, almost 11 million *U.S. citizens* speak English less than very well.

I have seen firsthand the growing diversity in our nation. In my district in East Los Angeles and the San Gabriel Valley, more than 60 percent of my constituents are Latino, and approximately 20 percent of individuals are of Asian Pacific Islander descent. Sixty-eight percent of families speak a language other than English at home.

For these communities, culture and language play vital roles in the provider and patient relationship. Culture can define how healthcare information received, interpreted, and acted upon by patients. Communication barriers, such as the lack of langauge services, between patients and providers contribute to reduced quality of care, adverse health outcomes, and increased racial and ethnic disparities. Such barriers can lead to lower patient adherence to medications and decreased participation in healthcare decision making. A study by the Access Project based at Brandeis University, titled "What a Difference an Interpreter Can Make," indicates that more than 25 percent of limited English proficient individuals who needed but did not get an interpreter reported that they did not understand their medication instructions. Non-English speaking patients are also less likely to use primary and preventive care and are more likely to seek care in emergency rooms.

Given the existing health inequities of our healthcare system, I introduced H.R. 3014, the Health Equity and Accountability Act with the support of my TriCaucus colleagues. I am proud that we now have the support of more than 100 Members of Congress. In addition, we also have a letter of support from more than 300 organizations. I would ask that this letter be inserted into the record.

This legislation, which we introduced in past years, is based on many of the Institute of Medicine's recommendations from *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. This legislation would require Federal agencies to improve access for individuals with limited English proficiency and create a Medicare demonstration project examining access to care, costs, and health outcomes for beneficiaries. Several provisions of H.R.3014 have been referred to this

Committee and I as stated in a letter addressed to Chairman Rangel and Ranking Member McCrery on October 23, 2007, I am eager to work with you to enact these provisions.

Improving access to health insurance, including Medicare, is a key part of reducing inequities in health. However, efforts that only address access to insurance are inadequate, as evidenced by continuing disparities seen within the Medicare population. The Institute of Medicare found marked disparities among Medicare beneficiaries, even after adjusting for socioeconomic differences. According to the *2007 National Healthcare Disparities Report*, among Medicare patients, Latinos and Native Americans are least likely to receive all recommended care for heart failure. In addition, an April 2008 article published in *Health Services Research* found that Spanish speakers enrolled in Medicare managed care plans have more difficulties with provider communication and timeliness of care when compared to non-Spanish speakers.

On August 11, 2000, the President signed Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." This Executive Order requires Federal agencies to examine the services they provide, identify any need for services to LEP individuals, and develop and implement a system to provide those services so LEP persons can have meaningful access to them.

I believe that Medicare, as a leading purchaser of healthcare, has the opportunity and responsibility to reduce racial and ethnic health disparities. Consequently, I am pleased that some of H.R. 3014's provisions were included in H.R. 3162, the Children's Health and Medicare Protection Act (CHAMP) of 2007. I and many of my colleagues worked hard to pass the CHAMP Act and to protect provisions related to the reduction of disparities. Unfortunately, the Senate failed to take up the Medicare provisions.

This past December, before another short-term Medicare physician fix bill was enacted, I urged the inclusion of provisions that would improve low-income Medicare beneficiaries' access to services. On June 4, 2008, I also led a letter from the Congressional Hispanic Caucus asking for the inclusion of the same provisions in the Medicare package recently developed by the Senate Finance Committee. I would like to insert this letter into the record.

I also strongly support a Medicare demonstration protect to improve communication between providers and limited English proficient seniors, a study on Medicare payments for language services, an Institute of Medicine report on the impact of language services on the health of Limited English Proficient beneficiaries, and a report on Medicare compliance with national standards on Culturally and Linguistically Appropriate Services (CLAS).

The CLAS standards, some of which are mandates for health organizations that receive Federal funding, were developed by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health. They are intended for adoption by healthcare organizations and represent a way to improve access to healthcare for minorities, reduce inequities, and improve quality of care. I strongly believe that all of the CLAS standards should be adopted by Medicare and other health organizations. I am pleased that several of these provisions were included in S. 3101, the Medicare Improvements for Patients and Providers Act, which was recently introduced by Senator Baucus.

In closing, I would like to take the opportunity to note that our health is the product of our social determinants of health, including income, race, education, environment and geography. Housing, transportation, education, energy, and agricultural policies all impact our health, although most Americans think only of our healthcare system when we speak about health.

Our current healthcare system is not the sole reason why racial and ethnic populations experience higher rates of death and illness. Given this Committee's jurisdiction, I kept my remarks limited to changes to our healthcare system. However, it is my hope that this Congress and future leaders will consider how seemingly-unrelated policies impact our health, particularly the health of vulnerable communities of color.

Thank you again for inviting me to testify before you today.

Chairman STARK. And the Honorable Madeleine Bordallo from Guam, would you like to proceed?

Ms. BORDALLO. Good morning again.

Chairman STARK. Would you pull the microphone right up close. Thanks.

STATEMENT OF THE HON. MADELEINE Z. BORDALLO, A DELEGATE TO CONGRESS FROM THE TERRITORY OF GUAM

Ms. BORDALLO. Good morning, and thank you, Chairman Stark and Ranking Member Camp, for the opportunity to testify on behalf of the Congressional Asian Pacific American Caucus.

Asian and Pacific Islander Americans are one of the fastest-growing populations in our country today. Over the last 18 years, the APIA community has more than doubled from 7 million to over 15 million individuals.

A significant number of Americans face challenges on a daily basis, but these challenges are unequally borne across the spectrum of our ethnically diverse country. Asian and Pacific Islander Americans, like Latino Americans and African Americans, struggle with overcoming the additional obstacle of disparities.

The sheer diversity in language and culture within the greater Asian and Pacific Islander American community presents its own challenges. Asian and Pacific Islander Americans encompass 49 ethnic groups and over 100 individual and distinct languages and cultures.

The common needs of our minority communities have led to the introduction of H.R. 3014, the Health Equity and Accountability Act. H.R. 3014, as you will hear today, is the product of collaboration between the Congressional Black Caucus, the Congressional Hispanic Caucus and the Congressional Asian Pacific American Caucus. It is a bill, Mr. Chairman, to comprehensively address the pressing issues resulting in and contributing today to identified healthcare disparities faced by the communities of color all across our country, whether it be in Indian country, in border communities, the inner cities or in the offshore territories.

This bill, which has now been introduced in three consecutive Congresses, demands this Subcommittee's attention and deserves your consideration. Its provisions have been scrutinized by the medical, health professional and academic communities.

My colleagues have touched upon different areas of H.R. 3014 in their testimony this morning. I will address the data collection title of the bill.

Today, there is a serious absence of up-to-date medical data on minorities. Because of its diversity, the data gap for the APIA community is more glaring and consequential. Right now, if you search for diabetes information on the Centers for Disease Control and Prevention Web site, for example, you will find only data characterized for black, white and Hispanic or nonwhite. 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. And this, simply put, is disturbing and it needs correction.

Although this one example is drawn from an agency that is not under the direct jurisdiction of this Committee, it nonetheless aptly

illustrates the information gap for minorities, particularly for the APIA community. We as a Congress simply cannot address or rightly aim to overcome the health challenges facing our citizens if we do not even know what they are or have some sound measure of the extent of their impact.

Equally disconcerting is the fact that it has now been over a decade since the Office of Management and Budget established new standards for the collection of Federal data on race and ethnic identification, yet their full adoption and implementation by certain Federal agencies remains outstanding. The Social Security Administration, for example, has made no revisions to its Social Security Card application to take into account the new standards. The OMB race and ethnic developed categories are by no means impossible to implement. Without the use of these standards, we are left with inconsistency in application; and sound public policy cannot be shaped without solid data.

Our caucus, CAPAC, believes that further disaggregation beyond the OMB standards established 10 years ago is warranted today to accurately reflect the diversity of the APIA community. However, we know this step cannot logically be taken or fully pursued into the spirit of the 1997 changes that are adhered to by our own Federal Government. Therefore, compliance with the 1997 standards and additional collection of data on primary language is a priority, both of which are required by H.R. 3014 and Subtitle D of the CHAMP Act. So we ask that you exercise due oversight to ensure compliance.

Apart from a compliance with these standards are other data collection priorities. Both H.R. 3014 and the CHAMP Act, for example, strengthen data collection and analysis by requiring that the data be collected from the parent or legal guardian of minors and reported to the Centers for Medicare and Medicaid Services and other agencies for proper analysis.

My final point today is to underscore my other colleague's statements relative to cultural and linguistic competencies in healthcare. This is vital for the APIA community. Roughly a third of Asian and Pacific Islander Americans live in linguistic isolation. Seventy percent of Cambodians, 68 percent of Laotians, 61 percent of Vietnamese, 52 percent of Koreans, 51 percent of Chinese, 39 percent of Tongans and 22 percent of Samoans are classified as limited English proficient. These barriers, Mr. Chairman, have severe effects on healthcare access, such as patients' ability to understand diagnoses, to understand prescription directions. People have and will continue to die as a result of misinformation or mistranslation.

It is for these concerns and the others that we urge your attention to focus on H.R. 3014. Health disparities for Asian and Pacific Islander Americans are very real, and people are suffering every day from these disparities.

I want to thank you, Mr. Chairman, for the opportunity to testify on this important issue. We look forward to working with you and other Members of the Committee on Ways and Means. Thank you.

Chairman STARK. Thank you for your efforts on this issue. I appreciate it.

[The prepared statement of Ms. Bordallo follows:]

Prepared Statement of The Honorable Madeleine Z. Bordallo, Delegate to Congress from Guam

STATEMENT OF HON. MADELEINE Z. BORDALLO
HEATH TASK FORCE CHAIR
CONGRESSIONAL ASIAN PACIFIC AMERICAN CAUCUS

BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
HEARING ON "ADDRESSING DISPARITIES IN HEALTH AND HEALTHCARE: ISSUES FOR REFORM"
JUNE 10, 2008

Thank you Chairman Stark and Ranking Member Camp for the opportunity to testify this morning on behalf of the Congressional Asian Pacific American Caucus on the health concerns and needs of the greater Asian and Pacific Islander American community.

Asian and Pacific Islander Americans (APIA) are one of the fastest growing populations in our country today. Over the last 18 years, the APIA 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. Almost 81 percent of the 170,000 residents in my home district of Guam are Asian or Pacific Islander American, and as many as 12.8 percent of the 36 million residents of the State of California today are Asian or Pacific Islander American.

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 and Pacific Islander Americans, like Latino Americans and African Americans, struggle with overcoming the additional obstacle of healthcare disparities.

Unlike other minority communities, however, the rapid growth and wide diversity in language and culture within the greater Asian and Pacific Islander American community presents its own unique healthcare challenges. "Asian" and "Pacific Islander" Americans encompass 49 ethnicities and over 100 individual and distinct languages and cultures.

As my distinguished colleagues before me have mentioned, the common needs of our communities led to the introduction of H.R. 3014, the Health Equity and Accountability Act. H.R. 3014 is the product of collaboration between the Congressional Black Caucus, the Congressional Hispanic Caucus, and the Congressional Asian Pacific American Caucus, in comprehensively addressing from a public policy perspective the pressing issues resulting in and contributing today to identified healthcare disparities faced by communities of color in our country. This bill, which has now been introduced in three consecutive Congresses, demands our attention and 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 want to recognize the extraordinary leadership and work of our two

dedicated colleagues who I have the privilege to join on this panel this morning: Congresswoman Donna Christensen, herself a physician and leading authority on healthcare in this Congress, and Congresswoman Hilda Solis. We have them to thank for the progress we as a Congress have made to date in developing and pursuing public policy to reduce and eliminate healthcare disparities. But we can achieve more, and that is what brings us back to H.R. 3014 and why we are here today. My colleagues have touched on different areas of the bill; however, 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 APIA 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 example is drawn from an agency that is not under the direct jurisdiction of the Committee of Ways and Means, it nevertheless aptly illustrates the information gap for minorities, particularly for the APIA 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 APIA 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— both of which are required by H.R. 3014 and Subtitle D

of the CHAMP Act. Such compliance and additional data collection is imperative for tracking and eventually eliminating health disparities in the APIA 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. Both H.R. 3014 and the CHAMP Act, for example, strengthen data collection and analysis by requiring that the 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. We urge the Subcommittee to hold the Social Security Administration accountable and to work with CMS and the agencies to ensure more robust data collection.

My last point is to underscore Congresswoman Solis' statements relative to cultural and linguistic competency in healthcare. This issue is vital for the APIA 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 all of the others that our colleagues beside me today have testified to and the ones for which we do not have the luxury of time to adequately detail, that we urge your attention to and focus on H.R. 3014. Health disparities for Asian and Pacific Islander Americans 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 testify on this important issue. We look forward to working with you and other members of the Committee on Ways and Means.

- 3 -

Chairman STARK. Jerry Moran, our colleague from the great State of Kansas, would you like to proceed?

STATEMENT OF THE HON. JERRY MORAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KANSAS

Mr. MORAN. Mr. Chairman, thank you very much. Thank you and Mr. Camp for including me in the invitation today.

I represent a congressional district that is nearly 60,000 square miles, 69 counties. The largest community has a population of about 45,000 people, what by all standards would be considered a very rural district. I think, in regard to districts like that across the country, we have a number of factors that come together to create significant disparities in the availability and affordability of healthcare.

Age, our population is very senior. Income, we are often—as rural citizens, our income levels are lower. Distance, the ability to travel to access healthcare. Financial, most healthcare providers make more money serving patients in a wealthier, younger and more urban environment.

Many of the items that my colleagues have indicated in regard to ethnicity and minority issues also are found in many rural districts across the country; and for much of the time that I have been in Congress, I have co-chaired with my colleague from North Dakota, Mr. Pomeroy, the Rural Healthcare Coalition, which, incidentally, has many issues in common with urban, particularly core center of city, communities across the country.

In addition to that, I have chaired the Healthcare Subcommittee in regard to Veterans Affairs in which, for example, in my congressional district there is no VA hospital and so access even to a government program, the VA, becomes very difficult.

Residents—in fact, I might just highlight some of those issues. Residents in rural Kansas have virtually no access to public transportation. Therefore, the ability to access healthcare before one becomes very sick is limited. Our population is very rural, and elderly are likely to have chronic diseases and yet 10 to 20 percent less likely to receive the recommended pre-screenings, preventative screenings or checkups.

Rural residents tend to be poorer. On the average, per capita income in rural areas of the country is more than $7,000 lower than in urban areas and nearly 24 percent of children in rural America live in poverty.

Higher rates of uninsurance are found in rural communities. In the southwest part of my congressional district, which is, in many ways, very Hispanic, 16.8 percent of the citizens lack healthcare coverage.

Healthcare professional shortage areas, as defined by the Department of Health and Human Services, 25 percent of all Kansas counties have a Federal physician shortage area. Of the 2,157 health professional shortage areas, those are in rural areas, as compared to 910 in urban areas.

It is hard to keep infrastructure in place. Fortunately for us in rural America, critical access hospitals have been a saving feature for access to healthcare for many across rural America. But, having said that, those hospitals face difficulties in reimbursement and face a tremendous challenge in keeping their doors open.

Medicare payments to rural hospitals and physicians are significantly less than those to their urban counterparts; and, in fact,

more than 470 rural hospitals have closed in the last 25 years. Medicare utilization is high in rural districts. In fact, Smith County Hospital along my Nebraska border, 8 out of every 10 patients admitted to the hospital are Medicare beneficiaries.

EMS is simply we sometimes forget about. And I often find myself talking to my constituents about hospitals in particular, and I am reminded that many of my counties have no hospital at all. The only services that they have immediate access to—or at least one hopes immediate access to—is emergency medical services, and yet statistics indicate that the response time in a rural community is 8 minutes less than response time in an urban area. And many, if not most all, of our emergency service providers are volunteers. In many communities those volunteers are now in their sixties, seventies and eighties; and there is virtually no one in their twenties and thirties and forties to serve as EMS providers.

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. But, again, community pharmacy is an important component of providing healthcare in rural communities; and yet 7 of my counties have no community pharmacy, 32 counties have only one pharmacist, and adequate reimbursement for our pharmacies are an important component and timely reimbursement as well. Nursing home, home healthcare, access to durable medical equipment all face significant challenges in rural America.

And, finally, I would say that it is difficult to recruit and retain healthcare professionals, nurses, doctors. At the moment, critical shortages of dental providers and almost no mental health services are available in most rural communities.

So as we look at ways that we can try to eliminate disparity, I would indicate that, along with the items that my colleagues have pointed out related to race and ethnicity, we face many of the similar challenges in rural communities across the country.

I thank the chairman and the Ranking Member for inviting me to testify, and I would be happy to respond to any questions.

[The prepared statement of Mr. Moran follows:]

Prepared Statement of The Honorable Jerry Moran,
A Representative in Congress from the State of Kansas

I. Disparities in the rural healthcare system

- Rural Kansas residents have greater transportation difficulties reaching healthcare providers, often traveling great distances to reach a doctor or hospital. There are very few public transportation systems and so many folks wait until they are very sick before they access the healthcare system.
- Rural Kansans have a higher percentage of elderly likely to have chronic diseases like heart disease and diabetes, but they are **10–20% less** likely to receive recommended preventive screenings or check-ups.
- **In addition, rural residents tend to be poorer.** On the average, per capita income is $7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level. Nearly 24% of rural children live in poverty.
- Higher rates of uninsurance are also found among rural communities. In 2001, the Southwestern region of Kansas had the highest proportion of uninsured at 16.8%. It is also in these rural regions where we find higher rates of delayed entry or too few prenatal care check-ups for pregnant women. Rural residents strain the capacity of rural hospitals when hospital emergency rooms are used inappropriately as a substitute for a medical home.
- There are 2,157 Health Professional Shortage Areas (HPSA's) 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 there are rural counties.

II. It is hard to keep the Healthcare infrastructure in place

- Having access to a local hospital and their services is important
  - There are 75 hospitals in the First District of Kansas, many of them being Critical Access Hospitals (25 beds or less). They allow people the ability to access local care when they are sick and are the cornerstone to the rural healthcare delivery system.
  - One challenge to keeping the doors open is that there is less volume than in many urban settings. In addition, Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years.
  - Many rural hospitals have higher Medicare utilization rates than their urban counterparts. In my district, Smith County Hospital, over 8 out of every 10 hospital admissions were from Medicare beneficiaries.
- **EMS providers face big challenges. There are higher rates of death and serious injury accidents in rural versus urban areas. O**ne 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.
  - National average response times from motor vehicle accident to EMS arrival in rural areas was 18 minutes, or eight minutes greater than in urban areas.
- Keeping the additional healthcare services and players in business is important as well.
  - Community Pharmacies are on the front lines of the healthcare delivery service. Currently, there are 7 counties in Kansas that have no drug store and 32 counties have only one available.
  - It is important that we are adequately reimbursing pharmacies for the Medicaid prescriptions that they are filling and it is important that we pass legislation to ensure that they are reimbursed in a timely manner.
  - Nursing homes, Home Healthcare and access to durable medical equipment is also very important to rural residents.

III. It is difficult to recruit Healthcare Personnel

- It is extremely difficult to recruit healthcare professionals to places where doctors are few and access to major metropolitan hospitals requires hours of travel. According to the U.S. Department of Health and Human Services, while a quarter of the population lives in rural areas, only 10 percent of physicians practice there.
  - Kansas has 234 physicians specializing in the specialty of obstetrics. Only 59 have practices located outside the large urban counties and in fact, only 21 are available in the entire western ½ of the state.
  - One lifesaving program has been the J–1 Visa Waiver program. The J–1 Visa Waiver program provides opportunities for graduates of foreign medical schools, who have trained in U.S. medical residency programs on the J–1 cultural exchange visa, to stay in the United States if they serve for three years in an area that has a health professional shortage. These designated health professional shortage areas can occur in rural areas as well as urban areas.
  - Kansas has been able to recruit 98 physicians to work in underserved areas and with underserved populations since 2002 through the J–1 Visa Waiver program.
- Additionally, the lack of mental health and dental services continues to be a significant problem in most counties in Kansas. The 2005 Health Professional Underserved Areas Report shows that only nine counties in Kansas have adequate numbers of mental health professionals (1 psychiatrist for 30,000 population) and only twenty counties have adequate numbers of dental professionals (1 dentist for 5,000).
- Anywhere from 57 to 90 percent of first responders in rural areas are volunteers

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Chairman STARK. Well, I thank all of our colleagues for joining us.

Dr. Christensen, it was a year ago I think you testified before us on the end stage renal disease issue, and we agreed then that any changes in the dialysis reimbursement must not be a one-size-fits-all. And we think this last bill had the requisite flexibility to respond to individual patient needs.

Modernizing that system is even more critical today because of the perverse incentives of the current system which has encouraged unusual dosing of Epogen and has put many patients' health at risk. So I hope we will work together on this issue, and I hope that the Senate puts the patient needs ahead of industry profits. I think we will have some time to review that again.

Congresswoman Solis, you brought up an issue on disparities that—and I think several of you have touched on this—that it is just not a coverage issue. It goes to access, that we find disparities among the Medicare population, which is a uniform coverage. Even if you adjust for social economic status, we could use your community as an example. Do you want to just expand on why addressing disparities transcends access and insurance and the other moves that we might make to correct that?

Ms. SOLIS. Well, I think one of the issues is that our healthcare system for many, many years has looked typically at majority population in terms of how that service delivery is provided. Just recently, you see some innovative, you know, footnotes by, for example, researchers through the Kaiser Foundation who realized that you can actually save a lot more money if you start to tailor the services to better fit and better suit the population at hand; and what we are finding is that we do have to do much more in providing incentives for our university medical schools, for example, to recruit and retain individuals from rural America, from inner city America who are reflective of the populations that are faced with these chronic illnesses. I think it says a lot when you do bring people who are much more familiar with individuals that they would serve, that there is much more ability to be able to break down those barriers of communication, understand culturally the differences that are unique to different populations.

I think that my colleague, Ms. Bordallo, evidently gave us some very good facts in terms of even the differences in the API community, Tagalog, Filipino, Mandarin, all the various different groups that need to have a different perhaps interpreter or type of service that is available to them.

I know that we have been reluctant in the last few years in the Office of Civil Rights to actually push for better outcomes in terms of what our healthcare hospitals and our centers are providing. I don't think that is a negative. I think that that is something that we should continue to work toward.

Mrs. Christensen. Chairman Stark, may I add?

Chairman STARK. Sure.

Mrs. Christensen. I just wanted to again call your attention to the IOM report on equal treatment of a few years ago, and the hundreds of articles that were reported on there and have been reported since that also point to discrimination within the healthcare system. So that individuals who have full insurance and present themselves either private or public within that system, everything else being equal except for race and maybe language, did not re-

ceive the same kind of diagnostic evaluation or if that diagnostic evaluation is done are not offered the same level of treatment and care.

Chairman STARK. I don't think you would find anybody who would disagree with that. And I think what we have to look forward or look for with all of your help is, from our standpoint, what can the Federal Government do, not what Blue Cross or Aetna or the private plans, over whom we have little jurisdiction. But what can we do as a Federal Ggovernment to change that.

And, Congresswoman Bordallo, you talked about better data. And it has been—what—11, 12 years since OMB published their standards for the collection of data; and we are still not doing it. Do you think that it is urgent and that we can do it without getting into discrimination questions, collect more data in our Social Security system so that we at least can begin to look at the numbers and see what is happening? Do you support that?

Ms. BORDALLO. Yes. Yes, Mr. Chairman, in answer to your question. Because I represent the Asian Pacific area, which is the fastest-growing; and we have so many different ethnic groups, 49, perhaps more. And, yes, I would say that this would be a priority, to gather the data before we can even have any understanding of what the situation is or how many people are affected.

Chairman STARK. Thank you.

Jerry, you are an outlier as far as topics go, because I really hadn't anticipated dealing with the rural issue. But it is one that this Committee, to my knowledge, in 20, 25 years has dealt with the issue in two ways. One, we have always known as a political fact of life that whatever we do to aid rural America through the Medicare system will be doubled or tripled on the Senate side when it gets there; and we have to resolve it in conference. And so we have always accepted that and always look forward to our colleagues in the other body correcting whatever inadequacies we might provide.

But let me point out a couple of things and let you comment on them.

You did mention, you know, 470 rural hospitals have closed in the past 25 years. That is my tenure both in the minority and majority on this Committee. But if you look at it, that is less than 15 hospitals a year, and we have never had a year when 20 hospitals have closed. So maybe three-quarters of them are rural. Out of 6,000 hospitals, that ain't bad. And we usually figure, as I have always said, that most of the cause of closing rural hospitals is because the doctor died or moved out of town.

And what I would like to think as times change and Mr. Pomeroy comes—I don't think he has any big towns in his State. But, I mean, you haven't seen little cities until you have gone to North Dakota.

But what I have noticed is that the clinics begin to take on more procedures and that transportation may be a solution. Because a 10- or 20-bed hospital just can't support the kind of care that you want when you are faced with a cancer or a cardiac problem. You are going to drive the 100 or 200 miles or get flown in a helicopter. And I think that is what you and I would want.

So my sense is that how—and I don't know whether you would agree with this. Politically, it is impossible to stand by and watch a hospital close on your watch. We recognize that.

We wrote in this Committee the peach and each act, which more or less said here is how a 10-bed hospital can get off-stage with the local politicians. We will make it a long-term care facility or an outreach facility somehow, quite frankly, to give political cover to people who may have to encourage their residents to take a longer trip to get them more sophisticated medical care, data, electronic data, if we had that more broadly, so it was available, teleconferencing, all of those things.

And I would hope that, if you don't find that offensive, that you would continue to support whatever efforts we can make to kind of modernize, if you will, the rural system and—because I do agree that we can help with the visa issue, and I think that that will help us with diversity. And I have no objection to that. So I hope that you will continue to be involved in this issue, because I would hate to see Mr. Pomeroy have to carry the whole ball all by himself.

Thanks for your testimony.

Any comment?

Mr. MORAN. As much as I admire and respect Mr. Pomeroy, I would like to say that he and I work closely together, and I have been to some of his communities. In fact, we took——

Chairman STARK. I am not sure you both voted the same way on the agriculture bill this year.

Mr. MORAN. We did not vote the same way on the ag bill or, more surprising, nor did we vote the same way on the prescription drug benefit.

But Mr. Pomeroy and I had the CMS administrator in my district and his State several years ago, Mr. Skully. And, incidentally, it was an interesting experience in my mind to listen to Mr. Skully see for the first time a critical access hospital. Here is the person who is in charge of the CMS program responsible for Medicare and Medicaid services and yet had not at that time ever seen a critical access hospital. His reaction was very foretelling to me, which was, Congressman, they deliver great quality healthcare here, don't they, but there are no frills, are there?

And, to your point, I think that is what we are anticipating. And it is the way we live our lives in much of rural America, is there are no frills. That is what our critical access, our small, less-than-25-bed hospitals provide, is basic services; and our ability to attract other healthcare professionals I think is dependent upon having that hospital there.

So while Mr. Pomeroy and I are very active in renewal of the J–1 visa, the Conrad 30 program, our ability to utilize the program—and I appreciate what my colleague said about attracting physicians into medical schools who have diverse backgrounds, in our case, a rural background. We have discovered that the best shot we have at getting a doctor to a rural community in Kansas is that they grew up in a rural community in Kansas or someplace. But what we discover is they go off to medical school, and they marry someone who likes restaurants and shopping, and even the hunting

and fishing that we have becomes less appealing when the spouse has different ideas.

So the point I would perhaps differ with you, Mr. Chairman, on is that those—particularly those critical access hospitals, yes, they are not there to provide every service imaginable; and we need regional medical centers and specialized hospitals in which a transportation system will allow rural residents, patients to be transported to receive that kind of care. But for the very basics, including just emergency room coverage and our ability to keep physicians and other healthcare providers in communities, those small hospitals are critical.

Chairman STARK. Thank you very much.

Mr. Camp, would you like inquire?

Mr. CAMP. Thank you, Mr. Chairman.

Thank you all for testifying.

Dr. Christensen, thank you for your leadership on end stage renal disease and dialysis.

I am interested in, Congresswoman Solis, your comment about a demonstration project to improve communication between providers and limited English proficient seniors. Is CMS doing any of that, are you aware, currently?

Ms. SOLIS. From what I have learned, there hasn't really been an adequate growth in terms of funding these kinds of efforts. I think maybe in the last 2 or 3 years you have seen some movement but not enough where we can actually even enforce the current codes in the law that say that we are required to provide better access services to those patients that have cultural linguistic, linguistic barriers. So I think that we still have a ways to go, and I would hope we could work with you and the Committee to see that we get support for that.

Mr. CAMP. All right. Thank you.

And, Congresswoman Bordallo, you mentioned a data gap; and we have seen that in all areas. We just had a hearing the other day on HSAs, and we are using data from the first year the program was enacted to try to draw our conclusions about where HSAs are today, even though much of the growth occurred well after the first year of implementation.

So there is a real data gap. There is a lag in health data all across the spectrum. I think we have difficulties in getting access to the right kinds of information. So I think that is something that we need to really work on particularly, and we are almost in 2009, making decisions for 2009 and 2010. To not know even the last couple of years is a very difficult thing.

Mr. Moran, you mentioned many of the disparities between rural and urban areas. One of the things I didn't hear you mention was the disparities in reimbursement; and we have long talked about this in this Committee about the difference between many of the large urban areas like Miami, for example, and just about anywhere else in the country in terms of the reimbursement rates.

Do you think that is a factor in some of the disparate health services and treatment available to rural Americans?

Mr. MORAN. Absolutely, Mr. Camp. A question that you know the answer to and that you and I agree totally on it.

In regard to our ability to attract and retain professionals, reimbursement is a significant component of that inability. If you are a physician that wants to make more money, you will choose to live in an area in which your Medicare and Medicaid components of your practice are less than most rural areas of the country.

Reimbursement of hospitals. Even the cost-based reimbursement that occurs in regard to a critical access hospital is not true of cost-based reimbursement.

And I remember my first year in Congress, 1997, we had the Balanced Budget Act. One of its premises was that we could reduce the amount of reimbursement for Medicare providers in an effort to balance the budget. Noble goal of balancing the budget. But when 80, 90 percent of your patient load are Medicare patients in a hospital, you have no place to turn, with perhaps the exception of raising property taxes to keep your hospital doors open.

So in each of these instances, the reimbursement rate, the disparity between rural and urban, the geographic factor that occurs in the physician reimbursement, there is an actual geographic component of the reimbursement a physician receives under the belief that it is less expensive to live and practice medicine in a rural community. I don't know that the facts would bear that premise out.

Mr. CAMP. All right. Thank you all very much.

Thank you, Mr. Chairman.

Chairman STARK. Thank you.

Mr. Doggett, would you like to inquire?

Mr. DOGGETT. Thank you, Mr. Chairman; and thanks to each of our witnesses. Congresswoman Solis, could you expand on the role that you believe Medicare can play in addressing the disparities that you have described?

Ms. SOLIS. Well, I think one of the issues that—actually, there are several items that I would touch on. And one is, of course, the lack of adequate healthcare professionals that are coming into the healthcare system, number one. We do have a shortage in our labor force there, and we have to really incentivize our teaching hospitals to identify individuals and even those that come from different countries who are qualified in giving them the ability to come and work here. I think that that is one way of addressing it.

I think also providing incentives so that people will work in rural, low-income or underserved communities. We face the same problems that rural America does when you see a low reimbursement rate. You see doctors in East Los Angeles and I am sure in the State of Texas where you find Latino doctors who will now refuse to take on any more Medicare/Medicaid patients because of the lack of low reimbursement. Even for those professional doctors that specialize in special treatment, orthopedic surgeons, we are also finding hip replacement, those kinds of things that we see occurring much more in our community, individuals are very far and few, maybe 1 to 10,000 a population, one specialty doctor for a population of 10,000. That is wrong.

We need to do more also to make sure that we fully utilize those public clinics. In our districts, for example, in Los Angeles we don't have access to many of those bigger hospitals, community hospitals. Much in our county have been closed down. So we rely very

heavily on the public hospital community centers there that provide assistance.

But to really do more—how can I say—extensive outreach to help identify treatment opportunities and prevention and education and to make sure that we have lay people that are fully trained this can provide that assistance in an atmosphere that is well received and that people will feel trustful of——

You know, there is a big issue now in our community with this whole immigration debate and why people sometimes won't even access healthcare because of fear that they may be somehow detained or denied healthcare when in fact they are eligible for this aid.

So I think that we have a long way to go; and there is multiple, multiple things that we can do, including beefing up our research institutions to do more specialized review in terms of why it is that there is a higher propensity of Latinas to have breast cancer, why it is we see an increasing number of teenage pregnancy amongst Latinas, what are the cohorts in our community so that we can provide prevention so that at the end of the day we don't end up having to pay for this accumulation of costs at our emergency hospital or trauma unit when the services could have been provided maybe, you know, a year ago in a more comfortable, informative manner. So there is many, many things that we can do.

I know that this Committee is very, very strongly supportive of some of the reforms we are talking about; and I would hope that we can challenge our Presidential candidates to adopt the discussions that we are having here today, because I really think this is the most burning issue of our time.

Mr. DOGGETT. One of the things that is at the top of the list is to see that our healthcare professionals reflect the population as a whole and that we have, especially in the medical specialties, a more diverse workforce that is aware and sensitive to these problems.

You made mention also to the term promotoras. I have met with some of the young women in south Texas that do that work, some of the very problems that you were referring to, breast cancer, teenage pregnancy. How would you use them and what—it is a demonstration project you referred to under CHAMP one might use them. What role would they play in this process?

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Ms. SOLIS. Well, they would be kind of the first responders, so to speak, out in the community that have a better map or design of what is taking place in their community, in their neighborhood; and they are trained individuals that typically will meet with the core group of families—typically in this case they may be females—and they'll talk about—and it's not just for one gender. They'll talk about how to go about prevention, what signs to look for for any diseases. There's a higher rate of asthma in the community. They can talk about what needs to be done to care for the family, the child, but also to help enlist these individuals on knowing what services are currently available so we don't duplicate our efforts

but we are more strategic also in a figure which program they can conceivably apply for. And I think that's our biggest test right now, that people get so overwhelmed with paperwork and not understanding which program fits their particular need.

So individuals in the promotoras program and even in the State of California where there are 1,200 promotoras right now and they're not all publicly funded, those efforts have shown very, very positive outcomes in terms of decreasing the amount of money that we could provide in terms of prevention and at the end of the day have more money to do more outreach and enrollment in some of these very important programs like the SCHIP program that are very helpful in our communities, especially in the State of Texas.

Mr. DOGGETT. Thank you.

Thank you, Mr. Chairman.

Chairman STARK. Mr. Thompson, would you like to inquire?

Mr. Pomeroy, would you like to inquire?

Mr. POMEROY. I would, Mr. Chairman.

First of all, I would like to commend this most superb panel. I think we are all used to member panels, and they put in their kind of constituent-provided or interest-provided talking points, and that is about the end of it. It is clear that each of the panel members has demonstrated a lot of knowledge that I would say is approaching policy expertise in these areas, and I really do commend them.

It has been my pleasure to serve with Mr. Moran as co-Chair of the Rural Healthcare Coalition, and I look forward to continuing working with him on rural issues. I think that he has advanced a number of issues that I completely agree with his take on them.

I want to, rather than ask questions of the panel, put into the record, Mr. Chairman, a group that is largely rural based but presents health disparities toward a minority population as profound, I believe, as any and that is the Native American and Alaska Native populations. The American Indian and Alaska Natives born today have a life expectancy of 2.4 years less than the general population. We have decreased the infant mortality rate with Native American children 64 percent during the years '72 to '99, and that's a tremendous achievement, but they still die at a rate of 10 per 1,000, which is 24 percent higher than other populations.

Of all of the disparity indices relative to Native Americans, to me the most stunning is mortality rates for specific causes compared to general population. Tuberculosis, Native Americans die at a 500 percent greater rate. Alcoholism, 638 percent greater rate. Diabetes mellitus impacting Native American mortality, in other words, the death rate for Indians dying of diabetes, 291 percent greater than the normal population. Unintentional injuries, 215 percent. Pneumonia and flu, 67 percent higher mortality. Gastrointestinal, 38 to 40 percent. Heart disease, 20 percent.

One of the more humiliating moments in my congressional service came when I went to an Indian reservation to talk about the great news of providing diabetes testing strips under Medicare. Having made my little presentation, I asked, by the way, what is the longevity rate here on the reservation? For males, it was 63 years. They were dying 2 years on average before they became even Medicare eligible. We see 73 percent of American Indians and Alaska Natives residing in health professional shortage areas, 90 doc-

tors per 100,000 compared to 229 per 100,000 across the general population.

Mr. Chairman, I would like to submit in the record my statement as well as two documents, Indian Health Service Facts on Indian Health Disparities and a document prepared by the Center for Rural Health in North Dakota on health disparities. I did not want to take panel time. I think it's important for this Committee to hear from other Members not on the Committee, but I do want this in the record on health disparities.

Chairman STARK. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Mr. POMEROY. Thank you; and I yield back, Mr. Chairman.

Chairman STARK. Mr. Becerra, would you like to inquire?

Mr. BECERRA. Thank you, Mr. Chairman, and double thank you for holding this hearing. Many of us have believed that for many years we should have had an opportunity to discuss this issue further, and I want to thank you very much for your interest and your commitment to having this issue raised and hopefully addressed in the near future.

To our panelists, thank you very much for your testimony. I think each and every one of you point out the reason why we need to move on this for any number of reasons. Whether it's race, ethnicity, geography, we have to take all those things into account.

And a special thanks to Congresswoman Solis for her active involvement not only in the Congressional Hispanic Caucus but back in California on the issues of healthcare over the years.

To me, I find something very stunning, and one of our witnesses, Dr. Michael Rodriguez, will I suspect testify to this a little later on, but three-quarters of physicians, when they are treating people who are limited in their English understanding, three-quarters of family physicians use family members to do interpretation, translation. Now I have got to tell you that maybe if you want directions on how to get to the monument a few miles away or how to get to the cinema to go see a great movie it's okay to have your family member translate for you. But when it's the issue of what medication you should take or whether you should have an amputation, having a family member doing the translation services for you I think is one of the biggest mistakes we make with regard to healthcare.

And when you take into account that the Civil Rights Act—Title VI of the Civil Rights Act actually mandates that healthcare providers that are receiving Federal funds provide meaningful access to all of their programs and activities to people who have limited English proficiency, you wonder what's going on. The Civil Rights Act says you are required to provide these services if you are taking Federal dollars. Yet, at the same time, you have a Medicare Program that doesn't reimburse providers to try to provide these interpretation services.

Dr. Rodriguez will probably testify on these. It's in his written testimony that the average cost to provide these interpretation services, competent interpretation services, professional interpretation services would probably add about $4 to a medical visit, 4

bucks to save an amputated leg or to make sure you are taking about your prescription medication correctly.

And perhaps more to the point and the reason why I think this hearing, Mr. Chairman, is so important is that the issue of trust for a lot of these patients who, whether it is because they are low income or a racial or ethnic minority or language challenged, don't receive the best medical assistance. Sometimes they leave the hospital with less than a good experience.

The problem with that in my encounters and my experience shows me is that that means you have people who are less confident in their medical providers and those professionals that are telling them what to do with their lives and their health. And if you are less willing to accept the word of a physician because you didn't have a good outcome or a good encounter, there is a very good chance that you are not going to trust what that physician is telling you when it comes to some perhaps lifesaving treatment or service. And so to undermine the trust that we would have between the provider, the doctor, and the patient to me is perhaps one of the greatest sins that we commit in allowing disparities to occur; and so I think it is critical that we begin to address this issue. And I want to thank my colleagues for their excellent testimony in bringing to light the different disparities and the types of solutions that we can devise to try to address this.

And with that, Mr. Chairman, I will yield back the balance of my time.

Chairman STARK. Thank you.

Mrs. Tubbs-Jones, would you like to inquire?

Mrs. JONES. Thank you, Mr. Chairman.

I want to thank all of my colleagues for appearing. Unfortunately, it seems like I end up at the end of the list, and I am not saying I was discriminated against. I am just saying I am at the end of the list, and all the people I want to ask questions of, unfortunately, had to leave. So I am going to ask my question and answer my question.

Chairman STARK. It is difficult for me to understand how a person so young could have risen to such seniority on this Committee.

Mrs. JONES. I know. It is because of the way the process operates. I won't talk about that about that now.

I'm joking.

All kidding aside, Mr. Moran, my colleague, your discussion has specifically been focused on urban and rural disparities. Can you shed any light on the disparities that occur in your congressional district as a result of race?

Mr. MORAN. Yes, in the sense that I represent a very Hispanic district, at least in comparison to other congressional districts in the Midwest, and what I would point out is the importance of community health clinics in meeting the needs not only of individuals with low incomes but particularly individuals with low incomes in the minority population.

In southwest Kansas, where the largest proportion of Hispanics reside, United Methodist Ministries is a community healthcare provider that provides medical services to that community. It is significant, it is important, and even in rural America somewhat contrary to the stereotype. Our population is very diverse.

Mrs. JONES. What percentage Hispanic is it?

Mr. MORAN. Eleven percent Hispanic.

Mrs. JONES. Your congressional district.

Mr. MORAN. Yes.

Mrs. JONES. And what is your district again?

Mr. MORAN. It is the First District of Kansas, which is every community in Kansas that you have never heard of.

Mrs. JONES. You don't know that.

Mr. MORAN. I don't know that.

Mrs. JONES. There you go.

Mr. MORAN. I am stereotyping in this case. But it is everything except Wichita, Kansas City, and Topeka.

Mrs. JONES. Okay. Thanks a lot.

I would have focused much of my questions to my colleague, Donna Christensen, because it is my job as the African American Member of this Committee to focus on issues that focus around the African American community, and I want to quickly just read kind of questions and answers that I would have asked Dr. Christensen were she still here.

One of those was the source of growth in stage renal disease in racial and ethnic minority communities; and it includes a spike in conditions such as diabetes, hypertension and a variety of socioeconomic factors. It can also be attributed to a lack of access to care and lack of coverage. Effective programs or tools or strategies to reduce the disproportionate number or burden of ESRD, or end-stage renal disease, in these communities can include access to care and health insurance coverage, education about diabetes and hypertension prevention, national policies that recognize the diverse needs of the end-stage renal disease population.

And one of the reasons I focus on this is because of the disproportionate number of people in my own community that I have seen have amputations as a result of end-stage renal disease. And to see a person lose limbs in the course as a result of that disease is devastating and to know that there are opportunities within our healthcare community to reduce some of that are significant.

I had an opportunity just the other day to speak with a physician who specializes in vascular surgery to attempt to reduce the number of amputations that occur in that community. I would have had a conversation with Dr. Christensen around efforts to address the issue of overprescription of Epogen and how do we address that and how we are looking at bundling and what impact that has on our community. And the reason we focus on that is because we don't want people to have the perception that physicians are overprescribing, but, on the other hand, we don't want to say we don't want to be involved in legislating a medical practice. That should be left to physicians and prescribers of prescriptions.

I do want to focus in on for a moment a recent American Journal of Kidney Disease report dated April, 2008, that indicates that when the travel time for dialysis increases from 1 to 15 minutes to 15 to 60 minutes, mortality increases by 20 percent.

Additionally, if you look in areas with high numbers of smaller facilities, they also happen to be areas in which high proportions of African Americans are treated. If these facilities are closed because of a flawed payment system, African Americans with ESRD

would face greater travel times to other dialysis facilities and thus would face greater risk for mortality.

I see I am out of time; and again I want to thank my Chair for hosting this Committee around healthcare disparities, racial and ethnic healthcare disparities. You can see that it is a topic that deserves much more time and much more attention. But we have an opportunity to address additional things such as cultural problems within the healthcare delivery service, access, and on and on and on.

I thank you, Mr. Chairman, for the opportunity to present in this area. I want to again thank my colleagues for taking the time to come before the Committee, and I look forward to the second panel where we will have a further opportunity to address some of these issues.

Chairman STARK. I thank you all, those that have been able to stay. I know that Congresswoman Christensen had a Subcommittee to Chair, and Ms. Bordallo had other appointments. So I appreciate your taking the time and patience to be with us this morning. Thanks very much.

Mr. MORAN. Thank you, Mr. Chairman, for allowing this outlier.

Ms. SOLIS. Thank you, Mr. Chairman.

Chairman STARK. I would like to ask our second panel to come on up to the witness table. And I won't go through each biography in the interest of time, but many of our witnesses have come from around the country, and they have considerable experience and expertise.

But I have to especially welcome Dr. Anthony Iton, who comes from my district in Alameda, California. He is the Alameda County Health Officer and has devoted his career to working on these issues before us today.

Just to give you a sense of Dr. Iton's qualifications, he has a medical degree from Johns Hopkins. He's board certified in internal medicine and preventative health. He has a law degree and a master's in public health from the University of California at Berkley. He is a member of the California Bar. And we just feel fortunate having him serve my constituents.

And I want to, as I say, welcome the other witnesses, all of who have outstanding credentials. They just aren't lucky enough to live in the 13th Congressional District of California.

And I am going to call on you as best I can read your names from here. We have, as best I can pronounce these—I am going to just through the list—Dr. Lillie-Blanton, Dr. Akhter, Dr. Jang, Dr. Iton we know, Dr. Satel, and Dr. Rodriguez.

Chairman STARK. Dr. Lillie-Blanton, would you like to lead off?

STATEMENT OF MARSHA LILLIE-BLANTON, DR.P.H., SENIOR ADVISOR ON RACE, ETHNICITY AND HEALTHCARE, KAISER FAMILY FOUNDATION

Ms. LILLIE-BLANTON. Thank you, Mr. Chairman and Members of the Subcommittee on Health, for the opportunity to testimony on the issue of racial disparities in health and in healthcare.

I am Marsh Lillie-Blanton, Senior Advisor on Race, Ethnicity and Healthcare at the Kaiser Family Foundation and also an asso-

ciate research professor in the George Washington University School of Public Health and Health Services.

In the past half century, the United States has made remarkable progress in improving the health of all Americans, including Americans of color. We also have seen tremendous gains in access to medical care since the mid-1960s. Medicaid and Medicare, along with the enforcement of the 1964 Civil Rights Act, deserve much of the credit for improved access. Yet disparities in health persist and our health system provides inadequate care for some and excludes millions of others.

My testimony today focuses on the role of health insurance in reducing disparities in healthcare and in health status, two distinct but related challenges. Although the causes of health disparities are complex and result from multiple interrelated factors, differentials in access and in quality contribute to these disparities.

The landmark IOM report, Unequal Treatment, provided compelling evidence that racial disparities in care persist. The extent to which medical care contributes to health outcomes may be relatively small when the outcome is defined as overall population mortality. However, the effects of medical care are immeasurable for individuals with specific health problems such as asthma or heart disease or who may need the guidance from the health system to help change personal behaviors.

However, addressing healthcare disparities is important for reasons far beyond their impact on health outcomes. The racial divides in the U.S., whether in education, employment, or healthcare, reflect the Achilles heel of this Nation. Healing the wounds that separate this Nation is important if we are to move forward as one Nation.

The U.S. was founded on ideals of equality of opportunity, and continuing efforts to realize those goals are warranted throughout all sectors of society. In the health system, assuring that individuals with similar healthcare needs are similarly treated is a basic matter of fairness.

Health insurance coverage provides the final means to access care in the U.S. Of the 47 million non-elderly Americans uninsured in 2006, approximately half, 24 million, are people of color. While younger adults are more likely than older adults to be uninsured, older adults, especially the nearly elderly, are a particularly vulnerable group because health problems increase with age.

The consequences of being uninsured can be serious. When compared with the insured, the uninsured are less likely to have a regular doctor and are more likely to be hospitalized for preventable conditions. Uninsured adults across racial ethnic groups are at least twice as likely as the insured to go without a doctor visit in the past year.

A recently completed study panel of the National Academy of Social Insurance concluded that racial disparities exist not only among the privately insured but also among Medicare beneficiaries in fee-for-service and managed care. One study cited in the report analyzed HEDIS measures for beneficiaries enrolled in Medicare managed plans. The study found that the white/black gap narrowed for seven of the nine HEDIS measures but was not eliminated in any category, and it widened for two measures.

One of the most important tools for tracking disparities in access and quality of care is the annual National Healthcare Disparities Report. The 2007 report found that there was either no change or a worsening of disparities in quality on more than half of the 16 indicators tracked over time across all racial ethnic groups. In other words, healthcare disparities in the last 5 years are not getting any smaller.

Race and ethnicity clearly matters in our healthcare system, but so do other many other factors such as the geographic availability of health services or the language capability of the providers. The wealth of evidence, however, that insurance makes a difference in opening the door to the health system suggests that reducing the number of uninsured would be one effective step in reducing racial and ethnic disparities in care.

Racial disparities among persons who are insured, however, are an indication that expansions in coverage, though necessary, are not sufficient. Efforts therefore are needed to increase the knowledge base of what works and then apply that knowledge to help close the gap in the quality of care.

I appreciate the opportunity to testify before the Committee today and welcome your questions. Thank you.

Chairman STARK. Thank you.

[The prepared statement of Ms. Lillie-Blanton follows:]

Prepared Statement of Marsha Lillie-Blanton, DrPH, Senior Advisor on Race, Ethnicity and Healthcare, Kaiser Family Foundation

Mr. Chairman and Members of the Subcommittee on Health, thank you for the opportunity to testify on the issue of racial disparities in health and healthcare. I am Marsha Lillie-Blanton, Senior Advisor on Race, Ethnicity, and Healthcare at the Kaiser Family Foundation, and also an Associate Research Professor in the George Washington University School of Public Health and Health Services.

Today, 1 in 3 Americans self-identify as either Hispanic/Latino, African American/Black, American Indian/Alaska Native, Asian American, or Native Hawaiian or Pacific Islander. By 2050, half of the U.S. population will be a person of color (*Figure 1*). This demographic shift in the population suggests that there are economic as well as health consequences of our failure to eliminate longstanding disparities in health status and in access to healthcare.

In the past half century, the United States has made remarkable progress in improving the health of all Americans, including Americans of color. We also have seen tremendous gains in access to medical care since the mid-1960s. Medicaid and Medicare, along with the enforcement of the 1964 Civil Rights Act, deserve much of the credit for improved access among low-income families, the elderly, and the disabled. Yet disparities in the health of the U.S. population persist and our health system inadequately cares for some and excludes millions of others.

My testimony today focuses on the role of health insurance in reducing disparities in healthcare and in health status, two distinct but related challenges. Disparities in healthcare—whether in insurance coverage, access, or quality of care—are one of many factors producing inequalities in health status in the U.S. Eliminating disparities in health among segments of the population (e.g., by race/ethnicity, education, income, gender, geographic location) was one of two overarching goals of Healthy People 2010, the Federal Government's blueprint for what it wanted to achieve in health by the end of this decade.

Let me begin with several examples of the urgency of these goals with two examples reflecting longstanding disparities, and one reflecting a more recent occurrence of a pattern of excess burden of disease that is unacceptable in a nation with the economic resources and technological know-how of the U.S. (*Figures 2–4*).

- A baby born to a Native American woman with a high school degree is almost twice as likely to die during the first year of life as a baby born to a Hispanic woman with the same years of education (9.2 vs. 5.3 per 1000 live births)
- A Black man earning less than $10,000 has a life expectancy at age 25 that is 3 years less than a White man earning the same income; and

- The rate of new AIDS cases among adults/adolescents is 3 times higher among Hispanics (26 per 100,000) than the rate among Whites (7 per 100,000).

Although the causes of health disparities are complex and result from multiple interrelated factors (some individual and some societal), differentials in *access* to care and in the *quality* of care contribute to these health disparities. Access to quality care matters. The extent to which medical care contributes to health outcomes may be relatively small when overall population mortality is the measure of health outcome (McGinnis et al 2002); however, the effects of medical care can be immeasurable for individuals with specific health problems such as asthma or heart disease or who need the guidance of the health system to help change personal behaviors. Nonetheless, efforts to address healthcare disparities are important for reasons *far* beyond their impact on health outcomes.

Why Addressing Healthcare Disparities is Important

The racial divides in the United States—whether in education, employment or healthcare—reflect the Achilles heel of this nation. Healing the wounds that separate this nation is important if we are to move forward as one nation. The U.S. was founded on ideals of equality of opportunity and continuing efforts to realize those goals are warranted throughout all sectors of society. In the health system, assuring that individuals with similar healthcare needs are similarly treated is a basic matter of fairness.

The landmark IOM report, *Unequal Treatment,* provided compelling evidence that racial disparities in care persist. However, national surveys continue to show that a sizable share of the population is unaware that all Americans don't receive the same access to medical care (*Figure 5*). Some of the disbelief is rooted in concerns about the quality of the evidence on racial disparities (i.e., whether the problem is real or largely explained by socio-economic differences in the population).

About five years ago, the Foundation working in partnership with a number of physician groups launched a campaign "Why The Difference" in an effort to increase awareness of healthcare disparities and ultimately encourage efforts to address them. We learned that the disbelief about whether a problem exists also extended to physicians. As such, a major component of the initiative was a thorough review of studies on racial differences in the care of patients with heart disease. We drilled down to the best studies designed to control for differences in heart disease severity, as well as socioeconomic status. The review, undertaken with the American College of Cardiology Foundation and Association of Black Cardiologists, provided credible evidence of lower rates of diagnostic and revascularization procedures for at least one of the minority groups under study in eight out of ten studies. This finding held true whether reviewing all studies meeting criteria for the review, the subset of studies defined as the most methodologically rigorous or that analyzed only clinical data (*Figure 6*). A number of efforts are now underway to improve the quality of cardiac care and reduce disparities in care, including one funded by the Robert Wood Johnson Foundation that is showing evidence of success.

The Role of Insurance in Racial Disparities in Care

Health insurance coverage provides the financial means to access care in the U.S. Whether or not one has health insurance or adequate insurance for their medical needs is linked to a number of factors including age, employment, state of residence, and even race/ethnicity.

Of the 47 million nonelderly Americans uninsured in 2006, approximately half—24 million—are people of color (*Figure 7*). While younger adults are more likely than older adults to be uninsured, older adults, especially the near-elderly (adults age 55–64) are a particularly vulnerable group because health problems increase with age. A racial disparity in coverage also exists among Americans ages 55–64. For example, in 2006, 23 percent of American Indian/Alaska Natives and 19 percent of African Americans ages 55–64 were uninsured, as compared with 10 percent of Whites in that age group (*Figure 8*). This disparity has consequences for Medicare costs since many of the uninsured in this age group will have unmet needs for medical care upon entering Medicare at age 65.

Insurance matters for adults of all ages. Uninsured adults across racial/ethnic groups are at least twice at likely as the insured to go without a doctor visit in the past year (*Figure 9*). Among Hispanic adults, for example, 21 percent of the insured had no doctor visit in the past year as compared with 53 percent of the uninsured. Numerous studies show that the consequences of being uninsured can be serious. When compared with the insured, the uninsured are less likely to have a regular doctor, and are more likely to be hospitalized for preventable conditions.

Medicare provides insurance coverage for virtually all persons ages 65 and older and for 7 million younger adults with permanent disabilities who qualify for Social

Security. However, racial/ethnic differences in supplemental coverage among Medicare beneficiaries also can affect differentials in care. An estimated 18 percent of African Americans compared to 11 percent of Latinos and 11 percent of White Medicare beneficiaries lack supplemental coverage to fill in the gaps and pay for services not covered by Medicare (*Figure 10*). In addition, because Medicare beneficiaries of color are disproportionately low-income, they are more likely than Whites to have supplemental coverage from Medicaid and thus are greatly affected by federal-state Medicaid policies that influence access to care. Without insurance or adequate insurance coverage, access to medical care suffers and can ultimately compromise one's health.

In a review of multiple studies on the contribution of health insurance to racial disparities in care, health insurance was found to be the single largest factor explaining racial disparities in whether an individual had a regular source of medical care (Lillie-Blanton & Hoffman 2005). For example, one study in that review found that health insurance explained approximately 42 percent of the access disparity between African Americans and Whites, and about 20 percent of the access disparity between Hispanics and Whites in having a regular source of medical care (*Figure 11*), a well recognized measure of one's ability to obtain access to timely and quality care.

Disparities in Care Among the Insured

Although the uninsured are clearly the most vulnerable for getting less than adequate care, disparities in access and in quality of care exist even among the insured. Evidence of racial/ethnic disparities in care among individuals who are similarly insured is particularly disturbing.

The National Academy of Social Insurance recently completed a study panel on Medicare and racial disparities (NASI 2006). After a review of the research, the panel concluded that racial disparities exist not only among the privately insured but also among Medicare beneficiaries in fee-for-service and managed care. One study cited in the report analyzed Healthcare Effectiveness Data Information Set (HEDIS) measures for elderly White and Black beneficiaries enrolled in Medicare managed care plans between 1997 to 2003 (Trivedi et al 2005). The study found that the White-Black gap narrowed for seven of nine HEDIS measures but was not eliminated in any category, and it widened for two measures: glucose control among patients with diabetes and cholesterol control among patients with heart conditions. Another study of Medicare patients with breast, colorectal, lung, and prostate cancers shows that disparities persist in treatment of these conditions as well (Gross et al 2008).

Evidence from the Medicare program also provides a positive example of how expansion in insurance coverage can diminish healthcare disparities (Daumit and Powe 2001). A nationwide study found that the racial disparity in cardiac procedure use among patients with chronic renal disease—a group at high risk for heart disease—was sharply reduced after patients qualified for Medicare (*Figure 12*). African American men and women were a third as likely as White men (the study reference group) to receive catheterization, angioplasty, and bypass surgery before enrolling in Medicare. After enrolling in Medicare and entering into a comprehensive system of care, there was no difference in cardiac procedure use between African American women and White men. For African American men, however, the disparity persisted. In other words, insurance coverage reduced the disparity for both population groups, and eliminated it for one population group.

Tools for Tracking Changes in Healthcare Disparities

One of the most important tools for tracking disparities in access and quality of care is the annual National Healthcare Disparities Report (NHDR), which examines differences in patterns of care across different segments of the population. The 2007 NHDR shows that disparities between racial/ethnic groups continue to exist for a number of conditions and services and that progress in reducing disparities has been modest at best. The NHDR found that there was either no change or worsening of disparities in quality on more than half (57%–69%) of the 16 indicators tracked over time for the four racial/ethnic groups of color compared to Whites (*Figure 13*).

It is important to note, however, that of the 42 quality indicators included in the 2007 NHDR, data on only 16 indicators were available to track over time for all racial/ethnic and income groups. Increasing our knowledge on healthcare disparities and effective interventions will require routinely collecting, analyzing, and reporting on data on healthcare use across population demographic characteristics such race/ethnicity, income and education. These efforts are needed to benchmark and track

our healthcare system's performance in serving all Americans, regardless of their background characteristics or where they live.

Race and Coverage Matter, but so do Other Factors

Race and ethnicity clearly matter in our health system, but so do many other factors—such as the geographic availability of health services or the language capability of the provider. We live in a society that remains highly residentially segregated by race/ ethnicity and by income. People of color tend to live in close proximity to each other and people of limited financial means and those of great wealth tend to live in the same neighborhoods. As a result, education, employment, and healthcare opportunities tend to cluster along those divides. This reality complicates our ability to neatly define the causes of the problems or their solutions.

The wealth of evidence, however, that insurance makes a difference in opening the door to the health system suggests that reducing the number of uninsured would be one effective first step in reducing racial/ethnic disparities in care. African Americans, Latinos, Native Americans, and some Asian and Pacific Islander Americans are disproportionately uninsured, and thus will face greater financial burden in obtaining access to care. Racial disparities among persons who are insured, however, are an indication that expansions in coverage, though necessary, are not sufficient. Efforts are needed to increase the knowledge base of what works and then apply that knowledge to help close the gap. Finally, collecting data to better track performance measures on our health system is important to monitor our progress in reducing disparities in care.

I appreciate the opportunity to testify before the Committee today and welcome your questions. Thank you.

Chairman STARK. Dr. Akhter, who is the Director of the National Medical Association, we are happy to have you here and look forward to your testimony.

STATEMENT OF MOHAMMAD AKHTER, M.D., MPH, EXECUTIVE DIRECTOR, NATIONAL MEDICAL ASSOCIATION

Dr. AKHTER. Thank you, Mr. Chairman and Members of the Committee. It is honor to testify before you on this very important subject not only to our community but to our Nation.

National Medical Association's 30,000 physicians provide every single day services to the minority community, so what I am about to tell you is the reality on the ground.

The first and most important contributing factor to the disparities is lack of affordable care. When the healthcare is not available, one out of three Hispanics and one out of four African Americans have no access to care. When the care is not available, they can't access the care in a timely manner. Then a small problem becomes a big problem. Like in our Nation's capital, a child who couldn't get dental care, the dental abscess became the brain abscess and the child died. And there are many examples like this. So access to care becomes the number one issue for our minority communities.

Even when we do have health insurance, people have difficulty getting the access because there are not many providers in those communities. Why would a provider open his office in a community where every third person coming in is uninsured or has no ability to pay? And so when there is no provider or very few providers, people are having difficulty getting care, even for Medicare patients.

Fifty percent of the Medicare patients in a study done by Hopkins shows they have difficulty finding a general practitioner to be taking care of their diabetes, their hypertension; and 81 percent of

the patients have no access to mental health services. So, without these services, it really becomes very, very hard.

So in areas of our country when people do have insurance and people do have access, they usually receive poor quality care in the minority communities. And one big reason for receiving poor quality care is a lack of coordination between the providers. Most minority patients with multiple chronic conditions have many doctors and many providers. They don't talk to each other.

So in this one study by Hopkins, 32 percent of the patients got conflicting medical advice from their providers. Twenty-five percent of the time they had to have duplicate tests done, and another 25 percent of the time they got wrong prescriptions or conflicting prescriptions. So no wonder 71 percent of Hispanics and over 50 percent of African Americans are dissatisfied with the care they receive when they go to get the care.

Mr. Chairman and Members of the Committee, the system is broken. We need to fix the system.

And when everything is available—the people have insurance, they have access to care, there are great institutions—the culturally competent care is not available. The language problem, low literacy rates, the communication between the doctor or the provider and the patient is not very good, so the treatment plan that's developed is not followed by the patient appropriately. So, as a result, despite our spending a lot of money in the healthcare delivery system, we continue to have these disparities.

And finally, Mr. President, when the system was put in place in the last century, in our Nation life expectancy was around 50 years, and most our people were of European descent. So the system put in place was for the sick care system or the acute care system. It has served us very well over the years.

But now our Nation has changed. Our population has grown older. Our society has become multicultural, multiethnic, and a bigger problem for our society is the chronic care, management of care. Seventy-five percent of the problem is management of chronic care. That is where the disparities come in. This acute care system is not designed to do deal with chronic care problems. So we need to transform the system from a sick care system to a healthcare system that includes prevention, disease management that is patient centered and is affordable.

Mr. Chairman, I know you've been very interested in this issue and the Members of the Committee, but really truly to address this issue not only we need to follow through on the TriCaucus bill but we also need to transform our healthcare delivery system so it could meet the needs of our population as it exists today and as it will be in the future.

I thank you very much for the opportunity today, Mr. Chairman, to testify before you.

Chairman STARK. Thank you, Doctor.

[The prepared statement of Dr. Akhter follows:]

Prepared Statement of Mohammad Akhter, M.D., MPH,
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10 June 2008

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

Presented before the Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

Addressing Disparities in Health and Healthcare: Issues for Reform

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

Disparities in health and healthcare remain the primary reason the National Medical Association (NMA) has stayed in business, and our commitment to this cause will continue until we see the reversal of these pernicious trends.

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.

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.

There are dissenting opinions about the severity of this problem. For some, the problem is a figment of our imagination. The epidemiology tells a different story however. The 2007 NHDR further elucidates the problem relative to African American populations. A few highlights follow:

- New AIDS cases are 10 times higher for Blacks than Whites;
- The proportion of Black children hospitalized due to asthma was almost four times higher than White children;
- Uninsured Black women were less likely to have a mammogram in the past 2 years (44.2% compared with 76.3% for privately insured Black women).

Another fundamental design flaw compounds our disparities problem - we have tried, unsuccessfully for several decades now, to use an acute care system to manage chronic conditions. As most of you know, about 130 million Americans have to live with at least one chronic condition. In addition, our population has grown older, and we have become a much more multicultural society. To serve the needs of our population now, and in the future, we need to transform the current sick-care system to a health-care system that includes prevention as well as management of chronic conditions. We also need to make the care affordable and patient-centered.

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.

Health Information Technology (HIT) – HIT can expedite all the aforementioned, but can also help us reduce medical errors, and help create more transparency in the healthcare system. The lack of said transparency makes it near impossible to create the consumer-directed marketplace that some insist will fix all our nation's healthcare problems.

The U.S. Department of Health and Human Services (HHS) has admitted that the benefits of HIT would include:

- improve health care quality;
- reduce health care costs;
- increase administrative efficiencies;
- decrease paperwork; and
- expand access to affordable care.

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.

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Chairman STARK. I guess it's Ms. Jang, who is the Policy Director of the Asian and Pacific Islander American Health Forum. Would you like to enlighten us, please?

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

Ms. JANG. Thank you. I guess I am a doctor, because I have a J.D.

But I want to thank you Chairman Stark, Ranking Member Camp and Members of the House Ways and Means Subcommittee on Health for inviting me to testify on disparities in health and healthcare and for your leadership on healthcare reform, especially your efforts to address health equity.

The Asian and Pacific Islander American Health Forum is a national advocacy organization dedicated to improving the health and well-being of Asian Americans and Pacific Islander communities through policy, programs, and research. My testimony this morning will discuss the disparities in healthcare coverage, health status, access to care, and quality of care for Asian Americans and Pacific Islanders. I will end by discussing some important policy proposals included in the House-passed CHAMP Act and H.R. 3014, the TriCaucus-sponsored health equity legislation.

Earlier today, Ms. Bordallo discussed the heterogeneity of Asian American and Pacific Islander communities in terms of ethnicities, languages spoken, culture, and socioeconomic status. As a group, Asian Americans and Pacific Islanders are more likely to be uninsured than nonHispanic whites. Specific Asian American and Pacific Islander groups face extremely high rates of uninsurance. For example, 24 percent of Native Hawaiians and Pacific Islanders and 31 percent of Korean Americans are uninsured.

The sources of insurance also varies greatly between Asian American and Pacific Islander subgroups. Southeast Asians have higher incidents of poor and near poor and are more likely to rely on Medicaid and the State Children's Health Insurance Program. Koreans, who are more likely to work in their own small businesses, are less likely to have employer-sponsored health coverage.

Any healthcare reform coverage that includes employer mandates must take into consideration the need for affordable health coverage for small business owners, and expanding public programs to cover more low-income individuals will also result in expanded coverage for Asian Americans and Pacific Islanders.

While health insurance coverage is an important predictor of access to healthcare in our communities, uninsured Asian Americans were more than four times as likely as insured Asian Americans to lack a usual source of care. However, disparities and access to care remain, regardless of healthcare coverage. Factors such as language and cultural barriers prevent many Asian Americans and Pacific Islanders from accessing quality care. For example, cancer is the leading cause of death among Asian Americans; yet Asian Americans were significantly less likely to receive preventative services such as cancer screenings or cholesterol checks or counseling about smoke cessation, diet, weight, exercise, and mental health.

There are two important strategies included in the CHAMP Act and H.R. 3014 that I want to highlight that should be included in any efforts to reform healthcare. First of all, standardizing the collection, analysis and reporting of data on race, ethnicity, and primary language in an accurate and appropriate manner and, sec-

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

Accurate, timely disaggregated data by race, ethnicity, and primary language on Asian Americans and Pacific Islanders and other racial and ethnic minorities are vital to developing and monitoring programs and policies aimed at improving health equity. Medicare data has provided a rich source of information about these populations and the disparities in health and healthcare among Medicare beneficiaries.

You have heard about the Robert Wood Johnson study that was mentioned earlier, but there has also been a recent study that found that, although there were variations related to geography and socioeconomic status overall, Asian Medicare beneficiaries were less likely than whites to receive mammography and colorectoral cancer screening and all three diabetic services.

And while there have been some improvements in the quality of data collected on race and ethnicity, there remains much more to be done. For example, the improvement in the data on race, ethnicity, and primary language in the Medicare system. The problem is that Medicare's data comes from the Social Security Administration, and this data is collected at the time that someone applies for a Social Security number. The problem is that the way that data is collected has not been updated to conform with the OMB revised standards in 1997 on the collection of race and ethnicity.

The second problem is the Enumeration at Birth process. That doesn't provide data on race and ethnicity.

And, 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.

Finally, in terms of language access, almost all health providers are obligated by the Civil Rights Act to provide language assistance, but we need more technical assistance and resources to pay for it. So while the Centers for Medicare and Medicaid Services has clarified that language services are reimbursable in the Medicaid and SCHIP program, no such reimbursement is specifically available in the Medicare Program. And although Medicare health plans are required to provide the language services, most of them are passing those obligations on to their contractor providers without any reimbursement or resources to help them do that. So we support the provisions in the CHAMP Act that will call for a study and evaluations and demonstration projects to assure that high-quality language assistance is provided in a cost-effective manner with incentives for providers to use it.

I thank you for the invitation, again, to testify. There is more data and details in my written statement, and I would be happy to answer any questions.

Chairman STARK. Thank you very much.

[The prepared statement of Ms. Jang follows:]

Prepared Statement of Deeana Jang, J.D., Policy Director, Asian & Pacific Islander American Health Forum

Thank you, Chairman Stark, Ranking Member Camp, and Members of the House Ways and Means Subcommittee on Health, for inviting me to testify on disparities in health and healthcare. I also want to thank Chairman Stark and Members of this

Subcommittee for your leadership on healthcare reform and for your efforts to address health equity within the context of reform.

The Asian and Pacific Islander American Health Forum, or "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.

Healthcare reform, or expanding access to healthcare for uninsured and underinsured Asian Americans and Pacific Islanders (AAs and PIs), is one of five major policy priorities for the Health Forum. But, as you'll see from my testimony, even with health coverage, disparities in health and healthcare persist in our communities. My testimony will also cover some of the unique factors that make it difficult for AAs and PIs to access quality healthcare; such as disparities in health coverage due to poverty, and a significant percentage who work in or own small businesses and barriers due to language and culture.

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] By providing small businesses with affordable options, healthcare reform efforts could significantly lower the number of uninsured AAs and PIs.

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 through healthcare reform efforts is critical for individuals who do not have access to affordable coverage through an employer or the private market.

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 U.S.

To address these disparities in coverage, many states developed strategies to help enroll individuals with limited English proficiency in Medicaid and SCHIP.[4] States also took additional steps to simplify enrollment and renewal procedures for children.[5] And, nearly half of states have continued to provide coverage for legal immi-

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[1] Kaiser Family Foundation and Asian & Pacific Islander American Health Forum, *Health Status, Coverage, and Access to Care for Asian and Native Hawaiian and Pacific Islander Americans* (Washington, DC: April 2008).

[2] Kaiser Family Foundation, op. cit.

[3] Kaiser Family Foundation, op. cit.

[4] M. Youdelman, J. Perkins and J. Brooks, *Providing Language Services in State and Local Health-Related Benefits Offices: Examples from the Field*, (New York: The Commonwealth Fund, January 2007).

[5] Kaiser Family Foundation, *Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles: A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost Sharing Practices in Medicaid and SCHIP in 2008*, (Washington, DC: January 2008).

grants during their first five years in the country through state-funded programs.[6] Ensuring that similar solutions are enacted through healthcare reform would help eliminate the health insurance disparities faced by AA and PI communities.

Disparities in Access to Care

Health insurance coverage is an important predictor of access to healthcare 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.[7]

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).[8] 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 Healthcare Quality Survey concluded that Asian Americans experience poor access to quality care on a range of measures."[9] Asian Americans reported greater communication difficulties and lower levels of satisfaction during their healthcare visits.[10] 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."[11]

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 Healthcare 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.[12] Less than half of Asian Americans with chronic conditions received the care they needed to manage their conditions.[13]

Disparities in Health Outcomes and Disease Prevalence

The lack of health coverage, limited access to healthcare, 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.[14] 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.[15]

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[6] L. Ku, *Reducing Disparities in Health Coverage for Legal Immigrant Children and Pregnant Women*, (Washington, DC: Center on Budget and Policy Priorities, April 2007).

[7] Kaiser Family Foundation, op. cit.

[8] Kaiser Family Foundation, op. cit.

[9] K. Collins, D. Hughes, M. Doty, B. Ives, J. Edwards, and K. Tenney, *Diverse Communities, Common Concerns: Assessing Healthcare Quality for Minority Americans: Findings from the Commonwealth Fund 2001 Healthcare Quality Survey*, (New York: The Commonwealth Fund, March 2002).

[10] Collins et al, *Diverse Communities, Common Concerns*, 2002.

[11] Collins et al, *Diverse Communities, Common Concerns*, 2002.

[12] Collins et al, *Diverse Communities, Common Concerns*, 2002. A. Beal, M. Doty, S. Hernandez, K. Shea, and K. Davis, *Closing the Divide: How Medical Homes Promote Equity in Healthcare*," (New York: The Commonwealth Fund, June 2007).

[13] Beal et al, *Closing the Divide*, 2007.

[14] C. Chappell, "Healthcare Needs of Asian American Women," *Issues, Concerns, and Responsive Human and Civil Rights Advocacy: Asian American Women, Second Edition,* Chapter 5, pages 101–120, 2007.

[15] Centers for Disease Control and Prevention, National Diabetes Fact Sheet, United States, 2005.

- Asian American women aged 15–24 and over 65 have the highest suicide rates across all racial and ethnic groups.[16] Furthermore, Asian American girls have the highest rates of depression across both race/ethnicity and gender.[17] 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.[18]

Strategies to address disparities in coverage, access and quality

There are two important strategies included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) that should be included in healthcare reform initiatives to 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.

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 Healthcare," 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.[19]

To help close the disparity gap, the IOM recommended that the Federal Government: (1) collect and report data on healthcare 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 healthcare 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.

A 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.[20] 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.[21]

Medicare data has provided a rich source of information about racial, ethnic, and socioeconomic disparities in health and healthcare among Medicare beneficiaries.

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[16] Centers for Disease Control and Prevention, "Deaths: Leading Causes for 2001," *National Vital Statistics Reports*, 52(9), 1–86, 2003.

[17] National Center for Health Statistics, "Health, United States, 2003," (Hyattsville, MD: U.S. Public Health Service, 2003).

[18] U.S. Surgeon General. 2001. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General*. Washington, DC: U.S. Department of Health and Human Services.

[19] E. Fisher, D. Goodman, and A. Chandra, *Disparities in Health and Healthcare among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project*, The Robert Wood Johnson Foundation, June 2008.

[20] E. Moy, L. Greenberg, and A. Borsky, *Community Variation: Disparities in Healthcare Quality Between Asian and White Medicare Beneficiaries, Health Affairs*, Vol. 27, No. 2, March/April 2008.

[21] Agency for Healthcare Research and Quality, *2006 National Healthcare Disparities Report*, December 2006.

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.[22]

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.[23]

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. 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. Such provisions would help identify and eliminate disparities in the quality of health services that minorities and women enrolled in the program receive.

The provisions included in Subtitle D of H.R. 3162, the Children's Health and Medicare Protection Act of 2007 (CHAMP Act) will substantially improve the collection of data on race, ethnicity and primary language. Specifically, we support:

- 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.
- Development of standards for collection of data on primary language spoken and written of Medicare beneficiaries.
- Technical assistance for health information technology improvements that will facilitate collection and analysis of racial, ethnic and primary language data; improving methods for collection and analysis of smaller populations and ethnic subgroups within the minimum OMB standards; and educating healthcare organizations, providers and health plans to raise awareness that collecting and reporting data on race, ethnicity and primary language are essential to eliminate disparities and is legal; and providing for the revision of the existing HIPAA claims-related code set to require collection of data on race and ethnicity and to provide a code set for the collection of primary language data.
- Identification of appropriate quality measures to monitor for disparities and to develop new quality measures related to racial and ethnic disparities in health and healthcare.

We also 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.

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

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 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

[22] A. McBean, *Improving Medicare's Data on Race and Ethnicity, Medicare Brief*, No. 15, National Academy of Social Insurance, October 2006.

[23] A. McBean, op. cit.

for persons with limited English proficiency.[24] 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.[25] However, more research is needed to determine the impact of language services on the health and healthcare of limited English proficient populations. We support the provision in ***H.R. 3162*** that requires the Secretary of HHS to arrange for the Institute of Medicine to conduct a study of the effects of providing language access services on quality of healthcare, access to care and reduced medical error.

Medicare programs should be ensuring that meaningful access to enrollment and healthcare 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.[26] 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 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 healthcare. In addition, we support requiring all Medicare providers to comply with Federal civil rights laws. This provision is included in Title I of ***H.R. 3014***.

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.[27] 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.

The Federal Government needs to 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.

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, language services are currently not specifically reimbursable by the Medicare program. 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,"[28] 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 require-

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[24] Green, A., et al. "Interpreter services, language concordance, and healthcare quality. Experiences of Asian Americans with limited English proficiency." *J Gen Intern Med*. 20(11):1050–6, Nov. 2005. Flores, G. "The impact of medical interpreter services on the quality of healthcare: a systematic review." *Med Care Res Rev*. 62(3):255–99, June 2005. Ngo-Metzger, Q. "Providing high-quality care for limited English proficient patients: the importance of language concordance and interpreter use." *J Gen Intern Med*. 22 (Suppl 2):324–30. Nov. 2007.

[25] N. Ponce, L. Ku, W. Cunningham, and E. Brown, *Language Barriers to Healthcare Access Among Medicare Beneficiaries, Inquiry*, Spring 2006.

[26] U.S. Department of Health and Human Services, Office for Civil Rights, *Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons*, 68 Fed. Reg. 47311, August 8, 2003.

[27] *Improving Access to Services for Persons with Limited English Proficiency*, 65 Fed. Reg. 50121, August 16, 2000.

[28] 42 C.F.R. 422.112(a)(8).

ment 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.

Healthcare providers from across the country have reported inadequate funding of language services to be a major barrier to LEP individuals' access to healthcare 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.

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, the approach taken by H.R. 3162 to support a study and demonstration projects to examine the ways that Medicare should develop payment systems for language services is necessary to determine the most efficient, cost-effective way to ensure the provision of language services that includes incentives for providers and that result in effective communication between providers and LEP persons. The National Health Law Program together with the Center on Budget and Policy Priorities has already taken a preliminary look at this issue and we urge HHS to consider their report on "Paying for Language Services in Medicare: Preliminary Options and Recommendations," October 2006. The major recommendations from the report are:

- Offer grants to hospitals, schools that train health professionals and community groups to increase the recruitment and training of bilingual and multilingual medical interpreters and clinicians.
- To improve language services in physician settings, provide Medicare reimbursements to in-person interpreters and develop a system of federal contracts for telephone interpretation firms.
- Improve monitoring and oversight of existing requirements to provide language services in Medicare managed care.
- Exempt language services from Medicare cost-sharing requirements.

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

In order to ensure coverage and access to healthcare 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.

We support the provisions in the CHAMP Act and H.R. 3014 to allow states to cover lawfully residing immigrant children and pregnant women in SCHIP and Medicaid. 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 must be repealed. We support these provisions in H.R 3162 and H.R. 3014 as well.

Conclusion

We look forward to working with Congress and the new Administration to achieve our mutual goals of guaranteed, affordable, high quality care that is truly accessible and equitable to all.

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Chairman STARK. Dr. Iton, would you like to testify, please?

STATEMENT OF ANTHONY B. ITON, M.D., J.D., MPH, DIRECTOR OF PUBLIC HEALTH AND HEALTH OFFICER, ALAMEDA COUNTY, CALIFORNIA

Dr. ITON. Good morning, Committee and certainly, Chairman Stark, as a practicing internist for the past 20 years, I have been very familiar with the Stark rules I and II, and it is an honor to be from a county that is represented by you and the leadership that you have shown in the Medicare Program.

Good morning, Ranking Member Camp and Members Becerra and Jones.

My name is Dr. Tony Iton. I am the Health Officer and Director of the Alameda County Public Health Department. I am a board-certified physician and an attorney, and I work in a department that serves about 1½ million people and have about 170,000 uninsured people in my county. Our combined agency expenditures are about $1 billion a year in healthcare.

I recently had the privilege to participate in the creation of a multi-part PBS television documentary entitled Unnatural Causes: Is Inequality Making Us Sick? In concert with the national airing

of that documentary series, my health department released a report on the preventable root causes of health disparities. We entitled our report Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County, and with your permission, Chairman Stark, I would like to submit that report for the record.

Chairman STARK. Without objection.

[The information follows:]

******** COMMITTEE INSERT ********

Dr. ITON. My testimony is largely based on research and data that appear in both the television series and the report as well as upon the experience of providing public health and healthcare services for the 1.5 million residents of Alameda County.

Now, the focus of this hearing is healthcare disparities in the Medicare system. My particular input will be on the evidence that, while access to healthcare is a critical contributor to overall health status, the healthcare system by itself cannot successfully reduce health disparities and that unless greater attention is paid to public health approaches to reducing health and social inequity the Medicare system will be bankrupt due to the inexorable burden of chronic disease.

I also try to address several false dichotomies and myths that are regularly entertained in policy discussions focused on health and health disparities.

I will endeavor to make the following four points in my testimony: One is that health does not equal healthcare; two is that health disparities do not equal healthcare disparities; three, health disparities are worsening and are overwhelmingly driven by chronic disease; and, four, chronic disease is preventable.

I also hope to touch on some of the false dichotomies related to the conflict between universal access and community based prevention and the notion of individual responsibility versus social responsibility. And, finally, if I have enough time—I doubt that I will—I would like to address the issue of the immigrant health paradox and the myth that immigrants are draining our healthcare system.

So, to start with, health does not equal heath care. Most people who live long and healthy lives in this country—many of us represented on this panel and in this room—do so without much assistance from the U.S. healthcare system. In fact, a reasonable goal of most Americans is to live a life that allows us to avoid hospitalization, emergency room visits and even our physician's office except for routine, clinical, and preventative screening services.

The best strategy for doing this is to avoid acquiring a chronic disease. According to CDC, the medical care costs of people with chronic diseases in this country account for 75 percent of the Nation's $2 trillion medical care costs. Chronic diseases are the cause of seven of every ten American deaths, and the prevalence of chronic disease in the community is a primary driver of the demand for healthcare services.

As a healthcare program administrator, I live with the reality of the so-called 80/20 rule, which refers to the fact that 80 percent of healthcare costs are driven by 20 percent of the population. Relatively modest shifts in the overall chronic disease burden in that 20 percent can have dramatic effects on healthcare costs and utili-

zation. Thus, the overall health of a community is not primarily shaped by access to healthcare. Instead, access to healthcare serves to remediate and repair the damage that the healthcare system is presented with as the result of the overall prevalence of chronic disease in a community.

Now, get me right here. Healthcare access matters, and this is one of the first false dichotomies. To argue that the overall community health status is not primarily controlled by access to healthcare is not equivalent to arguing that access to healthcare plays no role in shaping overall community health. We know about the consequences of lacking access to healthcare, and I am not going to repeat them here because we have many people on this panel and this Committee has heard this before. And we know certainly that access to healthcare reduces the chronic stress of poverty in many communities. Simply by reducing the specter of personal bankruptcy associated with catastrophic medical illness, universal access to healthcare will ease the chronic stress of being working poor in this country. It also reduces job lock, which is the fear of leaving your job when you have a pre-existing illness due to the fact that you are afraid that you will not be able to get insurance in your next job.

Healthcare disparities do not equal health disparities. Healthcare disparities are the result of a healthcare system that lacks accountability for health outcomes and lacks transparency regarding the selection and application of treatment regimes. Therefore, any policy initiatives that serve to increase accountability and transparency of the Medicare system will create pressure on the healthcare system to reduce differential treatment by race/ethnicity.

A particularly critical accountability and transparency measure, and is referenced in the CHAMP Act, is the collection of data on race, ethnicity, and primary language of beneficiaries. Such data allows health systems researchers and healthcare quality improvement practitioners to identify systematic biases in provider and system behavior and thereby adjust and correct their performances.

Now, health disparities are differences in health status and outcomes that occur largely independent of the health system and consequently are much broader in scope and impact than healthcare disparities.

In my county, Alameda County, we have mapped health disparities geographically using geographic information systems and have demonstrated geographic patterns of disease and death distribution that correlate closely with the distribution of other important health protective resources such as opportunities for employment, recreation, health, high-quality education, and living-wage income.

These strong correlations suggest that health disparities are substantially structural in nature and can be ameliorated by facilitating better access to proven health protective resources and opportunities for low-income communities and including rural communities regardless of race but with a particular focus on those communities that have a disproportionate concentration of African Americans, Native Americans, Latinos, and Pacific Islanders. The health status of these particular groups is demonstrably worse than other race/ethnic populations in terms of chronic disease, par-

ticularly around obesity, diabetes, and portend worsening outcomes for the larger population in America. And in many ways these populations represent canaries in our coal mine; and the vulnerability due to racial discrimination, low income, poor education, environmental pollution make these populations more prone to the impacts of larger disease-generating social trends that will ultimately seep into the larger population.

I see that my time has run out. I would like to make the point and hopefully in questioning we can discuss the issue of false dichotomies around individual responsibility versus community responsibility and address the myth that immigrants are somehow bleeding our healthcare system. That is patently false. Immigrants have in many cases in Alameda County and elsewhere much lower utilization of healthcare services than native-born or American-born populations and relatively good health status given the levels of poverty. So I am happy to address that issue if it comes up in the questioning.

Thank you.

Chairman STARK. Thank you.

[The prepared statement of Dr. Iton follows:]

Prepared Statement of Anthony B. Iton, M.D., J.D., MPH, Director of Public Health & Health Officer, Alameda County, California

Good morning Chairman Stark and Members of the Subcommittee on Health, thank you for the opportunity to testify today on addressing disparities in health and healthcare. My name is Dr. Anthony Iton, Director and Health Officer, Alameda County Public Health Department. I will keep my comments brief and concise. A copy of my written testimony will be submitted for the record. I am a dually board certified physician, an attorney and the Director of a large local public health department in Northern California. Approximately 11% or 170,000 people in my county are uninsured.[1] Our county runs three public hospitals, several outpatient health clinics and funds healthcare services for the uninsured at several other community-based health clinics. In addition we manage a large clinical mental health and substance abuse program as well as providing a broad array of public health and environmental health services. The combined cost of these county-provided services is about $1 billion dollars per year.

Recently, I had the privilege to participate in the creation of a multi-part PBS television documentary entitled *Unnatural Causes: Is Inequality Making Us Sick*. In concert with the national airing of that documentary series, my health department released a report on the preventable root causes of health disparities entitled *Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County*. My testimony is largely based on research and data that appear in both the television series and the report as well as upon the experience of providing public health and healthcare services to the 1.5 million residents of Alameda County.

The focus of this hearing is healthcare disparities in the Medicare system. My particular input will be on the evidence that while access to healthcare is a critical contributor to overall health status, the healthcare system, by itself, cannot successfully reduce health disparities and that unless greater attention is paid to public health approaches to reducing health and social inequity, the Medicare system will be bankrupted due to the inexorable burden of chronic disease. I will also address several false dichotomies and myths that are regularly entertained in policy discussions focused on health and healthcare disparities. Good policymaking will endeavor to avoid the trap of becoming locked into these unhelpful and simplistic dichotomies and instead look for opportunities to create mutually reinforcing strategies that simultaneously address several of the proximate and root causes of health disparities. Preventive policies that address root causes tend to be more cost-effective, sustainable, and socially just.

I will endeavor to make the following points in my testimony:

[1] California Health Interview Survey 2007.

- Health ≠ healthcare. Access to a high quality system of affordable healthcare is an important human right and a necessary strategy for improving health and quality of life and reducing health disparities, but healthcare alone is not sufficient to "produce" health in populations.
- Health disparities ≠ healthcare disparities. Healthcare disparities are a subset of health disparities and can only be reduced by increasing *accountability* and *transparency* within healthcare delivery systems. However, the healthcare system cannot effectively eliminate health disparities which are firmly rooted in larger social inequities related to the historical legacy of discrimination by race, class, gender, disability, and immigration status. These historical and present injustices are only remediable by focused social policy targeted at increasing opportunity across a broad range of policy domains.
- Health disparities are worsening and are overwhelmingly driven by chronic disease.
- Chronic disease is preventable.
- Individual responsibility versus community responsibility is a *false dichotomy*.
- The Immigrant Health Paradox and the myth of immigrants bleeding our healthcare systems.

This Committee has certainly heard testimony on numerous occasions regarding the need for universal healthcare in this country. I strongly support that view and consider universal access to a high quality and affordable system of healthcare to be a fundamental human right. Everyone of us should feel shame at our failure to achieve this basic policy goal. However, universal access to medical care alone will not eliminate the profound and worsening health disparities in the U.S. because these health disparities are rooted in deeply entrenched social inequity. Racial and ethnic health disparities are patterned on profound race/ethnic disparities in income, employment, education, and other critical social resources.

Health ≠ Healthcare

Most people who live long and healthy lives in this country do so without much assistance from the U.S. healthcare system. In fact, a reasonable goal of most Americans is to live a life that allows us to avoid hospitalization, emergency room visits, and even our physician's office, except for routine clinical preventive services. The best strategy for doing this is to avoid acquiring a *chronic disease*. According to the CDC, the medical care costs of people with chronic diseases account for more than 75% of the nation's $2 trillion medical care costs. Chronic diseases, (primarily heart disease, stroke, cancer, and diabetes), are the cause of seven of every 10 Americans deaths. Chronic, disabling conditions cause major limitations in activity for more than one of every 10 Americans, or 25 million people. The prevalence of chronic disease in a community is a primary driver of the demand for healthcare services.

As a healthcare program administrator, I live with the reality of the so-called "*80/20 rule* " which refers to the fact that 80% of healthcare costs are driven by 20% of the population. Relatively modest shifts in the overall chronic disease burden of that 20% of the population can have dramatic effects on healthcare costs and utilization. In general, our reactive healthcare system is primarily designed to mitigate the adverse consequences of chronic disease rather than prevent the occurrence of chronic disease in the first place. Thus the overall health of a community is not primarily shaped by access to healthcare, instead, access to healthcare serves to remediate and repair the damage that the healthcare system is presented with as a result of the overall prevalence of chronic disease within the community.

However, to argue that overall community health status is not primarily controlled by access to healthcare is not equivalent to arguing that access to healthcare plays no role in shaping overall community health. This is the first **false dichotomy** that serves to distract us from thoughtful policy solutions. Access to high quality and prevention focused healthcare is not only a basic human right, but this Committee has previously heard testimony from various individuals and organizations regarding the overwhelming evidence of the consequences of inadequate access to healthcare. These consequences include delayed and foregone care, increases in expensive care including emergency room visits and preventable hospitalizations, decreased quality of life and decreased productivity, and premature death.[2] Above and beyond that, access to healthcare reduces the chronic stress of poverty. Simply by reducing the specter of personal bankruptcy associated with catastrophic medical illness, universal access to healthcare will ease the chronic stress associated with being working poor in this country. It will also reduce so-called "job-lock" wherein people with pre-existing illness remain in sub-optimal employment in order to main-

[2] Kaiser Family Foundation. The Uninsured: A Primer.

tain health benefits. Access to healthcare is therefore necessary but not sufficient to eliminate persistent racial/ethnic health disparities.

Health Disparities ≠ Healthcare Disparities

Just as health does not equal healthcare, healthcare disparities are a *subset of* health disparities. Healthcare disparities are well-documented and are the differential outcomes that patients achieve after presenting to healthcare facilities. Healthcare disparities are the result of a healthcare system that lacks accountability for health outcomes and lacks transparency regarding the selection and application of treatment regimens. Therefore any policy initiatives that serve to increase the accountability and transparency of the Medicare system will create pressure on the healthcare system to reduce differential treatment by race/ethnicity. A particularly critical accountability and transparency measure is the collection of data on race, ethnicity and primary language of beneficiaries. Such data allows health systems researchers and healthcare quality improvement practitioners to identify systematic biases in provider and system behavior and thereby adjust and correct their performance.

Health disparities are differences in health status and outcomes that occur largely independent of the healthcare system and consequently are much broader in scope and impact than healthcare disparities. In Alameda County, we have mapped health disparities geographically using geographic information system (GIS) technology and have demonstrated geographic patterns of disease and death distribution that correlate closely with the distribution of other important health-protective resources such as opportunities for employment, recreation, high quality education, and living wage income. These strong correlations suggest that health disparities are substantially *structural* in nature and can be ameliorated by facilitating better access to proven health-protective resources and opportunities for low income communities regardless of race, but with a particular focus on those communities that have a disproportionate concentration of African-Americans, Native Americans, some Latinos and Pacific Islanders. The health status of these particular groups is demonstrably worse than other race/ethnic populations and trends in obesity, diabetes and chronic disease portend further worsening of health outcomes in these groups. In many ways, these populations are the "canaries in the coalmine" for the rest of the U.S. population. The vulnerability due to racial discrimination, past and present, low income, poor education, environmental pollution, and geography, make these populations more prone to the impacts of larger disease-generating social trends that will ultimately seep into the larger population. There is already some evidence for this phenomenon. CDC has predicted for many years now that children born in the year 2000 will have a 1 in 3 chance of developing diabetes in their lifetime. If that child is African-American or Latino, the odds are 1 in 2. Recently published research examining life expectancy for various regions across the United States now demonstrates for the first time, declining life expectancy in a cluster of counties in the Southeastern and lower mid-Western part of the U.S.[3] This unprecedented decline in lifespan can largely be attributed to changing chronic disease prevalence. It does not bode well for the overall health and productivity of the country.

Health Disparities are Worsening and are Largely Driven By Chronic Disease Disparities

Economic studies estimate the forgone economic benefit associated with the relatively poor health of less educated populations equates to roughly 7.6% of U.S. GDP or approximately 1 trillion dollars.[4] In Alameda County and elsewhere in the U.S., racial/ethnic health disparities in premature death, disability, and hospitalization are overwhelmingly due to a disproportionate burden of chronic disease in certain racial and ethnic populations, most notably, African-Americans, Native Americans, and Pacific Islanders. Alameda County Public Health Department has just released a report, entitled *Life and Death From Unnatural Causes*[5], which includes an analysis of over 400,000 death certificates in Alameda County over a four decade period that indicates that premature death is concentrated in certain geographic hotspots and that the disparity in life expectancy between these communities and the greater community is on the order of 11–15 years of life and increasing. All but

[3] The Reversal of Fortunes: Trends in County Mortality and Cross-County Mortality in the United States. Ezzati, M. et al. PLos Medicine April 2008, Volume 5, Issue 4, page 66.

[4] Technical Report for Overcoming Obstacles to Health: Report from the Robert Wood Johnson Foundation to the Commission to Build a Healthier America: Economic Value of Improving the Health of Disadvantaged Americans. William Dow, PhD.

University of California, Berkeley, Robert F. Schoeni, PhD, University of Michigan

[5] Life and Death From Unnatural Causes: Health and Social Inequity in Alameda County. Executive Summary. www.acphd.org.

about one year of that disparity is attributable to higher rates of chronic disease in these hotspot communities. Recent national studies examining regional disparities in life expectancy in the U.S. suggest that health insurance rates and health disparities are not well correlated and that expanding health insurance coverage alone would still leave huge disparities.[6]

Chronic Disease is Very Amenable to Prevention

Chronic disease in a population is highly amenable to individual and community-level prevention. The bulk of those preventive strategies, particularly the community-level strategies, occur outside of the healthcare system and are strongly influenced by social and economic policies particularly policies shaping land-use, employment, transportation, income, and education. California's experience with tobacco control is arguably one of the clearest examples of the benefits of primary prevention on health status, mortality and healthcare costs. Between 1990 and 1998, California saved more than $3 billion in smoking-related healthcare costs. Through a comprehensive and multi-faceted approach, California has been able to reduce the prevalence of smoking by 33%. Accelerated declines have been demonstrated in heart disease deaths and lung and bronchus cancer incidence in California. These reductions in morbidity and mortality are substantially greater than in the rest of the United States and have been attributed to California's success in reducing smoking rates.[7] Similar prevention benefits could be achieved through thoughtful and comprehensive primary prevention strategies targeted at diabetes. Approaches that prioritized prevention in those populations with the highest incidence of chronic disease would not only be cost-saving and productivity-enhancing, but they would go a longer way towards reducing health disparities, BEFORE people enter the healthcare system. In his healthcare reform strategy for California, Governor Schwartzenegger recognizes the critical role of community prevention and the contribution of the environment, both physical and social, to increasing the risk of chronic disease. The Governor's *Community Makeover Grants* follow the basic model of California's globally-renowned tobacco program by seeding multi-sectoral community collaborations to promote physical activity, increase access to healthy foods and address the root social and environmental causes of obesity and other chronic disease precursors.

Individual Responsibility vs. Community Responsibility

Smoking, consuming excessive alcohol, driving without a seatbelt and engaging in risky sexual practices, when informed of the potential consequences, are choices that individuals make. Similarly, skydiving, race car driving, and competitive skiing are inherently risky activities that can have potentially devastating health consequences. In health, individual responsibility matters and individuals should be held responsible for their choices and behaviors. However, many low income populations are compelled by circumstances *outside of their control* to live in neighborhoods with poor housing stock, lack of recreational facilities and youth programming, poor schools, inadequate transportation, high crime, concentrations of liquor stores and fast food outlets, and numerous sources of environmental pollution. All of these neighborhood environmental conditions are social consequences of poverty in this country. All of these conditions have demonstrable health consequences and have been implicated in the generation of health disparities. In addition to the unique impact that each of these health-injurious conditions has on individual health, the synergistic and cumulative effect of these conditions over a lifetime is even more profound and enduring. As demonstrated by research portrayed in the PBS documentary *Unnatural Causes*, these neighborhood-level conditions contribute directly to a high level of chronic stress among low-income communities. The conscious and subconscious desire to relieve chronic stress drives the desire for short term gratification such as that provided by cigarettes, alcohol and unhealthy eating. In this way social conditions constrain individual choices. Any of us subjected to the unrelenting stress of being a paycheck away from homelessness, or one uninsured hospitalization away from bankruptcy, or one bullet away from losing a child would be more likely to smoke, drink to excess or indulge in other manners of immediate gratification. Undoubtedly, many people growing up and living in these environments choose not to smoke, drink to excess or engage in other known health risks, however, the constant burden of chronic stress in these communities is substantially

[6] Eight Americas: Investigating Mortality Disparities across Races, Counties, and Race-Counties in the United States. Murray, C., et al.. PLos Medicine September 2006, Volume 3, Issue 9, page 250.

[7] California Tobacco Control Update 2006. California Department of Public Health, Tobacco Control Program. Available at: http://www.cdph.ca.gov/programs/Tobacco/Pages/CTCPPublications.aspx.

greater than that of more affluent communities and makes it *more likely* that individuals will succumb to these stressors in low income communities. The choices we make are shaped by the choices we have. Keeping your child indoors away from the park may well save his life in many American neighborhoods, including the one in which I work in Oakland, California.

The social consequences of poverty are greatly influenced by policies created by this Congress. In many low-income racially and economically segregated neighborhoods, as well as many economically deprived rural communities in this country, the social consequences of poverty have become more severe. These consequences are not inevitable or merely unfortunate, they are squarely within the control of policymakers. So the notion of policies supporting individual responsibility *versus* those focused on larger social responsibility is another **false dichotomy**. We need to create social policies and health policies that foster greater opportunities for all Americans to partake of exercise, healthy eating, as well as reduce the stress of poverty by reducing its social consequences. One obvious example is to create universal access to a high quality and affordable system of healthcare. Other strategies are more complex but eminently achievable and include improving high school graduation rates, access to living wage employment, and affordable housing. Improvements in all of these non-health outcomes will improve health outcomes. If we are serious about eliminating health disparities and preserving the solvency of the Medicare system, we need to begin to recognize these social policies as health policies.

The Immigrant Health Paradox

Immigrants to the U.S. are by and large healthier than American born residents. They live longer, have less chronic disease, and use less medical resources per capita than American born residents.[5,8] Over time as they acculturate and become more American, they get sicker and acquire more disease and their health profile begins to more closely resemble the American health profile. In this way, America is not good for your health. It is unfair, disingenuous and plainly wrong to lay the blame for the woes of our healthcare system at the feet of immigrants.

Thank you for this opportunity to testify on the larger context of health, healthcare and the root causes of health disparities. I invite you to go to the website of Unnatural Causes (www.unnaturalcauses.org) for a compelling overview of the role of social inequity in producing and maintaining health disparities as well as the description of some promising solutions.

Health Status, Health Insurance, and Healthcare Utilization Patterns of Immigrant Black Men. Lucas, J.W., et al. American Journal of Public Health. October 2003, Vol. 93, no. 10. page 1740–1747.

Chairman STARK. Dr. Satel, who is, if I didn't mention this before, the Resident Scholar at the American Enterprise Institute.

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

Dr. SATEL. Thank you, Mr. Chairman and Ranking Member Camp and Representatives Jones and Becerra. I appreciate the invitation to speak to you today.

I am a Resident Scholar at AEI, but I am here mainly because I am the staff psychiatrist at the Oasis Drug Treatment Clinic in Northeast Washington. So I speak to you mainly as a clinician.

I reiterate what we have heard a lot of today that remedies must go beyond access to care. Coverage is necessary. No question about that. But it is not always sufficient. A good many of our patients, for example, are on public insurance. But they wait until a health crisis before they get care.

I saw a patient the other day who the week before had an abscess on her hand from IV drug use. This is a methadone clinic. She was instructed to get antibiotics from her local doc, which she did have, but she didn't, and the next week she came back with cellulitis and a fever and had to go to the emergency room where

she was admitted for IV antibiotics. But she was a classic case of someone who had health insurance, which is critical, and that it may not be enough.

So why do patients who have access to healthcare not exploit it as much as they could or should? And how can systems be more responsive to low-income patients by helping them leverage the access that they do have? Three points to consider in answering that.

The first is that a large element in fostering healthcare seeking is establishing trust. The second is that, once patients have sought care, it is very important they adhere to the treatment regimens. And, ultimately, for both chronic illness management and effective prevention, it is very important that patients think in terms of a longer time horizon to help keep their encounters with the healthcare system from being driven by one crisis after the next.

What are some strategies that can help achieve these goals? One is to establish continuity of care with the same provider. Patients who see the same doctor from visit to visit will have the opportunity to establish rapport with him or her, which in turn will lead to better adherence with treatment regimens. This is very important. In fact, a new study from an economist at Columbia University found that increasing compliance could reduce the black/white health mortality gap by at least two-thirds. That is quite dramatic. And rapport, of course, enables conscientiousness about self care: exercise, diet, risky behaviors, smoking, alcohol and unprotected sex.

Another important way to achieve the goal of exploiting access to care is to expand the average length of the doctor visit. As you know, the average encounter is about 15 minutes. There is almost no time in that period, especially if it is a first visit or if the patient is in some sort of acute distress, to also elicit his concerns, needs, values, and preferences. These are key, but we need Medicaid codes expanded to pay for what we call cognitive and evaluative services because there really is no time for meaningful encounters.

In my clinic, oddly enough, I can spend as much time as with patients as I want, but we don't take Medicare or Medicaid. We have a very interesting consult pay system for the poor and working poor.

Also, we have to target adherence by recognizing that chronic illness is actually quite a chore. Compliance can be very difficult. Sociologist Linda Gottfredson put it very well when she said "chronic diseases are like jobs." She was actually referring to diabetes, although it applies to other chronic illnesses. There are duties to perform, glucose testing, of course, for one, but it requires a regimen of training to implement these tasks, continuously monitor one's own physical signs, adjust food, exercise, medications and, as someone mentioned, coordinate all the professionals that they see: the internist, the surgeon, sadly, the nephrologist because the diabetes has progressed to liver failure, the nutritionist, and so on.

Type 2 diabetics in general find it very hard to believe that they are truly sick until it is too late to avoid the complications. Because if you don't feel sick, you often don't act, especially when there are so many pressing daily realities in your life. The focus on healthcare will recede into the background.

I see this in my patients all the time, dealing with teen-age kids gone astray, neighborhood crimes, taking care of elderly relatives and, unlike the wealthier, who have their share of personal and social problems, too, lack of resources to buffer those setbacks.

Given these realities, I mentioned some of the ways we could help patients exploit the access they do have. Some others include, and these have been mentioned, outreach through black churches, social clubs, work sites, patient navigators—that can be very important; the idea is to give patients as much control as they can—language services, dietary habits.

There is an article today in the New York Times about a Harvard study showing that many physicians, even when they do provide counseling, aren't attuned enough to the dietary habits and cultural dispositions of their population. And so on.

So I will sum up by saying access to care is vital, of course, but will not alone improve the health of minorities low-income people as much as we would like because they are not often in positions where they can exploit the care.

Thank you very much.

Chairman STARK. Thank you.

[The prepared statement of Dr. Satel follows:]

Prepared Statement of Sally Satel, M.D., Resident Scholar, American Enterprise Institute

Dear Chairman Stark, Representative Camp and Members of the Committee. My name is Sally Satel. I am a resident scholar at the American Enterprise Institute, lecturer at Yale University School of Medicine, and the staff psychiatrist at the Oasis Drug Treatment Clinic in Northeast Washington D.C.

Thank you for the invitation to present my views on racial and ethnic minority health status and the key principles upon which remedies should be based.

Let me begin by noting that a number of realities are well-established.[1]

First, we know that differences in health status exist between various ethnic and racial groups, and that there are often discrepancies in indicated procedure rates across groups.

Second, we know that many of the factors linked to these discrepant rates (e.g., access to care, geographical differences, good quality care) are much more closely tied to socioeconomic (status), than to race per se.[2]

Third, and most relevant to my comments today, we know that these factors do not account for the full extent of discrepancy between groups.

Thus, enhancing access to care and quality of care, though essential steps toward improving health status among racial and ethnic minorities must be vigorously fortified by *other improvements that will enable patients to benefit the most from the care they do receive (and to need it less frequently and less intensively).*

My remarks today will focus of those additional areas of need. To effect these changes, healthcare systems and programs must have flexibility to target local needs in creative ways.

Correlates of Health Differentials

Geography

Geographic residence often explains race-related differences in treatment better than even income or education. Because healthcare varies a great deal depending on where people live, and because blacks are overrepresented in regions of the United States that are burdened with poorer health facilities, disparities are destined to be, at least in part, a function of residence. Researchers who fail to control for location effects of low-income will misdiagnose the underlying causes of many racial disparities in health.

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[1] For a comprehensive review see Klick J, Satel S. *The Health Disparities Myth* (2006), AEI Press at http://www.aei.org/books/bookID.847/book—detail.asp.

[2] Isaacs SL, Schroeder SA. Class—The Ignored Determinant of the Nation's Health, *New England Journal of Medicine* 351 (2004): 1137—42; Kawachi I, Daniels N, Robinson DE. Health Disparities by Race and Class: Why Both Matter, *Health Affairs* 24 (2) (2005): 336.

Hospital Quality

An underlying cause of disparities may be that minority patients are more likely to receive care in lower-performing hospitals. Hospitals that treat greater numbers of minority patients generally offer poorer quality service than those that treat fewer minorities. Conversely, within hospitals, the quality of care is generally comparable between whites and minorities when they are admitted for the same reason or receive the same hospital procedure.

Quality of Physician

National physician survey data indicate that physicians in high-minority practices depend more on low-paying Medicaid, receive lower private insurance reimbursements, and have lower incomes. These constrained resources help explain the greater quality-related difficulties delivering care—such as coordination of care, ability to spend adequate time with patients during office visits, and obtaining specialty care—that relate directly to physicians' ability to function as their patients' medical home.[3]

Beyond Access and Quality

Beyond the obvious need to expand access and enhance quality of care, other factors demand attention if health differentials are to be narrowed.

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 (which, in turn, will lead to better adherence with treatment regiment and conscientiousness about self-care).[4] Yet African Americans are more likely than whites to rely on emergency room care because they do not have a primary care physician.[5] Other venues of non-continuous care are community clinics and hospitals. (Note that having Medicaid does not necessarily correlate with having a regular source of care.)

The Commonwealth Fund 2006 Healthcare Quality Survey finds that when adults have health insurance coverage and a medical home—defined as a healthcare 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—One of the most effective ways to enhance the doctor-patient relationship is for doctors to spend sufficient time with each patient—more than the standard fifteen minutes—to elicit patients' concerns, needs, values, and preferences. We need to have Medicare codes expanded to pay for cognitive, evaluative services—and pay more for them.

Foster health literacy—A patient's accurate understanding of the nature of his illness and the purpose of various therapies 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.[6]

But compliance is difficult. Sociologist Linda Gottfredson puts it well when she says that "chronic diseases are like jobs." She focuses on diabetes but her list of tasks that patients have to perform to control and monitor their conditions can be generalized to other chronic conditions such as moderate to serious asthma, hypertension, renal failure, and chronic heart failure.

- Set of duties to perform
  - Requires training
  - Implement appropriate regimen
  - Continuously monitor physical signs
  - Diagnose problems in timely manner
  - Adjust food, exercise, meds in timely and appropriate manner
- Coordinate & communicate with others
- Exercise independent judgment with only occasional supervision from medical personnel. Efforts to control the condition are often tiring, frustrating, and affects family life

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[3] Reschovsky JD, O'Malley AS. *Health Affairs* (Web Exclusive, April 2008), 27(3):222–231.

[4] Halbert C et al. Racial Differences in Trust in Healthcare Providers *Arch Gen Med* 166 (2006):896–901.

[5] Oster A, Bindman AB. Emergency department visits for ambulatory care sensitive conditions: insights into preventable hospitalizations. *Med Care* 41(2003): 198–207.

[6] Simeonova, E. Doctors, Patients, and the Racial Mortality Gap: What Are the Causes? Columbia University, November 2007 at http://www.columbia.edu/es2085/research/jmpaper.pdf.

Most Type 2 diabetics find it hard to believe they are truly sick until it is too late to avoid the complications (pain, dysfunctional eyesight, infections, etc). This is why following disease prevention strategies is even more challenging for those with overwhelming personal and family and occupational problems. Health recedes into the background, surpassed by more pressing daily realities and stresses.

Common Sense Local Innovations

- Educational modules that prepare and coach patients to ask questions and present information about themselves to their doctors are promising where implemented.
- Grassroots outreach through black churches, social clubs, and worksites
- Patient "navigators" to help negotiate the system
- Language services
- Bonuses/incentives to get more good doctors into distressed neighborhoods.
- Clinic night hours: 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.

Conclusion

Resolving health differentials between racial and ethnic groups depends on improved access to care and quality of care. However, reform in those areas alone will not be sufficient. Individuals need to be able to exploit the care that is available to them. And the way to help them achieve this is to target problems that stem from habits and dispositions associated with life lived on the lower reaches of the socioeconomic ladder. To tailor interventions most effectively, healthcare systems need to have the flexibility to respond to specific needs of individual communities.

Chairman STARK. Now Dr. Rodriguez, who is Associate Professor and Vice Chair at UCLA Department of Family Medicine, will inform us. Thank you.

STATEMENT OF MICHAEL A. RODRIGUEZ, M.D. MPH, ASSOCIATE PROFESSOR AND VICE CHAIR OF RESEARCH, UCLA DEPARTMENT OF FAMILY MEDICINE, LOS ANGELES, CALIFORNIA

Dr. RODRIGUEZ. Chairman Stark and distinguished Subcommittee Members, thank you for inviting me to this important hearing on health disparities and possible solutions to address them.

I am a researcher, educator, and a practicing family physician at UCLA; and the focus of my work is on addressing health disparities and evaluating approaches to eliminate them. It is a great honor for me to be part of this star-studded panel of amazing choir singers, but, as the last singer, I will try to keep my song short.

With minority Americans expected to comprise 50 percent of the population by 2050, addressing their health needs is an increasingly important public policy goal. Providing culturally and linguistically appropriate services has the potential to improve health outcomes, increase the efficiency of clinical and support staff, and result in greater patient satisfaction. A good colleague of mine at Harvard demonstrated through research how practice policies to promote cultural competence are associated with high-quality care for children with asthma.

As has been mentioned, it is well established that language barriers contribute to health disparities. Approximately 55 million

Americans speak a language other than English at home. Half of these individuals report they speak English less than very well, making them limited English proficient. More than 10 million children live in limited English proficiency households. And, as was mentioned earlier, an inability to communicate with your doctor not only creates a barrier to accessing healthcare but undermines trust in the quality of medical care that is being received and contributes to these disparities in healthcare.

Patients with language barriers have worse access to healthcare, lower rates of physician visits and preventative services. Even when patients have access to care, if they have language barriers, they have less follow-up care for their chronic conditions, decreased comprehension of their diagnosis or treatment, decreased satisfaction with care, and increased medication complications. Language barriers have been found to result in longer hospital stays, more medical errors, and lower patient satisfaction.

Fortunately, the quality of medical care can be improved through the use of trained interpreters or provision of care by bilingual healthcare providers. They decrease medical clinician errors, increase patient comprehension, and improve clinical outcomes.

Unfortunately, as was mentioned, three-quarters of physicians use family members as interpreters when working with their limited English proficient patients. Barriers to the use of interpreters include cost and convenience. The need—there is a significant need to develop programs and policies to promote the provision of adequate language services to this rapidly growing limited English proficient population.

Research suggests that third-party reimbursement may improve the use of trained interpreters and quality of care; and an OMB study estimated that the overall cost of providing language services would be modest, average $4 more per visit, equivalent to 0.5 percent of the average cost per healthcare visit, and less, far less, than the cost of the disparities.

There is a critical need to develop reimbursement policies for interpretation. Testing alternative methods of delivering linguistically appropriate services will enable us to provide the best practices and vastly improve both access to and quality of services to beneficiaries with limited English proficiency.

A related issue is that, while the Congress passed this Title VI of the Civil Rights Act 1964 to ensure that Federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin, it is unclear to what extent recipients of Federal funds are taking reasonable steps to ensure that patients with limited English proficiency have meaningful access to programs and activities.

The Department of Health and Human Services should take steps to improve compliance and enforcement of its own Office of Minority Health Culturally and Linguistically Appropriate Services Standards. To improve quality, you need good policy informed by good research and good data. Unfortunately, we lack the data. Federal agencies should expand their work on data collection. The absence of this timely, reliable, and valid data is a limiting factor in measuring the progress of programs and status for targeted populations.

States and health surveys and health facilities should be mandated to collect data by race, ethnicity, and primary language and conduct interviews and have materials in major nonEnglish languages. Providers should also be required to monitor selected process and outcome measures by race and ethnicity.

As was mentioned by Dr. Satel, an increasing area that is important has to do with processes and organizational responses that may contribute to disparities, for example, continuity of care which has been found to be low particularly in the Medicare beneficiaries, many of whom have multiple chronic health conditions. Fortunately, recent research has shown that patient populations at risk for health disparities may particularly benefit from accessible, coordinated, comprehensive care delivered through the patient-centered medical home. Therefore, there is a particular need to transfer practices serving these populations and increase our efforts in this promising area.

I thank the Committee for inviting me to be here today and for its consideration of my testimony. I am grateful for your commitment and for your concern for the improvement of the health and well-being of all Americans.

Chairman STARK. Thank you, Doctor.

[The prepared statement of Dr. Rodriguez follows:]

Prepared Statement of Michael A. Rodriguez, M.D., MPH, Associate Professor and Vice Chair of Research, UCLA, Department of Family Medicine, Los Angeles, California

Chairman Stark and distinguished Subcommittee Members, thank you for inviting me to this important hearing on health disparities and possible solutions to address them. My name is Michael Rodriguez and I am a researcher, educator, and practicing family physician at UCLA and community clinics. A primary focus of my work is on addressing health disparities and evaluating approaches to eliminate them.

My testimony today will address three areas: first, I will speak on the importance of linguistically and culturally appropriate care; second, the need for data collection by race, ethnicity and primary language; and finally, the need for payment for language assistance services as well as compliance with and enforcement of national standards on culturally

BACKGROUND

A large body of literature has documented significant racial, ethnic and language disparities in health and healthcare. Racial and ethnic minorities have higher rates of disease, disability, and death and tend to receive a lower quality of healthcare than nonminorities, even when insurance status and income are taken into account. The fact that racial/ethnic minorities in this country receive poorer quality healthcare is undeniable and attributable to a range of patient, clinician, practice, healthcare system, community and social factors. The Institute of Medicine "Unequal Treatment" report provides guidance for why and how we should address this issue and highlights how eliminating racial/ethnic disparities in healthcare is an integral part of improving the quality of our healthcare system, and the healthcare of all Americans.

Many researchers and policy makers view racial and ethnic healthcare disparities through the lens of quality improvement. Improving quality through the components of patient safety, timely response, and evidence-based, patient-centered care provides a framework for eliminating disparities. Meeting the needs of the patient population should be the focus of our efforts. As physicians we have a professional and moral obligation to deliver the best possible quality of care to everyone we see.

With minority Americans expected to comprise 50% of the population by 2050, addressing their health needs is an increasingly important public policy goal. Providing culturally and linguistically appropriate services has the potential to improve health outcomes, increase the efficiency of clinical and support staff and result in greater patient satisfaction. Making sure that the healthcare provided to this diverse population takes into account the linguistic and cultural needs is a priority

for health systems and policy makers. As such, a growing body of laws and regulations seek to ensure that health systems respond to these linguistic and cultural needs. Recent research by Lieu at Harvard demonstrates how practice-site policies to promote cultural competence are associated with higher quality care for children with asthma.

Because culture and language are vital factors in how healthcare services are delivered and received, it is important that healthcare professionals embrace the principles of cultural and linguistically appropriate care. Cultural Competency Curriculum are being developed to equip clinicians with the cultural and linguistic competencies that will enable them to better treat the increasingly diverse U.S. population.

DISPARITIES DUE TO LANGUAGE BARRIERS

It is well established that Language barriers contribute to health disparities for limited English proficient (LEP) patients. Approximately 55 million Americans speak a language other than English at home. This is equivalent to one in five people in the United States. Half of these individuals report they speak English less than "very well" and these individuals are considered to be LEP. More than 10 million children live in have limited English proficiency households. An inability to communicate with your doctor not only creates a barrier to accessing healthcare but also undermines trust in the quality of medical care received and contributes to disparities in healthcare.

Patients with language barriers have worse access to care and rate their healthcare worse compared to English speakers, have less access to a usual source of care, lower rates of physician visits and preventive services. Even when patients have access to care if they have language barriers they have less follow up care for chronic conditions, decreased comprehension of their diagnosis or treatment, decreased satisfaction with care and increased medication complications. Language barriers have been found to result in longer hospital stays, more medical errors and lower patient satisfaction. Children in non-English primary language households also experience worse outcomes. These children are more likely to be poor, overweight, have suboptimal health but have higher risk of impaired access to health.

Consider the following clinical scenario: An Asian speaking mother brings her ill baby to an emergency room and cannot communicate with the staff. The baby has a fever and is sent home with medicine for the fever. Another Asian speaking mother brings her ill baby with similar symptoms to an emergency room with Asian-speaking staff and the baby is admitted with a diagnosis of appendicitis, is observed with worsening abdominal guarding and has emergent surgery and her life is saved.

Title VI of the Civil rights act of 1964 mandates that healthcare providers receiving federal funds provide "meaningful access to their programs and activities by LEP persons" without cost to the patient. Published reviews suggest that the quality of medical care is improved through use of trained interpreters or provision of care by bilingual healthcare providers. They decrease medication errors, increase patient comprehension, and improve clinical outcomes. Three quarters of physicians use family members as interpreters and less than half of physicians use trained interpreters when working with their LEP patients. Barriers to the use of trained interpreters include cost, inconvenience, limited availability of trained interpreters. Given the association of language barriers and compromised healthcare quality and safety, there is a need to develop programs and policies to promote the provision of adequate language services to the rapidly growing population of LEP families.

Research suggests that third party reimbursement may improve use of trained interpreters and quality of care and the overall cost of providing language services may be modest. The Office of Management and Budget estimated in 2002 that the cost of interpreter services for LEP persons, when averaged over all types of visits, would average $4.04 more per visit, equivalent to 0.5% of the average cost per healthcare visit and less than the cost of disparities.

LANGUAGE SOLUTIONS

Due to the barriers to using trained interpreters, we need to develop and evaluate programs that will improve the medical delivery systems of the future. Interpreter services should be developed for bilingual staff, bilingual providers as well consultant interpreters with certification and training programs. Spanish and other language training for clinicians (including CME programs) and for medical students should be supported significantly in targeted markets. There is a critical need to develop reimbursement policies for these and new interpretation technologies that are affordable, especially through Medicare and Medicaid.

Language barriers place LEP patients at a disadvantage that can be overcome by providing better linguistic access. Provision of interpreter services or direct access

to a provider can reduce disparities in care for LEP patients. Although recipients of federal funds are required to offer language services, Medicare does not reimburse for these services. Testing alternative methods of delivering culturally and linguistically appropriate services will enable Medicare to apply best practices and vastly improve both access to and quality of services to beneficiaries with limited English proficiency.

While congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin, it is unclear to what extent recipients of federal funds are taking reasonable steps to ensure that persons with limited English proficiency have meaningful access to programs and activities. The Department of Health and Human Services should take steps to improve compliance and enforcement to its own Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) Standards.

USING DATA COLLECTION TO DRIVE QUALITY

To improve quality, you need good policy informed by good research based on good data. Federal agencies should expand their work on data collection and disparities research. Without new knowledge with community-based research, we may never advance beyond the disparities that now exist in the healthcare system. Lack of data places policy makers at risk of making inappropriate decisions that reflect a lack of understanding of the mechanisms driving the increased burden of disease and death as well and its impact. The absence of timely, reliable, valid, and appropriate data is often a limiting factor in measuring progress of programs and status of the targeted population. States and health surveys and health facilities should be mandated to collect data by race and ethnicity and language use and conduct interviews and have materials in major non-English languages in order to develop a quality healthcare system.

At a minimum, hospitals, health plans, and other providers should be asked to maintain data on patients' race and ethnicity. Healthcare organizations could also be required to provide training for their staff in the delivery of culturally and linguistically appropriate services. Finally, providers could be required to monitor selected process and outcome measures by race and ethnicity. CMS can encourage accrediting organizations to adopt such standards voluntarily, or it can strengthen its own requirements. This will help to determine the extent to which disparities exist. Collecting such data will help CMS to establish baseline information about racial and ethnic disparities within Medicare which will assist in the development of interventions to address disparities and measure progress toward that goal.

A MEDICAL HOME

An increasing area of research to address disparities includes examining differences in care processs and organizational responses that may contribute to disparities. For example, continuity of care has been found to be quite low, particularly for Medicare Beneficiaries—many of whom have multiple chronic health conditions that benefit from having a primary care physician. One Commonwealth study found that 35% of Medicare beneficiaries' visits each year were with their assigned physicians, and a third of beneficiaries changed their assigned physician from year to year. If elderly people with multiple illnesses cannot receive good care, other healthcare reforms may have less impact.

Recent research has shown that patient populations at risk for health disparities may particularly benefit from the accessible, coordinated, comprehensive care delivered through the patient-centered medical home; therefore there is a particular need to transform practices serving these populations. While some of these medical home concepts have already been applied in the U.S., they are often in large pre-paid group practices or academic medical centers. Therefore a focus on recruiting smaller physician practices where much of the care occurs for Medicare beneficiaries is needed.

CONCLUSION

I thank the Committee for inviting me to be here today and for its consideration of my testimony. I am grateful for your commitment and for your concern for the improvement of the health and wellbeing of all Americans.

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Chairman STARK. I will call on Mr. Becerra and see if he would like to inquire.

Mr. BECERRA. Thank you, Mr. Chairman.

Welcome to you all. Thank you for your life's work and certainly for your testimony today.

A personal greeting to an esteemed physician and good friend, Dr. Rodriguez from UCLA.

And, Dr. Jang, I suspect you are like me, where my folks also hoped that I would be a medical doctor and I sometimes claim to be that doctor of law. If that doesn't satisfy them, at least I did the next best thing. I married into the profession. So, hopefully, you are close.

I want to just run a few things by all of you to see if you might have a chance to comment.

In the House bill that passed last year that dealt with Medicare and children's healthcare, the SCHIP program, we did a number of things. I want to thank the chairman right now for the work that he did in working with my staff, his staff and my staff, working to include a number of provisions to deal with these particular issues.

In the House-passed bill, the Children's Health and Medicare Protection Act, the CHAMP Act, we included an Inspector General study within HHS OIG, study to examine whether the culturally and linguistically appropriate services, the CLAS services, required by law are being enforced. We also included a demonstration project on outreach to previously uninsured Medicare beneficiaries. And just recently the Senate, which introduced its similar legislation on Medicare, included those two provisions as well in its bill, which is good.

Unfortunately, the Senate bill that was just recently introduced did include a number of other provisions which Chairman Stark and I worked very hard to include in the CHAMP Act which did pass the House, which include a provision to require the collection of ethnicity data for the Medicare fee-for-service program.

And I mention this because, Dr. Jang, I think you mentioned—in your testimony, you cited the Dartmouth Atlas Project, which shows that real disparities between some of the care that African Americans receive and whites. Unfortunately, because Medicare relies on its administrative data to determine race and ethnicity, if you think about it, that administrative data is dependent on SSA, the Social Security Administration, the SS-5 form. Well, Medicare beneficiaries today are 65 and over. That means they certainly applied well before 1980 for their Social Security number, which means back in those days the only demographic that we took into account was either white or black.

So that study, which pointed out some major disparities for African Americans, could tell us nothing for Asian Americans and Latinos and Native Americans because they were based on these previous applications for a Social Security card and number. Those different ethnicities and populations had to be categorized as either "other" or "unknown." So I guess a lot of folks in this chamber, me included, would all be either "other" or "unknowns" when it comes to Medicare's ability to track important data on disparity.

We put in the CHAMP Act, with the chairman's help, the provision to require the collection of ethnicity data for Medicare fee-for-service programs. Unfortunately, the Senate has not included that.

We also included in the CHAMP Act a provision which would provide funding for a demonstration project to provide paid language services to Medicare beneficiaries, to Dr. Rodriguez's point. Medicare providers say, well, it is really tough, especially with the cuts that we are seeing these days in Medicare reimbursement, to actually now increase fee-for-services by providing translation by interpreter services. This was a provision that would help fund that for a third party. That, unfortunately, was not included in the Senate bill recently introduced.

Another provision was a provision that required the Institute of Medicine to report on the impact on Medicare beneficiaries who need but do not get language access services. That provision was not included in the Senate. It is in the CHAMP Act.

And, finally, we include in the CHAMP Act a provision that would require a study on the impact of managed care plans on minority beneficiaries, because there is a great deal of talk about whether managed care is good or bad for populations that suffer from disparities.

RPTS MCKENZIE

DCMN HOFSTAD

Mr. BECERRA. And that provision, which did get included in the CHAMP Act, was excluded in the Senate's bill.

And so I guess my question to you is, I think while the House has done some remarkable work in trying to address the disparities issue, are you at all doing any work with our Senate colleagues to try to see if they can do a better job of including these very modest proposals—because cost-wise, they are very modest—these very modest proposal to make sure that they are included in the Senate Medicare bill that is working its way through the Senate?

And I know my time has expired, but if anyone has any particular comments, Chairman, I would love to see if they might have a chance. And Dr. Blanton might be the person who probably works on this most.

Ms. LILLIE-BLANTON. Well, actually, I want to agree with you that we need to do more data collection by race, by ethnicity, by language services. Our population is changing dramatically, and without the information to help us understand the quality of care these people are getting, the access that they get, it is impossible for us to know how much progress we are making. So I just want to say that is critically important.

You also raised concerns about research and analysis. And I think what we have to realize is that when we collect the data, we have to analyze the data and we have to report on the data. And unless we do both of the latter two, you will have data collected that is just sitting there. And so it is important for us to do further analysis to better understand how the information that we have collected is being used.

Demonstration projects is one way of learning more, but putting in place systems that can routinely monitor and assess and evaluate is a way to structurally assure that we know what is happening over time in our population. So in addition to demonstration projects, the systematic analysis and assessment is what is really needed.

We have moved to a whole new system of coverage and care delivery with our managed care plans. And putting in place the mechanisms for us to know how our beneficiaries in managed care are faring in relation to the care they are receiving is just as important as systems in place to know how are beneficiaries in fee-for-service.

So I actually just want to agree with you and with the provisions. But our organization is not one that actually is involved in advocating and working with legislation, so we are not involved directly. But there are others here on this body who are, so they may want to speak to that issue.

Ms. JANG. I can speak to that, Congressman.

The Asian Pacific Islander American Health Forum is working in coalition with a number of minority health organizations under the auspices of "Out of Many, One." And we have been working together with the American Heart Association to advocate for the inclusion in the Senate's Medicare bill of a provision that gives the Secretary of HHS the authority to mandate the collection of data on race, ethnicity and gender as part of the quality measures that Medicare health plans have to report on.

So we see that as a good step, giving the HHS—because we do think that they do have the administrative authority to do that. So we are hopeful that it has been included in the Senate Medicare bill.

Chairman STARK. Thank you.

Mr. BECERRA. Thanks, Mr. Chairman.

Chairman STARK. Mr. Camp, would you like to inquire?

Mr. CAMP. Thank you, Mr. Chairman.

And, Dr. Blanton, I agree with you on data collection and analysis. And you may have heard my comment to the other panel. We often get requests to act on data that is 3 and 4 years out of date. And you are correct, there is a dramatically changing healthcare environment out there, and we often don't get that. So I hope we can maybe improve that.

I had a question for Dr. Akhter. You mentioned about the importance of coordinating care and the difference between acute and chronic care, and that many seniors today have to deal with multiple diseases, go to different facilities, have different providers, doctors. And you say that this is especially true of those—and I am quoting from your testimony—of those seniors from minority populations, and exacerbates rather than reduces disparities.

And we have about 8 million seniors, including about 1 million minorities, who have chosen to enroll in Medicare Advantage that coordinates their care and helps manage their chronic diseases and illnesses. Do you believe this type of coordination would be helpful to greater minority populations and especially those with chronic conditions?

Dr. AKHTER. Thank you, Mr. Camp. This is a very important question.

Certainly, coordination will help, but we also need to collect data to monitor to see what the effect is going to be. And, you know, data collection is a very important part of us knowing what gets done, what gets measured that gets done. And if we have a measuring tool that measures whether this coordination is helping or whether we are just simply not doing the coordination or doing the coordination to provide less care, then it would not be very beneficial. So I——

Mr. CAMP. Do you think Medicare fee-for-service, which does not coordinate care, will ever be able to resolve these disparities that you mentioned are exacerbated by——

Dr. AKHTER. If we continue in this way, the way we have been doing business in the past, it certainly will not. But I think, again, coordination is important, but also monitoring is important, so that we all have a transparency in the system where we can all see what is being actually done on the ground.

Mr. CAMP. Thank you.

And I want to thank you all for your testimony today.

Dr. Satel, we have heard about the discrepancies that exist in health outcomes in certain populations. And if two people with the identical diagnosis but different races are admitted to the same hospital for treatment, what has research told us about their treatment and their recovery?

Dr. SATEL. Actually, the research is—some studies will show that there are differences in the receipt of certain services. Cardiac care has been one of the most incisively examined ones. What is interesting, though, is the fact that many of the studies, even though they saw a discrepancy in the rate with which African Americans—most of the early work has been done, really, black-white comparisons. Even though that the African Americans were less likely to receive certain procedures, mortality rates were similar. Not all studies found that, but a lot of them did. That didn't say anything about morbidity rates, but it said that mortality rates were—some of them found either equal or actually lower for the African Americans.

But the moral of that story is, as others have suggested, is that we have to look as carefully at outcomes as we do at the, you know, counting up of procedures. It is important to know how often procedures are administered. We also have to wonder are, perhaps, white people being overtreated because they tend to be more litigious, and malpractice considerations, that is something to think of.

It also raises another point that I would love to see more ethnographic research. When we do see discrepancies, we are left with trying to figure out what they are about. And often they indicate something very subtle that we really can't pick up from looking at

databases in retrospect. We really want to know, what did the physician tell the patient? What did the patient truly understand? What were the preferences of the patient? These kinds of considerations that are very, very fine-tuned and don't emerge from big databases and really does—I would love to see NIH fund that kind of work.

It is basically sociology, but that can be done in an empirical and standardized way. And I think that would be a big contribution to understanding the fine-grained explanations for some of these differences.

Mr. CAMP. All right. Thank you.

And I guess to the extent we have received some testimony on private-sector initiatives in the effort to eliminate healthcare disparities, there are a number of those that are taking place throughout the country as well.

But thank you all. I see my time has expired.

Chairman STARK. Mrs. Tubbs Jones, would you——

Mrs. JONES. Mr. Chairman, thank you very much.

And I want to thank all the witnesses for coming to this historic hearing, focused on racial and ethnic disparities in healthcare. I wish I had hours, and I don't. But there are two or three things I do want to focus on.

And I want to ask you, Dr. Satel, do you know who Linda Gottfredson is?

Dr. SATEL. A sociologist at the University of Delaware.

Mrs. JONES. And do you give credence to her research and her comments?

Dr. SATEL. Oh, on this, as far as the way she framed the, sort of, the comparison of having a chronic illness to almost having a job?

Mrs. JONES. No, not that one. I have another one for you.

Dr. SATEL. Oh, I know what you are referring to.

Mrs. JONES. You know what I am referring to?

Dr. SATEL. I am pretty sure I do.

Mrs. JONES. Tell me.

Dr. SATEL. I suspect—well, she has done a lot of work on IQ and race.

Mrs. JONES. And what has her work on IQ and race shown?

Dr. SATEL. Frankly, I didn't—that is not what I looked at. I looked at the work she has been doing on education, diabetes education and health literacy.

Mrs. JONES. Well, when you cite someone, you live with what you like what they say and what you don't like about what they say, don't you?

Dr. SATEL. Not necessarily.

Mrs. JONES. You give credence to them as—anyway, let me not argue. Let me quote her for the record so that it is clear that everybody understands who you rely upon.

Quote, "Health scientists have noted that differences in an individual's cognitive abilities may explain why some patients receive better care than others. This theory suggests that the variation of effective treatments may result from an inner quality of reasoning capabilities among patients. Patients with lower general reasoning

abilities are less likely to seek preventive care, to know signs and symptoms of disease, and to adhere to treatment regimes."

I personally, you know, think it is, like, code words. And we go back to the problem with discrimination among racial and ethnic minorities when we start talking about their cognitive abilities.

I am not looking for an answer from you. I am merely placing into the record a person whose statements you rely upon to make your point.

I want to raise with you, however—you are a psychiatrist; is that correct?

Dr. SATEL. Yes.

Mrs. JONES. Why haven't you talked at all about the issue about psychiatry, A very necessary part of health treatment and the disparities that exist among racial and ethnic minorities having access to psychiatry, as part of your presentation today?

Mrs. JONES. Right. Well, that is actually a place where—when I mentioned the ethnographic approach, that is where it is so important. Because there are so many cultural——

Mrs. JONES. No, I am asking you, why didn't you use that as part of your testimony here today, to talk about that very issue that you specialize in, psychiatry?

Dr. SATEL. Because I happen to—I just decided to take a broader approach. But I could talk about psychiatry.

Mrs. JONES. Thank you.

Let me go on to someone else.

Dr. Blanton, first of all, good morning—good afternoon. It is afternoon now.

Ms. LILLIE-BLANTON. Good afternoon.

Mrs. JONES. If there was one thing you could do, one, what would you—let me stop for a moment.

To people who are listening to this hearing out in the world and have not had a background or experience in healthcare and would like to provide some testimony that would be of assistance to the Committee, they gave me a convoluted way of you doing this, which is go to house.gov, link to the Committee on Ways and Means, link to this hearing, and send it in. But an easier way is to send it to me at stj@mail.house.gov. That is stj@mail.house.gov. Because I know there are others who would want to have an opportunity to add something to our discussion. And I am interested and I am sure the Committee is interested in having additional information.

Back to you, Dr. Blanton.

Ms. LILLIE-BLANTON. You said if there was one thing I could do?

Mrs. JONES. One piece of advice you would give us as Members of this Health Committee.

Ms. LILLIE-BLANTON. If there was only one thing that could be done, I would say we need to expand sources of coverage or reduce the number of uninsured.

While we know insurance coverage is not the only thing that makes a difference, we know that those who lack coverage face financial barriers to care that affect not only their health status but affect their ability to function in society, you know, in terms of—you know, financially function in society, with their jobs, with their families.

And so that would be the one thing, if there was only one advice.

Mrs. JONES. Dr. Iton, can you for a moment address the issue that there is some myth about healthcare disparities or access to healthcare among races?

Dr. ITON. The data is overwhelming. There is absolutely no credible argument that health disparities and healthcare disparities don't exist. My argument has been that the linchpin to understanding health and healthcare disparities is understanding chronic disease and the distribution of chronic disease throughout populations.

And I agree that the first thing we have to do is to get everybody into a universal system of high-quality, affordable healthcare. That is critical, and it is a matter of human rights.

But the second thing is, we are not going to be able to manage healthcare into the 21st century unless we get a handle on chronic disease, because that will bankrupt our systems. And we can do that. There is evidence of that. California has done it around tobacco and has shown a substantial decrease in tobacco-related heart disease, lung cancer, bronchus cancer, and a decrease of about $3 billion in healthcare costs between 1990 and 1998. California has set an example for this. Other States can do it. And we need to focus on obesity and diabetes next.

Mrs. JONES. I thank all of you.

I am way out of time, Mr. Chairman. I thank you for this extra minute or 2 for your testimony.

We, as Members of Congress, you know, we are viewed as politicians. So when I start talking about healthcare disparities, "Well, you don't have any background; what do you know?" So I am glad to be able to have someone with some background and some experience say and—what is the word—second or testify to the fact that there are healthcare disparities in America and how we need to address it.

Mr. Chairman, I thank you so much for the opportunity.

Chairman STARK. Thank you.

Mr. Johnson, would you like to inquire?

Mr. JOHNSON. Thank you, Mr. Chairman.

Ms. Blanton, you kind of got leaned on. I am going to ask you, you have heard from other witnesses, or we have, today that universal access to health coverage is important. However, your testimony cites research that found health disparities exist among different demographics, even in the Medicare program.

Is that what you said?

Ms. LILLIE-BLANTON. Yes, that is correct.

Mr. JOHNSON. Could you please elaborate on your findings? Since Medicare is a government-run entitlement program universally accessible to individuals in this country age 65 and over or those otherwise disabled, that ought to give us some insight. If you could discuss it, I would appreciate it.

Ms. LILLIE-BLANTON. Well, first of all, I think many of our panelists have already talked about some of the other factors that determine the access and the quality of care that people have.

One, very importantly, is the availability of health resources, whether it is physicians, whether it is other provider groups. So if you are living in a neighborhood where you don't have access to the

providers or you don't have access to the specialists, then you may not get the same care that someone else has. If you are living in a community where language barriers become an issue, you may not get the same care that someone else——

Mr. JOHNSON. Well, I will tell you what, I just ran into a situation in our hometown, which is full of hospitals, that there were two of them that didn't—closer to us that didn't have their emergency rooms open. And I don't know if that is happening across the country or not. Are you aware of that situation?

Ms. LILLIE-BLANTON. Well, I have not tracked whether or not it has occurred at any increasing frequency, but it is a reality. It is a fact that some hospitals are closing their emergency rooms. And part of that has to do with emergent patients, emergency patients who are uninsured and adding to the costs. So it is a financial issue, but it is still an issue that becomes a barrier to care for people, particularly in emergency situations.

So I would say that both availability of providers becomes a big issue and language becomes an issue. But there are still other factors that affect disparities in care. And sometimes the issue we really have a hard time understanding are just how personal biases about who is deserving and more deserving or less deserving of care for whatever reason. Sometimes it is racial discrimination, sometimes it is discrimination because of the condition that they are facing. Patients with mental health problems, patients with other kinds of substance abuse problems may have different access to care. So——

Mr. JOHNSON. Well, are you saying they categorize people who are over 65, even though they are all on the same program?

Ms. LILLIE-BLANTON. Let me say that there are very subtle ways where a bias about a patient may enter into the care delivery system. And so it may not be overt biases. It could just be judgments about the individual.

But in the research that has been done to look at the factors, there probably is a broader systemic factors, such as the availability of providers, that play a larger role. But you still can't discount the interaction between a patient and a provider as one of the factors that influences the quality of care and their access to care.

Mr. JOHNSON. Thank you very much.

Thank you, Mr. Chairman. No further questions.

Chairman STARK. Well, the answer that I think Dr. Blanton gave, as to what is the one thing we could do to begin the process of reducing disparities, would be to do in whatever way we are able to expand coverage to people that don't have coverage.

I have always been under the assumption that to not have a payment plan pretty much means, in this country, you are denied access to medical care. You may be able to get it at the eleventh hour in the emergency ward, but I think that I wouldn't get much argument to say that if you don't have a payment plan, you are not in the game.

I wanted to ask Dr. Iton, it has been discussed here, and both referred to obliquely and directly, what I am going to call the difference between race and class. My race is obvious. I hope my class isn't that obvious.

But, Dr. Iton, what is more important in determining the health of a senior citizen, their economic class, their education level, where they live, or their race?

Dr. ITON. Well, I think that is one of those either/ors that is sort of impossible to address, particularly with the limited data we have on class.

We have done pretty extensive analyses of health disparities according to race and income, you know, income being sort of a crude estimate of socioeconomic status. And when you stratify populations across incomes, you see very clear correlations between length of life and income. The poorer you are, the shorter your life is. The poorer you are, the more chronic disease you are saddled with.

When you substratify that by race, you see an additional burden imposed upon that stratification. That is pure race. In other words, that wealthy African Americans have a higher rate of chronic disease and health disparities than wealthy whites. And these kinds of associations suggest that race and class play an important role in mediating health disparities.

But one thing I would want to point out, though, is that immigrants seem to fly against that general rule. And we find that immigrants tend to, regardless of class, tend to have better health outcomes than nonimmigrants. And that is, I think, an important thing to try to understand, because there are variables here that will play an important role in designing how we approach the reduction and elimination of a heavy burden of chronic disease in low-income populations.

I can expand on that further, but I just wanted to raise that issue, because sometimes we lump things together in ways that don't help the discussion. And understanding, for instance, in California, how low-income Latino immigrants have longer life expectancies than high-income whites is something very important to understand in designing public health and health policy.

Chairman STARK. Do you want to——

Mr. BECERRA. Sure.

Chairman STARK. Why don't I yield to my distinguished friend.

Mr. BECERRA. Mr. Chairman, thank you.

Dr. Iton, it is a prescient observation that few know. But the disturbing part of that is, if you extend the observation a little further, you find that the longer the immigrant has been here, or with the next generation of the children that followed that first-generation immigrant, the outcomes start to mimic or reflect those of the native-born population. So if you are minority and poor and you are the son or daughter or the granddaughter or grandson of an immigrant, then chances are you are going to reflect more your peers who are native-born when it comes to health outcomes than you do your parents, your grandparents, who were poor but in better health.

So that is an unfortunate thing. It sort of flies contrary to what you think, the longer you are here in America, the worse your health gets.

Dr. ITON. Yes. We sometimes say that America is not good for your health.

Mr. BECERRA. Yes, exactly.

Dr. ITON. And the evidence suggests that. And that is important to understand, as well. Why does that happen? What is it about becoming less of an immigrant and more of an American that inures toward health behaviors and——

Mr. BECERRA. I think it is the lifestyle.

Dr. ITON. Exactly.

Mr. BECERRA. More smoking, more drinking, less exercise. The more affluent you become, the less you need to do physical labor. And you find a lot of these immigrants working very long hours, don't have the money or the time to go out and drink or smoke too much. And so it is—the fact that you have to live a modest way keeps you pretty healthy.

And I suspect if you were in a rural area—I suspect if Mr. Moran, Congressman Moran, were still here, he would probably tell us that he finds that in a lot of parts of Kansas, a lot of those folks who are still in rural America probably have pretty decent health because they have to work so hard as well.

Dr. ITON. Well, we spend a lot of time in public health trying to actually distill out what it is about that immigrant health behaviors that we can actually spread to the larger population, because we think immigrants teach us a lot about health-protective behaviors.

Mr. BECERRA. Maybe we can tackle that immigration political issue first.

Chairman STARK. I was going to ask Dr. Rodriguez to explain to me why Los Angeles hasn't gone bankrupt, which is—the one thing I have to say, Doctor, we have a marvelously diverse county, as the doctor knows. I am now a minority in the county. And we have a very liberal constituency, I might add. But where they lose their liberal foundation in my town meetings is that they are convinced that we are going to go bankrupt because of undocumented residents in our community. And I get yelled at every month at my town meetings and, I think, due to inaccurate data, if there is any data. But it is a kind of xenophobia that I haven't seen in a long time. And rarely can I say that I am disappointed in my constituents. But in this one area, I have been just terribly—I have been disappointed that they don't take a better approach to that problem that we have.

I wanted to just establish a few things here. I suspect—I am talking to the two JDs here, not the MDs, or the MD–JD combination. But there is nothing illegal, is there, about collecting data of either ethnicity or race when we collect it for Medicare or public health records; is that correct?

Dr. ITON. It is correct, as far as I understand it.

Ms. JANG. Yes, that is correct. And, in fact, the Title 6 regulations require recipients of Federal financial assistance to provide the Office for Civil Rights with the information necessary to determine whether they are in compliance. And so, therefore, recipients have an obligation to collect that information.

Chairman STARK. Then I am going to ask Dr. Blanton just to summarize as between Medicare, Medicare Advantage plans, private fee-for-service plans. What kind of data collection do we have? Do we have good data, sparse data? Can you kind of summarize? And what should we do?

Ms. LILLIE-BLANTON. Right. Our data are very sparse, especially on Medicare Advantage plans. In fact, we don't even require the same collection of information from Medicare Advantage plans as routinely are collected in other administrative proceedings. And so we at least need to make sure that we have comparable reporting for enrollees in fee-for-service as we have in——

Chairman STARK. And what about in the Part D pharmaceutical stuff?

Ms. LILLIE-BLANTON. Unfortunately, I am not——

Chairman STARK. Anybody know? I don't think we have very good data on that.

Ms. LILLIE-BLANTON [continuing]. Requirements by race, ethnicity. I know there are reporting requirements, but I am not sure if the data required reporting specifically in Part D.

So I do think we need to improve on our administrative data collection, at least for Medicare Advantage.

Chairman STARK. Okay. I agree. And, as I say, I hope that we can proceed on a nonpartisan or bipartisan basis to begin at least to collect more of the data. We should have been doing it more thoroughly in Medicare. We don't do it at all in Social Security. We do it pretty sparsely, I think, in Medicare. And I don't know that we can do away with a lot of the arguments and discussions if we can turn—if we can sort out the empirical issues before us. And I think that that would be extremely important for us.

Can you comment, Dr. Blanton, on how well the Medicare Advantage plans, insofar as we know, have done in terms of disparities versus fee-for-service, standard Medicare?

Ms. LILLIE-BLANTON. Well, only to the extent that there are two studies that are cited that, you know, I think give us some information. And from both of those studies—one that was by Trivedi, who is now at Brown University but I think then was at Harvard, and the other by Schneider. And both basically found that disparities still exist even in the Medicare Advantage program.

The study by Trivedi is fairly recent, in the sense that they tracked over time. And that is the one that actually looked at HEDIS measures and found that seven of the nine HEDIS measures, there was a narrowing, but still the disparities existed. And on two you actually had a widening. And the two were very important, because one was glucose monitoring for diabetics and the other was cholesterol monitoring for patients with heart disease.

So there is some fairly recent evidence that performance in Medicare Advantage plans has not resulted in eliminating disparities.

The work by Schneider is probably cited even more, but it is a little older data, but the findings are very similar. I mean, they looked at breast cancer, they looked at diabetic, eye exams, also looked at follow-up care after hospitalization.

And, you know, I think the potential exists for better coordination, for better care. But I think what Dr. Akhter is saying, you have to monitor it. It is not just a matter of because the organizational structure there allows for better coordination. There still has to be the monitoring to assure that the kind of coordination and followthrough occurs, that the organizational structure allows or would encourage to have.

Chairman STARK. Yeah, I have often felt that just to assign people, say, as we have, to a managed care plan, we start paying them, but we don't know if they ever show up. And somehow I have always felt that I am happy to pay them, but I think that they ought to somehow interact with the patient.

I am sorry, Dr. Satel, that you get this, but I can't help but ask a couple of things. I was disturbed, to say the least.

And did any of you go to Harvard Medical School? No.

Dr. SATEL. Brown.

Chairman STARK. These guys at Harvard doing research who were getting hundreds of thousands of dollars from the various parts of PhRMA, which I thought was not very ethical.

Dr. SATEL. You can't leave psychiatry out of this.

Chairman STARK. Well, but then—no, no, but the other thing then that troubled me—and that is what we are getting to—and this comes closer to my home than I like, but the fact that we are overmedicating and overdiagnosing children in the psych—and, I mean, what I am seeing where my 6-year-old twins are going to school, you know, half the class on meds? And I think, "Holy smokes, Doc. They can't all be"—do you share my concern that——

Dr. SATEL. Yes.

Chairman STARK [continuing]—that may have been created by the makers of these drugs, who have been instructing your colleagues at golfing outings and other—help me with that.

Dr. SATEL. That is a hard question about the interaction. But it is—most psychiatrists, apparently except for the physician at Harvard who was a large proponent of diagnosing childhood bipolar and appeared by most accounts to have a fairly low threshold for doing that and also a low threshold for urging medication treatment, he——

Chairman STARK. But also for attention deficit, which is one of the more common ones.

Dr. SATEL. Well, that can often overlap with bipolar or appear to look like it. Yeah, these are difficult diagnostic issues. And there has been a lot of concern among psychiatrists that it is way overdiagnosed and way overprescribed.

An interesting subset of that concern, however—and this has been well-documented—is that within this perhaps exuberant tendency to prescribe and to diagnose is subsets of minority children who may be underdiagnosed and undertreated. So it is a paradox within that larger phenomenon.

Chairman STARK. Well, you have all been patient and kind. And what you have really done is open yourself up for an awful lot of extra work after this, when we and our staff ask you if you will help us as we try to wind through. We are going to be dealing with this issue next year, I am sure. And it is important that we understand that just having an insurance plan may not guarantee to every resident of this country the right medical care or sufficient medical care.

But I think the witnesses have suggested to us that, as a first step, we ought to make sure that at least they have access and the money to pay for it, without which they are not going to have access. And then we have a whole lot of subtle differences that we have to deal with.

We really do appreciate your taking the effort to be heard here. Are there any of you who have a last comment that you would like to make to my colleagues?

Ms. Jones, would you like——

Mrs. JONES. For the record, there was some research done by a researcher at Cleveland State University and Case Western Reserve University and university hospitals around low-income recipients of healthcare and the cultural impediments to the receipt of that care. Unfortunately, as I sit here, I can't think of the name of the researcher or the name of the report. But if anybody is interested, please feel free to contact me. I will get that information for you. It was very interesting outcomes with regard to that whole issue of cultural sensitivity and a lot of other issues that were barriers to access to healthcare.

Chairman STARK. And the other suggestion that my friend, Mr. Becerra, mentioned earlier, but for those of you who have some relationship to advocacy groups or our colleagues on the other side of the Capitol who need some encouragement, we think, to do the right thing, and if you have a lot of extra time and we don't have thunderstorms this afternoon, maybe you can get over there and push them along a little bit toward what we think has been a good job on a bipartisan basis that my colleagues did here in the House over a year ago, or just a year ago, when we did the CHAMP Act. And we would like to see more of that survive.

And for those of you who are physicians, it isn't just the fact that you might get a 10 percent cut, but there is also more there that I think will help the entire country in the delivery of medical care.

Thank you all for your patience and your participation.

The hearing is adjourned.

[Whereupon, at 12:43 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

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.
Tahirih 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 Clinica 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 -- *Hartford, 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

Statement of America's Health Insurance Plans

I. INTRODUCTION

America's Health Insurance Plans (AHIP) is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also have demonstrated a strong commitment to participation in public programs.

We thank the Subcommittee for holding this hearing on healthcare disparities and we commend Congresswoman Hilda Solis and Delegate Donna Christensen for introducing H.R. 3014, the "Health Equity and Accountability Act," as well as Congressman Jesse Jackson, Jr. for the introduction of H.R. 3333, the "Minority Health Improvement and Health Disparity Elimination Act." We also applaud the Congressional TriCaucus for its leadership in promoting a national dialogue on the need for solutions to eliminate disparities in healthcare.

Our industry looks to the Agency for Healthcare Research and Quality's (AHRQ) annual National Healthcare Disparities Report as an important contributor to understanding continued gaps in care and our nation's progress toward reducing racial and ethnic disparities. Health insurance plans recognize that we serve an increasingly diverse population and that this trend will continue over the next several decades. In fact, by 2050, half of all Americans will be minorities. This shift in the racial demographics of America poses significant challenges to government, business, healthcare providers, and health plans to ensure that we are reaching diverse communities and serving them at their point of need. The health plan community is uniquely situated to address this challenge with meaningful solutions.

Our statement focuses on two broad topics:

- The importance of collecting data on race and ethnicities, based on uniform standards and categories, to identify disparities and develop programs that close the gaps in care; and
- Initiatives our industry is pursuing to improve data collection and eliminate disparities in healthcare.

II. DATA COLLECTION BASED ON UNIFORM STANDARDS

Health insurance plans are making significant contributions to this debate in the area of data collection. Data are the fundamental building blocks for: (1) identifying the differences in care experienced by specific populations; (2) developing programs to address these differences and ensure a higher standard of care; and (3) increasing access to culturally and linguistically appropriate health and wellness information, such as addressing language and interpretation needs. Recognizing this opportunity, health insurance plans are using the data that they are voluntarily collecting on race and ethnicity to support culturally and linguistically appropriate communications to members, to build wellness, prevention, and chronic care programs that are relevant for specific race and ethnic groups, and to implement or strengthen quality improvement efforts.

In 2003, we partnered with the Robert Wood Johnson Foundation (RWJF) and commissioned a broad survey to evaluate the extent to which health plans voluntarily collect or obtain data on their enrollees' race, ethnicity, and primary language using both direct or indirect methods. This allowed us to probe barriers to getting data, develop a strategy, and implement programs. This original survey found that just over half of enrollees were covered by organizations that collect or obtain data on the race and ethnicity of their members.

Despite this early sign of progress, the survey findings also identified major concerns as to why health plans choose not to collect data on the race and ethnicity of members. Primarily, the answer is that health insurance plans are concerned with how enrollees and communities will react to this activity. These concerns have been validated through AHIP focus groups with African Americans and Hispanics/Latinos in 2005, and a consumer survey funded by the RWJF. Focus group participants exhibited some willingness to answer questions about race, ethnicity, and primary language if they were asked on a voluntary basis, collected at the same time as other demographic questions, and if the reasons for data collection were fully explained, such as for quality improvement efforts.

In 2006, we partnered with RWJF to conduct a follow-up survey on data collection and found that two-thirds of consumers receive their health insurance coverage from an organization that collects data on the race and ethnicity of members. This is a significant improvement over the original 2003 study and an important step in eliminating healthcare disparities. We are continuing our collaboration with RWJF to conduct two additional surveys in 2008 and 2010 that move from assessing the collection of data by health plans to identifying strategies our member companies are utilizing to develop tailored interventions that meet the needs of diverse populations. AHIP also will be conducting health plan interviews to further explore challenges and opportunities with data collection and successful strategies to improve care through the use of these data.

Another significant concern is that there is no uniform method or standardization in the categories used to collect data by race and ethnicity. Instead, conflicting categories are used by various government agencies, such as the Centers for Medicaid

& Medicare Services (CMS) and the Centers for Disease Control & Prevention (CDC), even though it is widely recognized that the usefulness of data collection efforts in identifying and reducing health disparities is largely dependent on the accuracy and sharing of information. To address this shortcoming, it is essential for public and private stakeholders to work together to develop comprehensive standards that will ensure uniformity of data categories for measuring progress in reducing disparities across the entire healthcare sector.

AHIP, the National Health Plan Collaborative (NHPC), the Health Research and Educational Trust (HRET), the RAND Corporation, and several other public and private entities have stressed the need for standardization of race and ethnicity data categories. Currently, the NHPC is working with AHRQ and the HHS Office of Minority Health to encourage a study committee convened by the IOM to identify best practices for data collection and recommend the use of uniform data categories for measuring and reporting quality of care across diverse populations.

III. INITIATIVES BY HEALTH INSURANCE PLANS

AHIP's members have been working pro-actively through a number of initiatives and partnerships to improve data collection and take steps toward eliminating healthcare disparities.

Eleven major health insurers have formed a public-private partnership—the National Health Plan Collaborative—that is working to reduce racial and ethnic disparities and improve the overall quality of care. This initiative, established in December 2004, is the first national effort of its kind to move beyond research and actively test possible solutions to inequalities in the delivery of healthcare services.

From 2004 through 2006, a central goal of the Collaborative was to test ways to improve the ability of health insurance plans to collect and analyze data on race and ethnicity. Other top priorities included developing methods of measuring improvement in the care of diabetes for specific populations and testing interventions that have the potential to improve healthcare quality for racially and ethnically diverse populations.

During the current phase of this initiative, health plans are looking at ways to standardize primary data collection, address language access services, and create innovative programs that address gaps in care. Looking forward, the Collaborative is focused on sharing strategies and tools that prove successful in improving healthcare quality with healthcare decision-makers and leaders, including other health insurance plans serving commercial, Medicare, and Medicaid populations. Ultimately, this needs to be an effort involving all payors including public programs.

AHIP's Addressing Disparities in Health program was forged in 2003 through the leadership of our member organizations to highlight the importance of designing quality improvement programs for populations of different racial and ethnic needs. This program consists of:

- Four regional workshops conducted across the country to educate health plans and key stakeholders about the importance of data collection, how to get leadership and community buy-in, and to provide recommendations for collecting and analyzing data on race, ethnicity, and primary language of their enrollees. Feedback from these trainings resulted in the development of a data collection toolkit, *Data as Building Blocks for Change,* for health plans interested in initiating racial and ethnic data collection efforts and developing targeted interventions.
- Educational sessions with health plan communications staff and other health plan professionals on cross-cultural communication messaging that reinforces the need for cultural sensitivity information for all populations.
- Programs emphasizing an understanding of information relevant to race, ethnicity, and culture and its significance to the effective communication and delivery of health services. One key strategy is to help healthcare professionals break down cultural communication barriers through continuing medical education. AHIP, in collaboration with the Manhattan Cross Cultural Group, has commissioned a continuing medical education course that provides physicians with the tools and skills to communicate more effectively with patients from diverse backgrounds. To date, over 500 physicians have participated in AHIP's cultural competency module that features a case study geared for improving asthma care among African Americans. We will be expanding the existing cultural competency training modules to new audiences such as nurses, case managers, and non-clinical health professionals (e.g., health plan customer representatives). The clinical and non-clinical modules will include a variety of case studies addressing chronic conditions, such as hypertension and asthma, as well as how to better serve diverse populations, such as individuals with limited English proficiency.

- Health plan "Models that Work" to facilitate the sharing of information on proven strategies for reducing disparities. This clearinghouse will highlight a wide range of health plan strategies for reaching out to culturally and ethnically diverse populations that are at risk for certain medical conditions. This initiative continues our industry's long tradition of sharing information on effective models so these programs, or elements of them, can be adapted for more widespread use and to benefit more people.

The industry's efforts are beginning to have an impact. In addition to an increase in data collection, plans are analyzing these data to determine where health disparities exist and implementing programs to address gaps in the treatment of chronic conditions, adherence to medications, and the use of preventive services and medical procedures. To build upon this progress, we will be reaching out and working with key stakeholders to increase patients' awareness about the utility of data in improving health and healthcare.

IV. CONCLUSION

Looking forward, leadership from all stakeholders is the key to eliminating disparities in healthcare. We all must come together in recognizing that action on this priority is essential to improving quality of care for all Americans.

While data collection and analysis are building blocks to eliminating disparities, another very crucial component of our challenge is to put the data to use in developing and implementing programs to reduce disparities that are relevant to the specific communities we serve. To meet this challenge, we need to break out of silos and use our collective expertise to work collaboratively on initiatives that will have a demonstrable impact in eliminating disparities in healthcare and improving overall quality. We stand ready to work with the Subcommittee and others to advance these important priorities.

Statement of American College of Physicians

As the largest medical specialty society and the second largest medical organization in the United States, the American College of Physicians (ACP) is committed to eliminating disparities in healthcare access and quality. ACP represents 125,000 doctors of internal medicine, residents and medical students. The College is addressing healthcare disparities in its public policy research, educational initiatives and foundation activities. ACP applauds Chairman Pete Stark for holding this hearing to improve understanding of the many factors that contribute to health disparities, including access to care. The College recognizes that addressing this issue is vital to improving the health status of Americans and achieving a highly performing healthcare system that is accessible to all.

Racial and ethnic disparities in healthcare are well-documented. Addressing these inequities became a national movement with the development of the Healthy People 2010 goals and objectives. In 2002 a landmark report was released by the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*. Since then, a significant amount of research has increased our understanding of the scope and causes of disparities. Despite these efforts, large gaps in access, quality of care and health outcomes still persist. Earlier this year, the Agency for Healthcare Research and Quality (AHRQ) released its annual *National Healthcare Disparities Report*, which found that disparities in healthcare quality and access have not decreased, and for many indicators, the gaps are expanding. Specifically, the 2007 report notes that:

1. Blacks had a rate of new AIDS cases 10 times higher than Whites.
2. Asian adults age 65 and older were 50% more likely than Whites to lack immunization against pneumonia.
3. American Indians and Alaska Natives were twice as likely to lack prenatal care in the first trimester, compared with Whites.[i]

Timely access to appropriate healthcare is critical to improving health outcomes. It is undeniable that uninsurance is a major barrier to eliminating healthcare disparities. According to the AHRQ report, individuals without health insurance fared worse than individuals with private insurance on all access measures and almost 90% of quality measures. Compared with the insured, the uninsured are about six times as likely to lack a usual source of care and nearly three times as likely not to get care as soon as wanted for illness or injury. Unfortunately, the uninsured rates are high among many racial and ethnic minorities. In 2006, 49% of Hispanics and 28% of African Americans adults (ages 18 to 64) were uninsured,

compared with 21% of whites and 18% percent of Asian Americans.[i] The College advocates that all Americans should have affordable health insurance coverage to eliminate the financial barriers to accessing care.

The College also recognizes that disparities exist even among the insured. It is for this reason that ACP is deeply committed to improving access to care through a delivery model called the patient-centered medical home. This team-based model of care, led by a personal physician, provides continuous and coordinated care to maximize health outcomes. Recent research has shown that many racial and ethnic disparities related to access and quality are reduced or eliminated when patients have a medical home. Among adults with a medical home, Blacks and Hispanics were just as likely as Whites to receive preventive care reminders, which have been proven to increase the rates of routine preventive screenings.[ii] Ensuring all individuals have a medical home will require restructuring of healthcare deliver systems, including payment structures to support patient-centered care.

Effective patient-provider communication increases patient understanding and is a critical component of patient-centered care. Unfortunately, racial and ethnic minorities are more likely to report poor communication with health providers than their White counterparts.[i] Approximately 52 million Americans speak a language other than English at home. Of these individuals, more than half speak English less than "very well" and are considered limited English proficient (LEP) patients.[iii] Language barriers can result in the exchange of inaccurate or incomplete information, which can affect access to and delivery of care and healthcare costs. LEP patients disproportionately underutilize less costly preventive care.[iv] However, when competent language services are available, LEP individuals can communicate effectively with their healthcare providers, improving their encounters and health outcomes. A number of federal and state policies require healthcare providers who receive federal funds to ensure access to services for patients with LEP. However, often times these services are not being offered because of time, costs, and availability of qualified interpreters.[v]

An ACP survey found that the majority of practices represented by internists that have LEP patients provide language services. However, these services are limited and are typically provided by a bilingual physician or staff member and hardly any practices rely on external sources for language services or provide such services during off hours. In addition, few physicians perceived a need for tools or training to assist their practices in providing language services.[v] A clearinghouse to provide translated documents and patient education materials would be useful, but providing reimbursement for the added costs of clinical time and language services would be the most effective means of expanding the use of language services.[v]

Language is just one aspect of an individual's culture that may affect patient-provider communication, quality of the encounter and patient outcome. Physicians and other healthcare providers must realize the impact of culture on health status. There are many negative health consequences that could result from ignoring culture, including missed opportunities for screening because of a lack of familiarity with the prevalence of conditions among certain minority groups; failure to take into account differing cultural responses to prescription medication; lack of knowledge about traditional remedies, leading to harmful drug interactions; and diagnostic errors resulting from miscommunication.[vi] Research has shown that quality healthcare requires attention to differences in culture—the "integrated pattern of human behavior that includes thoughts, communications, actions,

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[i] Agency for Healthcare Research and Quality. 2007 National Healthcare Disparities Report. Rockville, MD: U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality; February 2008. AHRQ Pub. No. 08–0041.

[ii] Beal AC, Doty MM, Hernandez SE, Shea KK, and Davis K. Closing the Divide: How Medical Homes Promote Equity in Healthcare: Results From The Commonwealth Fund 2006 Healthcare Quality Survey, The Commonwealth Fund, June 2007.

[iii] U.S. Census Bureau. Language Spoken at Home for the Population 5 Years and Over, Tbl B16004, data from 2005 American Community Survey.

[iv] AM. Doty. Hispanic Patients' Double Burden: Lack of Health Insurance and Limited English. The Commonwealth Fund; February 2003.

[v] American College of Physicians. Language Services for Patients with Limited English Proficiency: Results of a National Survey of Internal Medicine Physicians. Philadelphia: American College of Physicians; 2006: Position Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.) Accessible at *http://www.acponline.orgK/advocacy/where_we_stand/policy/lep_paper.pdf.*

[vi] Brach C, Fraser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med Care Res Rev. 2000;57 Suppl 1:181–217.

customs, beliefs, values and institutions of a racial, ethnic, religious or social group."[vii]

Eliminating health disparities will require an adequate supply of culturally-competent healthcare providers. Cultural competence in healthcare has been defined as the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs. Cultural competence techniques have been shown to effectively change provider and patient behavior by improving communication, increasing trust, improving racially or ethnically specific knowledge of epidemiology and treatment efficacy, and expanding understanding of patients' cultural behaviors and environment.[viii] Accordingly, the College supports cultural competency training that is incorporated in the training and development of all healthcare providers, at all levels.[ix]

A diverse workforce of health professionals is also an integral part of eliminating disparities among racial and ethnic minorities. [ix-x] Currently, many racial and ethnic minority groups are poorly represented in the health professions, relative to their proportion in the overall U.S. population. Increasing the diversity of the healthcare workforce is a key to increasing access to care and improving the quality of care for minorities. Minority staff, because of shared cultural beliefs and common language, may improve communication, create a more welcoming environment, and structure health systems to better reflect the needs of minority communities. Also, racial and ethnic minorities are more likely to serve in a community of underrepresented individuals.[xi-xii] National and local workforce policies are needed to:

- Strengthen the education of racial and ethnic minorities at all levels in the areas of math and science to create a larger pool of qualified minority applicants for medical school.
- Revitalize efforts to improve medical and health professional school matriculation and graduation rates of minority students. ACP supports the consideration of race and ethnicity in determining admissions to institutions of higher education.
- Expand programs that provide outreach to encourage minority enrollment in medical and health professional schools.
- Increase efforts to recruit and retain minority medical school faculty.
- Enhance funding for programs and initiatives that work to increase the number of healthcare providers in minority communities.

Eliminating health disparities and improving quality of care requires evidence-based policies and programs. Research to identify sources of disparities, as well as effectiveness of initiatives targeted to eliminate disparities, will necessitate the collection of better data on race, ethnicity, and primary language using reliable and standardized measurement tools. Unfortunately, inadequate data continues to limit the analysis of health disparities.[xiii] ACP supports efforts to improve collection of racial and ethnic information within the healthcare system. ACP has supported legislative efforts to eliminate disparities in healthcare, improve collection of racial and ethnic data from Medicare participants and to incorporate race, ethnicity, and primary language measures in quality improvement projects. The College regards research to be a vital part of identifying, monitoring, and addressing disparities in healthcare that disadvantage racial/ethnic minorities.

Conclusion

The American College of Physicians appreciates the opportunity to provide the Health Subcommittee with this summary of our views on eliminating healthcare disparities. We recognize that health disparities are multi-dimensional and will re-

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[vii] Betancourt JR, Green AR, Carillo JE. The Commonwealth Fund: Cultural Competence in Healthcare: Emerging Frameworks and Practical Approaches. New York: The Commonwealth Fund; October 2002.

[viii] Brach C, Fraser I. Reducing disparities through culturally competent healthcare: an analysis of the business case. Quality Management in Healthcare. 2002; 10:15–28.

[ix] American College of Physicians. Racial and Ethnic Disparities in Healthcare. Philadelphia: American College of Physicians; 2003: Position Paper (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)

[x] Association of American Medical Colleges. Diversity in the Physician Workforce: Facts & Figures 2006. Washington, D.C.: Association of American Medical Colleges;

[xi] Komaromy M, Grumbach K, Drake M, et al. The role of Black and Hispanic physicians in providing healthcare for underserved populations. NEJM.1996;334(2):1305–10.

[xii] Stinson MH, Thurston NK. Racial matching among African-American and Hispanic physicians and patients. J Human Resources.2002;37(2):410–28.

quire comprehensive efforts to eradicate the gaps that currently exist. We urge the Subcommittee to continue to address this critically important issue.

Statement of the American Dental Education Association

The American Dental Education Association (ADEA) represents all accredited dental schools, dental residency training programs and allied dental programs in the United States, as well as the faculty, dental residents, and dental and allied dental students at these institutions.[1] In these academic dental institutions (ADI) future practitioners and re searchers gain their knowledge; the majority of dental research is conducted; and significant dental care is provided.

U.S. dental schools operate dental clinics and serve as safety net providers. As such, they are the dental homes to a broad array of vulnerable and underserved low-income patient populations, including racially and ethnically diverse patients; elderly and homebound individuals; migrants; mentally, medically or physically disabled individuals; institutionalized individuals; HIV/AIDS patients; Medicaid and State Children's Health Insurance Program (SCHIP) children; and uninsured individuals.

In addition to providing oral health services to vulnerable and underserved communities through clinics associated with dental schools, ADEA has partnered with the Association of American Medical Colleges (AAMC) to recruit and prepare underrepresented minority (URM) students for the health professions. Building a diverse healthcare workforce, which can better serve the needs of a culturally, ethnically, and racially diverse population, is a critical step in addressing the oral health disparities that now exist in both rural and urban communities.

Disparities in Oral Health

The first-ever U.S. Surgeon General's report found that there are "profound and consequential oral health disparities within the population," particularly among "racial and ethnic minorities, rural populations, individuals with disabilities, the homeless, immigrants, migrant workers, the very young, and the frail elderly."[2] These disparities, the report asserts, have resulted in a "silent epidemic of dental and oral disease affecting the most vulnerable among us." This disturbing reality, in combination with the current shortage of dental school faculty, the scarcity of underrepresented minority (URM) dentists, and the need for targeted incentives to draw dentists to practice in rural and underserved communities, makes the Subcommittee's examination of health disparities timely and necessary.

The challenge facing policymakers and the dental community is not only how to address the oral health disparities that exist in our nation but also how to improve access to oral healthcare. According to Delta Dental Plans Association and the National Association of Dental Plans, 134 million American adults and children do not have dental insurance. The lack of insurance is a significant barrier to receiving needed preventive and restorative care. Having insurance, however, does not guarantee quick access to dental care.

Despite concerted efforts by Congress and the dental community to address issues affecting access to dental care, there has been little substantive progress made since the untimely death of 12-year old Deamonte Driver in February 2007. This Maryland boy died from an infection caused by an abscessed tooth that spread to his brain. Timely delivery of appropriate dental care at any point along the trajectory from cavity to root canal to abscess could have saved Deamonte's life and the state of Maryland nearly $250,000. This tragedy could have been avoided if his Medicaid coverage had not lapsed and if he had had better access to dental care. In this regard ADEA supports Congress' continuing bipartisan effort to include a guaranteed dental benefit in the bill to reauthorize the State Children's Health Insurance Program (SCHIP). ADEA pledges to work for passage of this important legislation in the 111th Congress.

[1] There are 57 dental schools, 714 dental residency training programs, 285 dental hygiene programs, 271 dental assisting programs and 21 dental laboratory technology programs in the United States.

[2] U.S. Department of Health and Human Services. Oral health in America: a report of the surgeon general. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000.

U.S. Population and the Dental Workforce

The U.S. Bureau of Labor Statistics (BLS), which placed the number of *practicing* dentists at 161,000 in 2006,[3] projects a 9 percent growth in the number of dentists through 2016. This rate would bring the total number of practicing dentists to 176,000. The vast majority of the professionally active dentists in the U.S. are White non-Hispanic. At the present time the U.S. population is 303,375,763.[4] At the time of the last census, when there were 22 million fewer people, the largest segment of the U.S. population was White (75 percent) but an increasing percentage was minority with 35.3 million (13 percent) Latino, and 34.6 million (12 percent) Black or African Americans.

According to the U.S. Surgeon General, the ratio of dentists to the total population has been steadily declining for the past 20 years, and at that rate, by 2021, there will not be enough active dentists to care for the population. The number of Dental Health Professions Shortage Areas (D–HPSAs), designated by the U.S. Health Resources and Services Administration (HRSA), has grown from 792 in 1993 to 3,527 in 2006. In 1993, HRSA estimated 1,400 dentists were needed in these areas; by 2006, the number grew to 9,164. Nearly 47 million people live in D–HPSAs across the country. Although it is unknown how many of these areas can financially support a dentist or attract a dentist by virtue of their infrastructure or location, it is clear that more dentists are needed in these areas.

The disproportionate burden of oral diseases and disorders indicates that specific population groups are in greater need of oral healthcare. Unfortunately, millions of Americans experience dental pain daily and cannot afford to buy dental insurance or pay for dental care out of pocket. Since few oral health problems in their early stages are life-threatening, people often delay treatment for long periods of time. Often, when they do seek care, it is in hospital emergency rooms or other venues in the dental safety-net system, that is, academic dental institutions clinics, community health centers, school-based clinics, municipal clinics, etc. This system of care is inadequate to effectively deal with the magnitude of the problem. Most ADI clinics are filled to capacity and have long waiting lists.

Diversity in Dental Schools

The number of African American, Hispanic, and Native American students in dental schools remains disproportionate to their numbers in the U.S. population. In 2006, underrepresented minority (URM) students comprised 12.4 percent of the applicants and 11.6 percent of first-year enrollees. Asian/Pacific Islanders and whites comprised 69.7 percent of applicants and 71.1 percent of first-year enrollees. The proportion of URM students applying and enrolling in U.S. dental schools is far less than the proportion of URMs in the communities served by the dental school. For example, during the 2003–04 academic year, 7 percent of dental students enrolled at the University of California Los Angeles (UCLA) and the University of Southern California (USC) were Hispanic, while 46.5 percent of the Los Angeles population was Hispanic. Also, in 2003–04, total African American enrollment at all U.S. dental schools was 5.41 percent, while 12.8 percent of the U.S. population were black. The proportion of URM dentists also remains significantly lower than the proportion of URMs in the U.S. population. Currently, about 6.8 percent of professionally active dentists are URM, while 27.9 percent of the U.S. population are URM. Increasing diversity in the dental profession is vital to the future of the profession and it is central to achieving optimal oral health for racial and ethnic minority groups, which experience a higher level of oral health problems and have limited access to dental care.

Response from Academic Dentistry

Recognizing that enrollment of underrepresented minorities (URM) students has remained largely stagnant, the American Dental Education Association has become actively engaged in supporting programs that bolster underrepresented minority recruitment and retention into dentistry and has partnered with foundations and others to make progress:

- The "Pipeline, Profession, and Practice: Community-Based Dental Education" program sponsored by the Robert Wood Johnson Foundation (RWJF). This program has also been supported by the California Endowment and the W.K. Kellogg Foundation. The five-year initiative launched in 2003 to help increase access to oral healthcare. This program provided institutions with grants to link

[3] U.S. Bureau of Labor Statistics, at: http://www.bls.gov/oco/content/ocos072.stm, February 5, 2008.

[4] U.S. Bureau of the Census, at: http://www.census.gov/population/www/popclockus.html, February 5, 2008.

their schools to communities in need of dental care and to boost their URM and low-income (LI) student enrollment numbers. Dental Pipeline I successfully concluded with 15 dental schools participating. Dental students and residents in the program provided care to thousands of low-income patients through partnerships with 237 community-based clinics.

- The "Summer Medical and Dental Education Program (SMDEP)," a collaborative program administered by ADEA and the Association of American Medical Colleges (AAMC) and funded by the Robert Wood Johnson Foundation-RWJF, offers freshman and sophomore college students intensive and personalized medical and dental school preparation. The program runs from summer 2006 through summer 2009 and offers academic enrichment for disadvantaged undergraduate freshmen/sophomores. Nearly 1,900 students have participated (333 dental and 1,564 medical). Seventy-one percent of the participants have been women, 48 percent have been Black or African American, 21 percent have been Hispanic or Latino, and 2 percent have been American Indian.
- ADEA has received a grant from the Josiah Macy, Jr. Foundation to increase the diversity of the dental workforce in the United States. The grant funds the planning process to implement a flexible seven-year dental curriculum, modeled after one currently used in medicine, to prepare a new cadre of underrepresented minority and low-income (URM/LI) students for the practice of dentistry. The program aims to move toward the implementation of a seven-year curriculum that will significantly increase the number of URM students that receive a dental education and then enter the workforce as dental school graduates.

Recommendations to Congress

There are several straightforward steps that Congress can take to immediately address the oral health challenges we face. The American Dental Education Association stands ready to work with Congress to address oral health disparities and ameliorate access to dental care problems. Specifically, ADEA recommends:

1. Strengthen and Improve Medicaid

Early intervention is the key to assuring that children have good oral health. While children enrolled in Medicaid have a Federal guarantee for access to dental services through the Early Periodic Screening Diagnosis and Treatment program (EPSDT)[5], accessing services is often difficult due to low reimbursement rates and the number of participating dentists. Unfortunately, millions of children covered by Medicaid are not getting regular dental care. We urge Congress to work with states to increase reimbursement rates and to simplify and streamline the application, enrollment and recertification process for Medicaid, and lessen the administrative burden associated with this program.

2. Include Dental Guarantee in SCHIP

Congress can address oral health disparities and increase access to dental care for vulnerable children covered by the State Children's Health Insurance Program (SCHIP) by: 1) Establishing a federal guarantee for dental coverage in SCHIP; 2) Developing a dental wrap-around benefit in SCHIP; 3) Facilitating ongoing outreach efforts to enroll all eligible children in SCHIP and Medicaid; and 4) Ensuring reliable data reporting on dental care in SCHIP and Medicaid.

3. Restore Funding for Title VII Diversity Programs

The only federal programs whose goal it is to strengthen and diversify the health professions are the Title VII Centers of Excellence (COE) and Healthcareers Opportunity Program (HCOP). These programs work in diverse communities to achieve this national goal. The programs remain woefully under-funded after several years of significant cuts. Congress should restore their funding at least to FY 2005 levels.

Table 4: COE and HCOP Funding by FY

	FY05	FY06	FY07	FY08
COE	$35 million	$12 million	$11.88 million	$12.77 million

[5] Medicaid statutes, PL 101–239, Section 6403, require that dental services for children shall at a minimum, include relief of pain and infection, restoration of teeth, and maintenance of dental health. Medicaid guarantees medically necessary services, including preventive dental care, under its EPSDT provision.

Table 4: COE and HCOP Funding by FY				
	FY05	**FY06**	**FY07**	**FY08**
HCOP	$33 million	$4 million	$3.9 million	$9.8 million

The COE and HCOP programs assist institutions in developing a more diverse applicant pool; establishing and strengthening the academic performance of under-represented minority students enrolled in health professions schools; improving institutional academic, research and library capacity; and enhancing pipeline efforts to undergraduate and pre-college students. Also, HCOP makes grants to community-based health and educational entities to support student pipeline and other academic activities.

4. Prioritize Dental Access in Rural Health Clinics

Rural communities across America rely on rural health clinics to provide care to everyone, including those who are uninsured or underinsured. Full-service community hospitals in rural areas are safety net providers, offering basic health services but often oral healthcare is unavailable. To improve the oral health status of rural America, Congress should incentive rural health clinics to add preventive and restorative dental services to the list of core services they provide on-site or under arrangement.

Oral Healthcare and Reform

A sustained federal commitment is needed to meet the challenges that oral health disparities and oral disease pose to our nation's citizens, including children, the vulnerable and underrepresented minorities. It is imperative that Congress address the growing needs in educating and training health professionals, including dentists, to meet the growing and diverse needs of the future. The American Dental Education Association is eager to partner with Congress to develop and implement a national oral health plan that eliminates oral health disparities; guarantees access to dental care for everyone; bolsters the nation's oral health infrastructure; and successfully addresses academic and dental workforce shortages.

Consequently, oral healthcare coverage and access to affordable oral health services must be included as integral components in any proposal to reform the U.S. healthcare system.

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Statement of American Dental Hygienists' Association

On behalf of the American Dental Hygienists' Association (ADHA), thank you for the opportunity to submit testimony on "Addressing Disparities in Health and Healthcare: Issues for Reform." ADHA applauds Subcommittee Chairman Stark for holding a hearing to examine disparities in health and issues that will impact discussion on policy efforts that seek to reform our healthcare system. This is a timely and important issue and ADHA is pleased to participate in the dialogue about disparities that impact the delivery of oral healthcare and ways in which those disparities can be lessened or eliminated. Oral health *is* a part of total health and the oral healthcare delivery system requires reform along with the medical care delivery system.

ADHA is the largest national organization representing the professional interests of more than 150,000 licensed dental hygienists across the country. Dental hygienists are oral health professionals licensed in each of the fifty states who are committed to improving the nation's oral health, a fundamental part of overall health and general well-being. In order to become licensed as a dental hygienist, an individual must graduate from an accredited dental hygiene education program and successfully complete a national written and a state or regional clinical examination.

As an organization, ADHA has a fundamental commitment to better oral healthcare for all people and advocates in support of oral health programs for underserved populations. ADHA and its state associations actively pursue efforts to increase the public's ability to access preventive oral healthcare services.

Unfortunately, disparities in the delivery of healthcare services tend to be even more pronounced within oral health. According to the U.S. Surgeon General, over 108 million Americans lack dental insurance—more than 2.5 times the number of

Americans who lack medical insurance. The May 2000 report, *Oral Health in America: A Report of the Surgeon General*, brought to light the socioeconomic, regional, and educational barriers that contribute to oral healthcare disparities. The report also specifically noted that disparities are exacerbated by the lack of community programs that provide needed oral healthcare services.

The death of twelve-year old Deamonte Driver in 2007 from complications of an abscessed tooth provided all of us with a tragic reminder that lack of access to oral health services can have serious—even fatal—consequences. Deamonte's death from a dental infection is particularly heartbreaking because virtually all dental disease is fully preventable. But, despite this proven prevention capacity, dental caries (tooth decay) remains the single most common chronic disease of childhood, five times more common than asthma. Dental caries—which is an infectious transmissible disease—still affects more than half of all children by second grade. Until the oral healthcare delivery system is restructured to improve access to care, children will continue to suffer needlessly from preventable dental disease.

Preventable dental disease disproportionately affects our Nation's most vulnerable populations, including many children eligible for Medicaid and the State Children's Health Insurance Program (SCHIP). The current oral healthcare delivery system is simply not meeting America's oral health needs, particularly the needs of Medicaid and SCHIP children such as Deamonte Driver. As prevention specialists, dental hygienists understand that recognizing the connection between oral health and total health can prevent disease, treat problems while they are still manageable, conserve critical healthcare dollars, and save lives. While the practice of dental hygiene varies from state to state, in the 26 states that allow patients to directly access dental hygiene services, dental hygienists are able to work more readily in public health settings—bringing patients otherwise disenfranchised from the oral healthcare system into the pipeline for care.

As one of the fastest growing healthcare occupations in the country, as identified by the Bureau of Labor Statistics (BLS), the dental hygiene profession is well placed to significantly impact the delivery of care in the U.S. BLS data indicates the number of dental hygienists is expected to grow by more than 30 percent from 2006—2016. The population of dentists is growing at a much slower rate and according to the BLS; the growth of the profession is not anticipated to keep pace with the need for dental care in coming years. Dental hygienists are committed to working as part of a comprehensive healthcare team in order to improve access to oral health services. Indeed, one of ADHA's enunciated priorities is to "work in partnership with dentists to advance the oral health of patients."

ADHA welcomes the opportunity to work with the Subcommittee and all Members of Congress as well as the entire dental community and all those who care about the nation's oral health to work towards solutions to improve access to oral healthcare and ensure that all Americans have access to oral healthcare providers in the future. Indeed, healthcare reform efforts present an opportunity for ADHA to demonstrate its commitment to partnership with organized dentistry as well as other stakeholders in healthcare. Certainly, the elimination of healthcare disparities will require a collective effort and will involve efforts to reform and improve the current system.

U.S. Surgeon General Report on Oral Health in America Confirms that Oral Health is a Fundamental Part of Overall Health

In May 2000, the U.S. Surgeon General issued *Oral Health in America: A Report of the Surgeon General.* This landmark report confirms that oral health is an integral part of total health and that good oral health can be achieved. The Surgeon General's Report on Oral Health challenges all of us—in both the public and private sectors—to address the compelling evidence that not all Americans have achieved the same level of oral health and well-being. The Report describes a "silent epidemic" of oral diseases, which affect our most vulnerable citizens—poor children, the elderly and many members of racial and ethnic minority groups.

Key findings enumerated in the Report include:

1. Oral diseases and disorders in and of themselves affect health and well-being throughout life.
2. Safe and effective measures exist to prevent the most common dental diseases: dental caries (tooth decay) and periodontal (gum) diseases.
3. Lifestyle behaviors that affect general health such as tobacco use, excessive alcohol use, and poor dietary choices affect oral and craniofacial health.
4. There are profound and consequential oral health disparities within the U.S. population.
5. More information is needed to improve America's oral health and eliminate health disparities.

6. The mouth reflects general health and well-being.
7. Oral diseases and conditions are associated with other health problems.
8. Scientific research is key to further reduction in the burden of diseases and disorders that affect the face, mouth and teeth.

U.S. Surgeon General Notes Significant Disparities in Oral Health

The Surgeon General's Report on Oral Health highlights numerous disparities in oral health relative to age, race, gender, insurance status, and income level. Some of the significant disparities noted include:

- Children from families without dental insurance are three times more likely to have dental needs than children with either public or private insurance.
- Poor children suffer twice as much dental caries as their more affluent peers.
- 34% of black older Americans have lost all of their teeth compared to 23% of whites.
- A national survey found that employed Hispanic adults were twice as likely to have untreated dental caries as non-Hispanic whites
- In general, the American Indian and Alaska Native populations have much greater rates of dental caries and periodontal disease in all age groups than the general U.S. population.
- Adult females are less likely than males at each age group to have severe periodontal disease as measured by periodontal loss of attachment of 6 mm or more for any tooth.

As follow-up to *Oral Health in America,* the Surgeon General issued *A Nation Call to Action to Promote Oral Health* in 2003 which called on stakeholders in oral health to change perceptions of oral health, overcome barriers to care, and increase collaborations. The report also called on stakeholders to make strides to "increase oral health workforce diversity, capacity, and flexibility"—moving towards optimal use of healthcare professionals.

The Oral Healthcare Delivery System Must be Reformed Along with the Medical Care Delivery System

As prevention specialists in one of the fastest growing professions, dental hygienists are well positioned to work as part of the overarching effort to increase access to oral healthcare, particularly for those in underserved populations. Workforce experts have recognized that dental hygienists can and must play an increasing role if the nation's oral health needs are to be met. An article in *Health Affairs* explored the oral health workforce and found:

> "abundant evidence that a sizable segment of the population does not have access to private [dental] care, while the dental safety net is "poorly defined and underdeveloped." Dentists' participation in Medicaid is not robust; community health centers and public health facilities have scant dental capabilities; and Medicare offers no dental coverage. "Radical steps" will be needed to correct "a growing disconnect between the dominant pattern of practice . . . and the oral health needs of the nation," . . . including new practice settings for dental care, integration of oral and primary healthcare, and expanded scope of practice for hygienists and other allied professions."

Increasingly, states are recognizing the benefits associated with policy changes that make it easier for dental hygienists to work with less supervision in settings outside of the private dental office. Currently, 26 states have policies in place that enable patients to access preventive services offered by dental hygienists via direct access, meaning a patient can be treated without the presence or prior authorization of a dentist. In the past ten years, 23 states have enacted policies that facilitate care via direct access, making it easier for dental hygienists to treat patients in schools, community clinics, long term care facilities, mobile health units, and other public health settings.

Similarly, the last decade has brought about an insurgence of policies at the state level to allow dental hygienists to be directly reimbursed by Medicaid for dental services included in their scope of practice. Currently, 12 states allow for direct Medicaid reimbursement, making it easier for dental hygienists to work within the Medicaid system to provide care.

These types of policy changes better leverage the existing dental hygiene workforce and make care more accessible for those who currently have difficulty securing services in the private dental office. Bringing patients into the oral healthcare system for preventive and other oral healthcare services through additional access points such as schools, community health centers, and nursing homes can avert

more costly restorative care, allow appropriate referral to dentists, and help save valuable healthcare dollars in the long-run.

A New Oral Healthcare Provider to Improve Access to Care: The Advanced Dental Hygiene Practitioner

In response to the Surgeon General's identified need to enhance the oral health workforce capacity, ADHA has supported efforts to improve the delivery of care by dental hygienists, but has also striven to come up with new ideas to improve the system. ADHA has defined a new oral healthcare provider, the Advanced Dental Hygiene Practitioner (ADHP). This new provider would provide preventive, therapeutic, diagnostic, prescriptive, and minimally invasive restorative services directly to underserved Americans. The ADHP would be a member of a comprehensive healthcare team, and would refer patients in need of more advanced oral healthcare services to dentists. This new provider would be state-licensed and be a graduate of a Master's degree ADHP program.

ADHA has been working in a transparent and inclusive fashion to shape this advanced practitioner concept. An ADHP Advisory Committee that included representatives of major oral healthcare organizations, the Federal Government, health advocacy groups and others interested in oral health access issues was convened by ADHA in 2005 to solicit feedback on the new provider. ADHP competencies have been developed by the ADHP Task Force which worked for two years to systematically define the educational domains and competencies that will serve as the framework for ADHP educational programs. ADHP competencies were finalized by ADHA's Board of Trustees in 2008 and are available at www.adha.org.

The ADHP will function as a mid-level oral healthcare provider akin to the nurse practitioner in medicine. The medical fields have long accepted mid-level providers as integral components of the healthcare team able to reach out to patients currently unable to access care. Similarly, the ADHP is being developed to provide a new point of entry into the oral healthcare system for those currently disenfranchised, offering a wider range of services in public health settings. A key component to making care accessible is offering the services patients need most in settings they are able to reach, such as schools, public health clinics, and nursing homes.

In the National Governors Association Center for Best Practices issue brief entitled, "State Efforts to Improve Children's Oral Health," the authors noted that "Maximizing auxiliary personnel can increase access to preventive services. . . . In most states, the scope of practice for auxiliary personnel is quite restricted, even when the services necessary don't require a dentist. Some states are restructuring their Dental Practice Acts to maximize the use of dental hygienists." Two illustrative examples highlighted by the NGA are set forth below.

- Maine changed the rules governing the practice of hygienists to allow them to practice in public health settings such as school health centers, hospitals, and public clinics without a dentist on site—provided that the hygienists have an established relationship with a dentist. The state believes this strategy offers great promise for addressing dentist shortages. In 2008, the state passed legislation to allow dental hygienists to own and operate dental hygiene practices.
- Minnesota passed legislation in 2001 to allow dental hygienists to perform certain primary care functions without dentist supervision, provided they are employed by one of the following entities: hospitals, nursing homes, group homes, home health agencies, state-operated facilities, federal, state or local public health facilities, or community or tribal clinics. In order to qualify, the hygienist must meet prescribed practice experience requirements and must engage in a collaborative agreement with a dentist who authorizes and accepts responsibility for these hygienist services.

Minnesota is slated to become the first state to house an ADHP education program. In late 2007, Metropolitan State University in St. Paul approved a Master's degree ADHP program that is anticipated to accept its first class in mid-2009. Additionally, Minnesota is the first state to consider legislation to facilitate the expanded scope of practice for the Advanced Dental Hygiene Practitioner. Legislation was introduced in both the Minnesota state House and Senate in mid-February 2008 and is supported not only by the dental hygiene community, but also by a number of state healthcare stakeholders and dentists. A legislative compromise, supported by the Minnesota Dental Association, was reached in May 2008 which established the need for a mid-level provider in state statute and established a baseline scope of practice that nearly mirrors the clinical services outlined in the ADHP competencies. As a result of the compromise, a workgroup will convene in mid-2008 to

further define the educational and licensure requirements for the new provider, known as the Oral Health Practitioner.

As the April 2004 "Report to the Secretary: Rural Health and Human Services Issues" found, "oral health has been described as one of the single greatest unmet healthcare needs in the United States. The Report also finds that "in rural areas that face acute and growing dentist shortages, some form of alternative provider model may be particularly useful as a means to extend basic dental demonstrations to evaluate the viability and efficacy of models."

ADHA urges this Subcommittee and all Members of Congress to shape a future in which oral health services will be readily available to children and other vulnerable Americans who need them. Facilitating better utilization of dental hygienists through the establishment of the Advanced Dental Hygiene Practitioner is a vital part of this future.

Additional Support for Improving Access to Dental Care through Exploration of the ADHP

The National Dental Association included support to "expand the role of the dental hygienist as the Advanced Dental Hygiene Practitioner in underserved areas" in its Access to Care statement.

The American Public Health Association Oral Health Section also supports the Advanced Dental Hygiene Practitioner concept, calling it "a role comparable to the Medical Nurse Practitioner," which "presents a timely and appropriate way to explore new approaches to delivery of oral healthcare to those populations in rural and underserved areas, i.e. the 25percent in whom 80percent of oral disease is found."

The National Rural Health Association determined that "It is time for exploration of a new way to deliver oral health services—it is time to test the feasibility of an advanced dental hygiene practitioner—similar to the nurse practitioner but in the dental arena. NRHA sees great potential for the advanced dental hygiene practitioner to improve access to oral healthcare in rural areas."

The National Rural Education Association writes that "For a child to be ready to learn in school, a child must be healthy and free from pain. One proven strategy for reaching children at high-risk for dental disease is providing oral health services in school-based health centers; another strategy is to support linkages between schools and dental providers in the community. Presently there is a shortage of dentists. We must better utilize the dental hygienist. NREA is excited about the prospect of an advanced dental hygiene practitioner."

Major media outlets are also recognizing the access to oral healthcare crisis Americans face and the ways in which the current delivery system is failing millions of Americans. In the wake of the tragic death of Deamonte Driver in February 2007, national attention has become more focused on the dangers associated with not obtaining oral healthcare services.

An article from the October 11, 2007 edition of the *New York Times* stated, "American children are dying because of a lack of access to healthcare. . . . There are nine million children who lack healthcare in the U.S. and millions more who are eligible for coverage but fall through the cracks for one reason or another."

Similar sentiments were echoed by *The Washington Post* in a July 13, 2007 article, "At the heart of this issue is a lack of understanding of the importance and implications of good oral healthcare—every day there are children who can't pay attention in school and who can't fall asleep at night because they have problems with their teeth."

On April 22, 2008 *The Washington Post* featured an article, "Brushed off no Longer: citing Gaps in Care, Hygienists are Beginning to Treat Patients Without Direct Supervision by Dentists,", which stated that allowing dental hygienists to have a wider role in public health settings without direct supervision by dentists allows dentists to take care of more acute issues and which could in turn prevent "many difficult and expensive problems from developing in the first place."

Medicaid and the State Children's Health Insurance Program

Medicaid dental coverage for children is an essential benefit; regrettably, too few Medicaid-eligible children access dental care. More must be done to ensure that Medicaid-eligible children are able to access this essential benefit. Today, twelve states recognize dental hygienists as Medicaid providers of oral health services and provide direct reimbursement for their services. These states are: California, Colorado, Connecticut, Maine, Minnesota, Missouri, Montana, Nevada, New Mexico, Oregon, Washington, and Wisconsin. Other states should adopt this approach, which appropriately recognizes the experience, education and expertise of dental hygienists and fosters increased access to much needed Medicaid oral health services.

While the profession of dental hygiene was founded in 1913 as a school-based profession, today the provision of dental hygiene services is significantly tied to the private dental office, which many patients are unable to access. With over 90 percent of all practicing dentists in the private sector, it is time to promote the provision of oral health services directly to Medicaid and SCHIP-eligible children at schools, community health centers and other public health settings by better utilizing the education, experience, and expertise of dental hygienists, who could be linked through referrals and/or teledentistry to dentists.

SCHIP has extended dental coverage to millions of additional children who would otherwise be without dental insurance. ADHA and others in the dental community strongly support reauthorization of and adequate funding for SCHIP. As this Subcommittee well knows, although all states presently include dental benefits in their SCHIP program, dental benefits are not required to be included in the SCHIP program.

In order to stabilize and buttress the dental component of SCHIP, the dental community urges (1) a federal guarantee for dental coverage in SCHIP; (2) development of a dental wrap-around benefit in SCHIP; (3) support for outreach and enrollment of all SCHIP-eligible children; and (4) support for a national performance measure that would provide data necessary to evaluate SCHIP dental benefits. Strengthening SCHIP, however, should not come at the expense of Medicaid. SCHIP stands on the shoulders of Medicaid, and any effort to erode Medicaid will adversely affect SCHIP.

ADHA strongly supported the State Children's Health Insurance Program Reauthorization Act (CHIPRA), which included significant dental provisions, including a guaranteed dental benefit and a study on dental access and workforce that would examine the "feasibility and appropriateness" of dental mid-levels such as the ADHP. The association will look forward to the opportunity to work collectively with others in oral healthcare on future efforts to reauthorize SCHIP.

Improving the Nation's "Oral Health IQ"

Changing perceptions of oral health and oral disease is a critically important step in the movement to have the general public recognize oral health as an accepted component of general health. Indeed, the perceptions of the public, policymakers and health providers must be changed in order to ensure acceptance of oral health as an integral component of general health.

The national oral health consciousness will not change overnight, but working together we can heighten the nation's "oral health IQ." ADHA is already working to change public perceptions so that oral health is rightly recognized as a vital component of overall health and general well being. For example, ADHA has launched a public relations campaign to highlight the link between oral health and overall health; our slogan is "Want Some Lifesaving Advice? Ask Your Dental Hygienist."

This ADHA campaign builds on the Surgeon General's report, which notes that signs and symptoms of many potentially life-threatening diseases may appear first in the head, neck and oral cavity precisely at a time when the conditions are most treatable. For example, dental hygienists are educated to conduct a head and neck examination and a screening for oral cancer at every visit and can advise patients of suspicious conditions.

Conclusion

The American Dental Hygienists' Association appreciates this Subcommittee's interest in addressing healthcare disparities. The oral healthcare delivery system needs radical restructuring as evidenced by the untimely death of Deamonte Driver and national statistics that bring to light the systemic realities that serve as barriers to care for the underserved. ADHA wants to be part of a collaborative solution to the current problems of oral health disparities and inadequate access to oral health services for many Americans. ADHA firmly believes that exploration of the Advanced Dental Hygiene Practitioner model will better utilize the existing oral healthcare workforce and improve access to care for vulnerable populations, which in turn will work to ameliorate the nation's persistent oral health disparities. ADHA is committed to working with this Subcommittee—and all Members of Congress—to improve the nation's oral health, a fundamental part of overall health and general well-being. As lawmakers work to reform our nation's healthcare delivery system, please remember that the oral healthcare delivery system also requires reform and oral healthcare must be a part of the overall healthcare reform effort. Thank you for the opportunity to share the views of the American Dental Hygienists' Association.

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Statement of American Hospital Association

"Addressing Disparities in Health and Healthcare: Issues for Reform"

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, and our 37,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record addressing the issue of disparities in health and healthcare. America's hospitals take very seriously their charge to provide healthcare to everyone in their communities, regardless of race, color or creed. But there are challenges to meeting that mission.

BACKGROUND

Research confirms that healthcare delivery can differ for different patient populations; that significant variations exist by ethnicity and gender; and that care provided to Black and Latino patients can differ from care otherwise provided and lead to poorer health outcomes. Healthcare providers realize that multiple factors contribute to these disparities, including whether a patient has health coverage and access to preventive medical care, different cultural norms, and whether the patient has a limited understanding of English.

In fact, the Institute of Medicine's 2002 landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Care*, suggests that disparities in care can result from both patient-related and provider-related factors.

WHAT THE AHA IS DOING

Racial and ethnic disparities in health outcomes are systemic. As the above chart notes, they are caused not by a single factor but by a host of factors. Because hospitals provide care 24 hours a day, seven days a week to many diverse patients, hospitals must develop policies and systems to address all of these factors.

To address this issue, the AHA convened in December 2007 the Special Advisory Group on Improving Hospital Care for Minorities. The group has met several times to address its charge of examining and providing guidance on how hospitals can help eliminate disparities in care. This diverse group includes national leaders representing civil rights organizations, hospitals, public health agencies, state and Federal Government, academic medicine, healthcare researchers and others. Their specific priority is to answer the question: How can the hospital field improve the care we provide to minorities and eliminate disparities in care?

The group developed a consensus on specific activities that hospitals can undertake and identified areas where hospital executives should focus time, attention and resources, which would address the urgent need to reduce or eliminate disparities in healthcare outcomes while also strengthening overall operations. These are the group's recommendations:

- **Further investment in quality improvement.** A commitment to quality improvement by hospitals improves healthcare for all, not just minorities. Pay-for-performance efforts should focus on reducing disparities among conditions that disproportionately affect minority populations, such as infant mortality, diabetes, asthma, HIV, heart disease and cancer.
- **Enhanced transparency and data collection measures.** Gathering meaningful data in a systematic and uniform way can pinpoint whether and what type of disparities exist within a hospital's service areas. Linking these data to medical records and other patient information can provide hospital leaders with a compelling landscape of their communities—the demographics of their patients, what their healthcare needs are, the health outcomes that are attained, and where there might be gaps or disparities in health outcomes that need to be addressed. The Health Research and Educational Trust (HRET), an AHA affiliate, has developed a useful tool kit to guide hospitals through the process of collecting data on patients' race, ethnicity and primary language.
- **Enhance governance.** Through its Center for Healthcare Governance and Institute for Diversity in Health Management, the AHA is developing an ongoing training and board development program to expand the diversity of governing boards. By identifying and training potential minority trustees, hospitals and health systems will have a larger pool of qualified governance candidates. The goal is to make the governing body a better mirror of the community it serves.
- **Greater focus on public health issues.** The public health sector has identified several priority health issues as leading causes of poor health among minority groups—smoking, alcohol and drug abuse, obesity and poor nutrition and lack of exercise among them. For many people in lower socio-economic areas, these lifestyle management issues pose just as much a risk as a genetic pre-

disposition to heart disease, diabetes or other chronic conditions. Hospitals can work with groups that focus on mitigating these risk factors.

- **Improve connections with communities and populations within service areas.** Use established organizations such as community-based ethnic organizations, the YMCA, churches, colleges and others as partners in promoting health. Hospitals and healthcare systems should develop and sustain relationships with civil rights organizations, local outreach groups, networks and others, to determine specifically how the healthcare provider and community organizations can work together for the benefit of the community.
- **Enhance wellness and prevention outreach efforts among uninsured patients.** Reducing the number of acute healthcare episodes among uninsured patients, thereby improving their overall health, is essential. Helping connect uninsured patients with coverage and care options can ensure that they have continued access to healthcare services.
- **Enhance healthcare workforce opportunities.** Creating recruitment opportunities for minority populations not only can offer healthcare-related training, it also can generate a clinically and culturally proficient workforce that mirrors the community it serves.

By focusing on these factors, hospital leaders can help improve outcomes not just for minority patients, but for all patients.

WHAT HOSPITALS ARE DOING

Addressing disparities in care is not new to America's hospitals. Hospitals around the country have identified healthcare needs within their communities, determined how to address them, and dramatically improved the health of their minority patient populations. For example:

- The Cambridge Health Alliance in Boston, Massachusetts, created the Volunteer Health Advisor Program (VHA) in 2001. This is a volunteer-driven program that provides multicultural and multilingual health education and outreach to the communities in the Boston area, all in an effort to improve community health status. In 2007, the VHA staff and more than 200 volunteers offered health and wellness services to more than 5,500 people through 93 community events in 16 languages. Their outreach efforts resulted in 1,500 screenings for blood pressure, glucose and cholesterol levels in traditionally medically underserved and hard to reach minority populations.
- Adventist HealthCare System in Rockville, Maryland, recognized that 25 percent of the people in their service area speak a language other than English—part of an increasingly diverse community. In September 2005, the Adventist Board of Trustees appointed a blue ribbon panel of community leaders to develop a locally driven approach that addresses and eliminates healthcare disparities in all of the communities served by Adventist HealthCare. The panel recommended and the health system implemented the Adventist HealthCare Center on Health Disparities.

The Center's three areas of focus are increased services for underserved populations; a research program to identify and promote best practices; and an education initiative to improve the ability of caregivers to provide quality care to those populations. Their efforts include three education modules that will foster culturally competent care: *Health Disparities: Understanding Our Population* is a discussion of local demographics, the definition of culturally competent care and a diversity training program; *Stereotypes, Biases and Assumptions* focuses on characteristics that can have an impact on patient care and adherence to treatments, and includes cross-cultural communication tools; and *Health Beliefs and Practices of Different Populations* helps caregivers incorporate differing beliefs into care and treatment plans. The Center also instituted patient advocacy and linguistic access programs, and incorporated an infrastructure for research into healthcare disparities that exist in their region of the Metropolitan Washington, D.C. area.

- *Expecting Success*, a national program sponsored by the Robert Wood Johnson Foundation, is a multi-hospital collaborative focused on reducing disparities in cardiovascular care. The program is helping 10 general acute care hospitals measure the quality of cardiac treatment they provide to patients based on race, ethnicity and primary language. For the first time, these hospitals, using the HRET data collection tool mentioned above, are tracking data to identify racial and ethnic disparities in the care they provide by focusing on the continuum of cardiovascular care delivered in inpatient and outpatient settings, and specifically care delivered to African American and Latino patients.

These are just a few examples of what hospitals around the country are doing to eliminate healthcare disparities in their communities. There is a growing body of research around disparities—where it exists, why it exists, etc.—and the AHA is working to compile the case studies and best practices of these programs.

CONCLUSION

There are several immediate steps that Congress can take to address disparities in care. First, safety net providers must be protected. These hospitals play an important role in caring for all populations, including minority populations in inner cities, patients in rural areas, and the uninsured and underinsured.

Congress should ensure that the moratorium on proposed Medicaid regulations is approved, thus providing safety net hospitals with the resources to treat those most affected by disparities in care. If these regulations are implemented, it will affect coverage of rehab services for people with disabilities; certified public expenditures and intergovernmental transfers; graduate medical education; outpatient services; provider tax arrangements and outreach and enrollment in schools and specialized medical transportation to school for children covered by Medicaid. These budget-cutting policies proposed by the Centers for Medicare & Medicaid Services would have a devastating effect on state Medicaid programs, along with the hospitals and physicians that serve our nation's most vulnerable populations. Much of Congress has expressed opposition to these rules with bipartisan support.

Congress also should support the permanent ban on self-referral to new physician-owned facilities, with appropriate grandfathering of existing facilities. The rapid proliferation of physician ownership must be slowed to ensure that safety-net services and the continued viability of full-service hospitals in communities are maintained. Studies have found that physician-owned limited-service hospitals have a devastating impact on communities by, among other effects, reducing patient access to specialty and trauma care at community hospitals; damaging the financial health of full-service hospitals that must maintain stand-by capacity for emergencies, even if they lose elective services; and "cherry-picking" the most profitable patients by avoiding low-income populations, both uninsured and Medicaid.

In addition, as Congress considers legislation to implement value-based purchasing, legislators should be mindful that minority populations often have unique and vastly different cultural and health needs. Standardizing delivery of care in order to measure and reward improvement is a laudable goal, but we must ensure that members of minority populations do not slip through the safety net.

In the long term, Congress should include elimination of disparities in care—fair and equitable care for all—in its deliberations as the country seems poised to debate the future of our healthcare system.

The price of poor health is high, but ensuring that disparities in care are eliminated, that wellness and prevention measures are implemented in a community-partnership mode and that America's hospitals continue to improve care for all can dramatically enhance our efforts to close the gap and eliminate disparities. Providing quality care to every patient is at the heart of a hospital's mission. Continually striving to eliminate disparities in care is a major priority for America's hospitals, but can only be achieved if all stakeholders work together for the good of patients.

Statement of **Glenn Flores, M.D.**, Director of the Division of General Pediatrics, Professor of Pediatrics and Public Health, and the Judith and Charles Ginsburg Chair in Pediatrics, UT Southwestern Medical Center and Children's Medical Center, Dallas, Texas.

Thank you, Chairman Stark and the Ranking Member Camp, for inviting me to provide this written testimony on cultural and linguistic issues in healthcare and their importance in addressing disparities in health and healthcare in the United States.

My name is Glenn Flores, M.D., and I am Director of the Division of General Pediatrics, Professor of Pediatrics and Public Health, and the Judith and Charles Ginsburg Chair in Pediatrics at the University of Texas Southwestern Medical Center and Children's Medical Center Dallas. I am a pediatrician who has cared for under-served children for 16 years, as well as a researcher who has conducted many studies on racial/ethnic disparities, cultural competency, and language issues in health and healthcare.

My testimony will address cultural and linguistic issues in healthcare, and how culturally competent healthcare is crucial in the reduction and elimination of disparities in health and healthcare.

Why Is Culture So Important in Healthcare?

The world's population of 6.7 billion people inhabits 191 countries and speaks over 6,000 languages. In the U.S., approximately 103 million people (34% of the nation's population) are of non-white race/ethnicity. By 2050, racial/ethnic minorities will comprise half of the U.S. population. Since 2000, minorities have comprised more than half of the population of the nation's 100 largest cities, and 42 of the 100 largest U.S. cities are "minority majority" (defined as populations in which racial/ethnic minorities outnumber whites).[1] Rapid growth in diversity makes it increasingly likely that healthcare providers will care for patients from different cultures.

Mounting evidence demonstrates the profound impact culture can have on healthcare. Failure to consider a patient's culture can have serious clinical consequences, including inaccurate histories, miscommunication, and difficulties with informed consent; decreased access to care and lower likelihood of having primary care provider; non-adherence and decreased satisfaction with care; and less preventive screening, inadequate analgesia, delayed immunizations, and receipt of fewer prescriptions.[2]

Normative Cultural Values

Normative cultural values are defined as beliefs, ideas, and behaviors that a particular cultural group values and expects in interpersonal interactions. Lack of awareness of normative cultural values can have a profound impact on healthcare. For example, central to the Navajo concept of *Hozhooji* is the importance of thinking and speaking in a positive way, and the belief that thought and language have the power to shape reality and control events. The expectation is that communication between healers and patients will embody the concept of positive thoughts and words, and that negative thoughts and words can actually cause harm. A lack of awareness of *hozhooji* can therefore cause an inadequate discussion of medical risks, miscommunication about advanced directives, and failure to obtain informed consent. For example, a Navajo patient was told by a surgeon that in all operations there is a risk of not waking up; the patient viewed this to be a death sentence, so he refused to consent to having surgery. One study documented that 86% of Navajo patients said that advance care planning (establishing a living will or durable power of attorney) was a dangerous violation of the traditional Navajo values and thinking, and many would not discuss this issue because they felt it to be too dangerous.[3]

Fatalismo (fatalism) is the belief that individual can do little to alter fate. It has been noted as a normative cultural value among Latinos, African-Americans, and other ethnicities and cultures. *Fatalismo* can lead to avoiding effective therapy for cancer and chronic diseases and less preventive screening. For example, a study of cancer beliefs revealed that Latinos were significantly more likely than whites to prefer not to know if they had incurable cancer, and to believe that there is little one can do to prevent getting cancer, having cancer is like a death sentence, and cancer is God's punishment.[4]

Protective Effects of Traditional Culture and Improving the Health of All Americans

Multiple studies document that for a variety of health issues, *less* acculturation (e.g., less "Americanization") is associated with *better* health indicators. For example, less acculturation is associated with lower low birth weight rates, higher immunization rates, less teen depression and suicide, less cigarette smoking, less illicit drug use, and a significantly older age at first sexual intercourse for Latino girls. The reasons for this "healthy immigrant effect" are not yet completely understood, but further studies of this phenomenon hold potential for improving the health of all Americans.[5]

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[1] The Brookings Institution Center on Urban and Metropolitan Policy. Census 2000 Matters. Racial Change in the Nation's Largest Cities: Evidence from the 2000 Census. Available at: http://www.brookings.edu/es/urban/census/citygrowth.htm.

[2] Flores G. Culture and the patient-physician relationship: achieving cultural competency in healthcare. *Journal of Pediatrics* 2000;136:14–23.

[3] Carrese JA, Rhodes LA. Western bioethics on the Navajo reservation. Benefit or harm? JAMA 1995;274:826–9.

[4] Pérez- Stable EJ, Sabogal F, Otero-Sabogal R, Hiatt RA, McPhee SJ. Misconceptions about cancer among Latinos and Anglos. *JAMA* 1992;268:3219–23.

[5] Flores G, Brotanek J. The healthy immigrant effect: A greater understanding might help us improve the health of all children. *Archives of Pediatrics and Adolescent Medicine* 2005;159:295–297.

The Critical Impact of Language on Healthcare

English Proficiency in the U.S.

Fifty-five million Americans (20%) speak a language other than English at home, and 24 million (9%) have limited English proficiency (or LEP, defined as self-rating one's English-speaking ability as less than "very well"). Eleven million school-age children (19%) speak a language other than English at home.

Adverse Consequences of Language Barriers in Healthcare

Studies demonstrate a wide range of adverse effects that LEP can have on health and healthcare, including impaired health status, a lower likelihood of having a regular physician, lower rates of mammograms, pap smears, and other preventive services, non-adherence with medications, a greater likelihood of a diagnosis of more severe psychopathology and leaving the hospital against medical advice among psychiatric patients, a lower likelihood of being given a follow-up appointment after an emergency department visit, an increased risk of intubation among children with asthma, a greater risk of hospital admissions among adults, an increased risk of drug complications, longer medical visits, higher resource utilization for diagnostic testing, lower patient satisfaction, impaired patient understanding of diagnoses, medications, and follow-up, and medical errors and injuries.[6,7] For example, one study found that 26% of mothers of Latino children cited language problems as single greatest barrier to healthcare, and 6% reported not bringing their child in for needed medical care because of language problems. LEP patients in psychiatric settings experience a greater likelihood of diagnosis of more severe psychopathology, are more likely to leave hospital against medical advice, are less likely to establish a good rapport with physician, are less likely to receive adequate explanation of therapeutic regimen, and are less likely to give feedback to physician.

LEP patients have a higher risk of experiencing adverse healthcare outcomes. For example, Mexican-American children whose parents speak English were found to be 12 times more likely to have a regular healthcare provider vs. those with LEP parents (regardless of insurance).[7] Another study revealed that LEP women receive fewer mammograms and pap smears.[7] Asthmatic children with LEP parents are three times more likely to be intubated for their asthma than those with English proficient parents, and monolingual Spanish-speaking adults with asthma whose physicians speak English are three times more likely to miss one or more follow-up appointments.[7] A recent nationally representative survey of over 102,000 U.S. households revealed that children in households speaking a non-English primary language experience numerous disparities in medical and oral health, access to care, and use of services, even after adjustment for health and dental insurance and family income.[8]

Patient Safety: Language Barriers, Medical Errors, and Injuries

Research documents that language barriers can result in preventable medical errors and injuries. Dramatic examples in the medical literature include:

- A 2-year-old fractured her clavicle after falling off her tricycle. A resident physician misinterpreted two Spanish words, diagnosed child abuse, and contacted the Department of Social Services, who, without an interpreter, had the mother sign over custody of her two children. The mother did not regain custody of her children until 48 hours later, when a medical interpreter finally was obtained.[9]
- A 10-month-old girl with iron-deficiency anemia was given a 13-fold overdose of iron and hospitalized for iron intoxication after her LEP parents were given medication instructions and a prescription only in English by their healthcare provider. The parents gave 15 ml of iron elixir (one tablespoon instead of a dropperful) based on a prescription label that read: "15 mg per 0.6 ml, 1.2 ml daily."[10]
- Misinterpretation of single Spanish word ("intoxicado") resulted in an 18-year-old's quadriplegia after being misdiagnosed with a drug overdose. The patient's

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[6] Flores G. The impact of medical interpreter services on the quality of healthcare: A systematic review. *Medical Care Research and Review.* 2005;62:255–299.

[7] Flores G, Laws MB, Mayo SJ, et al. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics* 2003;111:6–14.

[8] Flores G, Tomany-Korman S. The language spoken at home and disparities in medical and dental health, access to care, and use of services in U.S. children. *Pediatrics* 2008;121;e1703–e1714.

[9] Flores G, Abreu M, Schwartz I, Hill M. The importance of language and culture in pediatric care: case studies from the Latino community. *Journal of Pediatrics* 2000;137:842–848.

[10] Flores G. Language barrier. *AHRQ WebM&M Morbidity and Mortality Rounds on the Web* 2006;April. Available at: http://www.webmm.ahrq.gov/case.aspx?caseID=123.

hematomas, brain-stem compression, and paralysis were actually due to a ruptured aneurysm, and the hospital paid $71 million in a malpractice settlement.[11]

The Importance of Medical Interpreters in Healthcare

Data indicate that medical interpreter services are often inadequate for millions of LEP patients in America. One study of an urban emergency department revealed that no interpreter was used for 46% of LEP patients for whom an interpreter was needed, interpreters were not called in 1/3 of cases when both the clinician's Spanish and patient's English were poor, and 39% of interpreters used had no training. LEP patients who need but don't get interpreters are more likely than LEP patients who use interpreters and English proficient patients to have a poor or fair self-reported understanding of their diagnosis and treatment plan, and to wish their healthcare provider explained things better.

The Dangers of Medical Interpretation by Family Members, Friends, and Untrained Staff

All too often, ad hoc interpreters (including family members, friends, untrained medical staff, strangers pulled from the waiting room and the streets, and custodians) are used when language barriers are encountered in healthcare. The hazards of using these ad hoc interpreters are well documented, and include the patient being less likely to be told about medication side effects, and more frequent interpretation errors that are more likely to have actual or potential clinical consequences. In addition, studies show that family members misinterpret 23–52% of questions asked by physicians; children who interpret are embarrassed by and tend to ignore questions about menstruation, bowel movements, and other bodily functions; non-medical staff who interpret can exclude or distort key clinical information; and patient satisfaction with ad hoc interpreters is significantly lower than with other interpreter types.[6]

The dangers of ad hoc interpreters are dramatically illustrated in the following actual patient encounter that occurred in an emergency room and was published in the *New England Journal of Medicine*.[12] A 12-year-old boy presented to the physician with dizziness, and attempts to interpreter for himself and his mother:

Mother: *La semana pasada a el le dio mucho mareo y no tenía fiebre ni nada, y la familia por parte de papá todos padecen de diabetes.*	Last week he had a lot of dizziness and he did not have fever or anything, and his dad's family all suffer from diabetes.
Doctor: Uh-hum	
Mother: *A mi me da miedo porque el lo que estaba mareado, mareado, mareado y no tenia fiebre ni nada.*	I'm scared because he's dizzy, dizzy, dizzy and he didn't have fever or anything.
Doctor: Ok. So she's saying you look kind of yellow, is that what she's saying?	
Patient: *Es que si me vi amarillo?*	Is it that I looked yellow?
Mother: *Estaba como mareado, como palido.*	You were like dizzy, like pale.
Patient: Like I was like paralyzed, something like that.	

The Many Benefits of Providing Adequate Language Services to LEP Patients

Multiple studies document the many benefits of providing trained, professional medical interpreter services to LEP patients.[6] Interpreter services have a positive impact on preventive screening, including increased breast cancer screening after implementation of language services in clinics, and elimination of disparities between LEP and English-proficient patients in flu vaccinations and fecal occult blood testing. Interpreter services positively impact health outcomes. In children presenting to the emergency department, LEP patients with professional interpreters did not differ from English-proficient patients in test costs or use of IV hydration, and had a lower likelihood of testing. LEP patients with Type 2 diabetes mellitus who have trained professional interpreters are two times more likely than English-proficient patients to receive care meeting American Diabetes Association guide-

[11] Harsham P. A misinterpreted word worth $71 million. *Medical Economics* 1984;June:289–292.

[6] Flores G. The impact of medical interpreter services on the quality of healthcare: A systematic review. *Medical Care Research and Review.* 2005;62:255–299.

[12] Flores G. Language barriers to healthcare in the United States. New England Journal of Medicine 2006;355:229–231.

lines, three times more likely than English-proficient patients to have dietary consults, and did not differ from English-proficient patients in 18 other processes and outcomes. In patients with hypertension and diabetes, health status, physical functioning, psychological well-being, health perceptions, and pain scores are higher in those with language concordant vs. discordant physicians.

Providing Language Services to All Americans Who Need Them Would Not be Costly

In a 2002 report to Congress, the Office of Management and Budget[13] estimated it would cost only a $4.04 premium per patient to provide interpreter services to all LEP patients needing these services, which is equivalent to a 0.5% increase in overall U.S. healthcare expenditures. This cost estimate includes coverage for LEP patients of interpreter services for inpatient hospitalizations, as well as outpatient, emergency room, and dental visits.

Ethnomedical Conditions or Folk Illnesses and Their Impact on Medical Care

Folk Illnesses and Their Impact on Healthcare

Ethnomedical conditions, or folk illnesses, are culturally constructed diagnostic categories commonly recognized by an ethnic group. The prevalence of beliefs varies tremendously, depending on subpopulation, region, levels of acculturation. The prevalence of certain folk illness beliefs, however, can be as high as 96% in certain Mexican-American communities. Folk illness beliefs and practices can affect clinical care because the symptoms often overlap with important biomedical conditions, the first healthcare provider contact may not be a physician, some folk remedies can be harmful or even fatal, and satisfaction with care and adherence can depend on the accepting response of healthcare provider

Example: How Folk Illnesses Can Affect Healthcare

Empacho is a Latino folk illness in which food or saliva is believed to get "stuck" in the stomach because of dietary indiscretions such as eating the wrong foods or eating at the wrong time. One study[14] found that 90% of Latino parents knew of *empacho*, and 64% said that a child in the household had suffered from it in past. Symptoms of *empacho* include vomiting, diarrhea, anorexia, bloating, and fever. These symptoms overlap with such biomedical conditions as gastroenteritis, milk allergy, formula intolerance, gastrointestinal obstruction, intussusception, and appendicitis. But the treatment of choice for *empacho* is not usually a physician visit. The most common treatments of choice among parents whose child has *empacho* include a *santiguadora* (a traditional healer) in 77%, home remedies for 58%, and doctor visits for only 37%. Only 9% of parents reported physicians as the initial choice for treatment, and 85% of those visiting physicians for *empacho* sought another form of therapy afterwards.

Most traditional *empacho* treatments are harmless, and include dietary restriction, teas, abdominal massage with warm oil, and treatment by folk healers or parents. But some *empacho* treatments are harmful or even fatal. For example, Mexican-American families may treat *empacho* with powders containing high concentrations of lead (*greta*, *azarcón*, *albayalde*) whose lead content varies from 70% to 97%. Multiple cases of severe lead toxicity have been reported in the medical literature, with outcomes that include lead levels as high as 124 μg/dl (normal is considered <10), severe lead encephalopathy, and death. The use of lead-based *empacho* remedies in certain communities can be as high as 35% in Mexico and 11% in U.S. Cultural competency training of healthcare providers that includes education about common folk illnesses and their treatment thus has the potential to save lives. There are dozens of other ethnomedical conditions that have similar important clinical ramifications.

Patient and Parent Beliefs and Their Impact on Healthcare

Patient and parent beliefs are defined as a cultural group's beliefs about disease causality (excluding specific folk illnesses). Treatments associated with these beliefs include home remedies, folk remedies (except those used for specific folk illnesses), and over-the-counter medications. Patient/parent beliefs can profoundly affect different aspects of clinical care, including prevention, therapy, and seeking medical

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[13] Office of Management and Budget. Report to Congress. Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency. Washington, D.C.: 2002.

[14] Pachter LM, Bernstein B, Osorio A. Clinical implications of a folk illness: *Empacho* in mainland Puerto Ricans. *Medical Anthropology* 1992;13:285–299.

care. Several home treatments for common childhood symptoms can result in clinical findings that can be confused with child abuse, and misunderstandings can lead to costly and unnecessary medical evaluations. In addition, certain harmful parent/patient beliefs and practices can cause serious morbidity and fatalities.

Lack of Awareness of Patient Beliefs Can Lead to Costly, Unnecessary Medical Evaluations

Infant head molding (the application of pressure or bindings to cranial bones to alter their shapes) is practiced by various Caribbean, Latino, European, African-American, Asian, and Native American groups, with the intent of promoting infants' beauty, health, or intelligence. The failure of healthcare providers to inquire about infant head molding could lead to unnecessary, expensive evaluations for such medical conditions as dysmorphism or craniosynostosis. Indeed, one study documented that none of the 30 parents interviewed told their child's physician that they were molding their infant's head.

Serious Morbidity and Fatalities Resulting from Harmful Cultural Beliefs/Practices

An outbreak of Gonococcal conjunctivitis occurred in Florida due to the use of adult urine to treat conjunctivitis in children. Serious *Salmonella* infections have been caused by use of rattlesnake meat capsules, powder, or jerky by Mexican-Americans to treat various ailments (including diarrhea, infections, AIDS, diabetes, heart disease, cancer). Liver injury and death from liver failure have been caused by a cough treatment using a tea made from the herb *Senecio longilobus,* which contains potent toxins.

Culturally Biased Attitudes and Practices and How They Can Affect Healthcare

Cultural bias in the attitudes and practices of some healthcare providers can have a profound impact on clinical care, including access to care, impaired diagnostic evaluations, lower quality of care, and causing and perpetuating racial/ethnic disparities in healthcare.

Provider Practices That Impair Diagnosis

Among adolescent girls presenting to the emergency department with abdominal pain, race/ethnicity was found to be a significant determinant of whether physicians obtain sexual histories.[15] Physicians significantly more often obtained sexual histories on Latino and African-American girls (88%) compared with whites (50%), and for girls <15 years old, 100% of minority girls but only 44% of white girls were asked about sexual activity. In a study of a white psychotherapists in which two case histories presented were identical except for race of adolescent boy (white vs. African-American), therapists gave significantly lower ratings of the clinical significance of eight of 21 pathological behaviors in the African-American adolescent. White therapists were less concerned about the African-American adolescent beating his girlfriend, stealing cars, mistrusting the interviewer, and hating his mother. The findings supported the hypothesis that mental disorders in African-American adolescents are under-diagnosed because pathological behaviors are rated less severely.

Provider Practices and Quality of Care

Studies show providers give less pain medication to Latinos. For example, Latino adults presenting to an emergency room with long-bone fractures were found to be seven times more likely than Whites to receive *no* pain medication (after adjustment). Multiple studies also document that minority children are significantly less likely to receive known effective asthma therapies, even after adjusting for insurance coverage and family income.

Are These Healthcare Provider Practices Due to Inadequate Cultural Competency Training?

A study of the teaching cultural issues in U.S. and Canadian medical schools revealed that very few schools (8% in the U.S. and 0% in Canada) have separate courses on cultural issues.[16] Eight percent of U.S. medical schools were found to offer no courses on cultural issues. In addition, few schools teach about the specific cultural issues of the largest minority groups in their geographic area. For example,

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[15] Hunt AD, Litt IF, Loebner M. Obtaining a sexual history from adolescent girls. A preliminary report of the influence of age and ethnicity. Journal of Adolescent Healthcare 1988 9:52–4.

[16] Flores G, Gee D, Kastner B. The teaching of cultural issues in U.S. and Canadian medical schools. *Academic Medicine* 2000;75:451–455.

only 35% of U.S. schools address the cultural issues of the largest minority groups in their state.

Cultural Competency is Associated with High-Quality Patient Care

A recent study of asthmatic children in five health plans in three states found that practice sites with the highest cultural competency scores have significantly lower patient under-use of preventive asthma medications and significantly better parent ratings of the quality of asthma care.[17]

Summary

Failure to consider a patients' culture can have serious clinical consequences. Dissatisfaction with care, miscommunication, less preventive screening, and failure to obtain informed consent and advance directives can occur when normative cultural values not considered. Decreased access to care, impaired health status, lower use of services, adverse outcomes, and medical errors and injuries are documented among those facing language barriers. Serious morbidity and fatalities have been associated with harmful folk remedies and parent beliefs and practices. Delayed medical care, confusion with child abuse, and unnecessary and costly medical evaluations are associated with certain parent cultural beliefs and practices. Decreased access to care, impaired diagnostic evaluations, lower quality of care, and racial/ethnic disparities are associated with biased provider practices. Multiple studies in the medical literature document that the highest quality of care is delivered when healthcare providers are able to effectively overcome language problems and are culturally competent.

Action Steps: Enhancing Culturally Appropriate Care and Eliminating Disparities

Action steps in five areas would substantially enhance culturally and linguistically care and have the potential to eliminate disparities in healthcare. They are as follows:

Routine Collection of Data on Race/Ethnicity, Primary Language, and English Proficiency

- **Healthcare institutions and health plans should routinely collect data on patients' self-reported race/ethnicity.** Racial/ethnic disparities in health and healthcare cannot be monitored and eliminated without this essential measure.
- **Healthcare institutions and health plans should routinely collect data for all patients on the primary language spoken at home and English proficiency.** Such data are essential not only to monitor and eliminate linguistic barriers to healthcare, but also to anticipate the future language service needs of patients who regular access healthcare services and systems.

Strategies to Eliminate Language Barriers

- **Provide nationwide third-party reimbursement for medical interpreters and other language services.** Only 13 states and the District of Columbia currently provide third-party reimbursement for interpreter services, and only through Medicaid and SCHIP—not through Medicare or other health insurance plans. It is time for our nation to provide third-party reimbursement for interpreter services for all LEP patients.
- **Increase the number of trained medical interpreters and their pay.** Training programs and recruitment strategies need to be developed to take advantage of the 55 million Americans who are bilingual or multilingual.
- **Increase the number of bilingual healthcare providers.** This can be achieved by having medical and other health professions schools offer or require population-relevant foreign language instruction.
- **Do better at teaching our children foreign languages.** Only 44% of U.S. high-school students are currently enrolled in foreign language courses.
- **Implement and fund more free or low-cost English classes to help LEP patients and families learn English.** In my 16 years caring for underserved children and their families, I have never met a parent that did not want to learn English. The biggest barrier to English proficiency for the families that I provide care to is the lack of availability of free or low-cost English classes.
- **Ensure comprehensive, "door-to-door" language access and services for LEP patients.** Key services that often are overlooked include multilingual phone operators and phone trees for making appointments, and multilingual signage, consent forms, patient information materials, and prescriptions.

[17] Lieu TA, Finkelstein JA, Lozano P, et al. Cultural competence policies and other predictors of asthma care quality for Medicaid-insured children. *Pediatrics* 2004;114:e102–10.

Trained interpreters also need to be present throughout the medical visit (especially when scheduling follow-up appointments and during radiological and laboratory procedures).

- **Enforce compliance with Title VI requirements.** The Office of Civil Rights issued a 1998 guidance memorandum regarding the Title VI prohibition against national origin discrimination affecting LEP persons which states that denial or delay of medical care for LEP patients because of language barriers constitutes a form of discrimination, and requires recipients of Medicaid or Medicare funds to provide adequate language assistance to LEP patients. When all other options fail, legal action has been successful in enforcing compliance with Title VI requirements, as occurred in recent settlements with four New York state hospitals.[18]
- **Funds and more research should be devoted to evaluating telemedicine options for enhancing access to language services.** Telemedicine may prove to be highly cost-effective means for states and health plans to provide language access, allowing hospitals and clinics to quickly link to centralized bank of trained interpreters.

Strategies to Enhance Cultural Competency in Healthcare

- **Cultural competency should be a standard component of curricula in health professions schools.** Cultural competency knowledge and skills should be an essential part of the education of healthcare providers, given the substantial medical literature documenting that the highest quality of care and optimal patient outcomes occur when providers are culturally competent and are able to effectively overcome language problems.
- **Cultural competency may need to be a requirement for certification of healthcare professionals and licensing of healthcare facilities.** In 2004, the state of New Jersey enacted a law requiring that medical professionals be trained in the provision of culturally competent healthcare as a condition of licensure to practice medicine in NJ.[19] As part of its state-required hospital licensure renewal process, Rhode Island mandates that hospitals demonstrate evidence that they are providing meaningful access to language services for their LEP patients.[20]

Strategies to Reduce Healthcare Disparities through Community-Based Interventions

- **More federal funding should be devoted to innovative, community-based, culturally appropriate interventions targeting elimination of healthcare disparities.** For example, a recent randomized, controlled trial was performed that resulted in the elimination of a healthcare disparity. This study demonstrated that, compared with traditional Medicaid/SCHIP outreach and enrollment, community-based health workers are substantially more effective in obtaining health insurance for Latino children, obtaining insurance quicker, continuously insuring children, and achieving high parental satisfaction with the process of obtaining insurance.[21] To ensure that healthcare disparities are eliminated for all Americans, more such studies and programs are needed.

Statement of the National Black Nurses Association

Mr. Chairman, I am providing a written statement for consideration by the Committee and for inclusion in the printed official record of the hearing regarding an important issue the elimination of health disparities. I applaud your efforts for addressing this critical matter facing millions of Americans.

The National Black Nurses Association's mission is to provide a forum for collective action by African American nurses to "investigate, define and determine what the healthcare needs of African Americans are and to implement change to make

[18] Office of New York State Attorney General Eliot Spitzer. Spitzer reaches agreement with two Brooklyn hospitals to provide language assistance for patients with limited English proficiency. URL: http://www.oag.state.ny.us/press/2003/mar/mar03a—03.html.

[19] Senate Substitute for Assembly, No. 492. State of New Jersey 211th Legislature. Adopted March 22, 2004.

[20] Rhode Island General Laws Section 23–17–54; 14 090 CRIR 007 Section 20.3. Available at: http://www.rilin.state.ri.us/statutes/title23/23%2D17/23–17–54.HTM.

[21] Flores G, Abreu M, Chaisson CE, et al. A randomized trial of the effectiveness of community-based case management in insuring uninsured Latino children. *Pediatrics* 2005;116:1433–1441.

available to African Americans and other minorities healthcare commensurate with that of the larger society".

Eliminating health disparities is one of the most pressing challenges facing the Nation on all fronts. Report upon report outline racial and ethnic disparities in health and healthcare. At issue are access, quality and accountability to culturally competent healthcare services. The IOM study entitled, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* documented disparities in quality of healthcare that are NOT due to access-related or solely economic factors. It focused on disparities related to how healthcare systems operate, including their regulatory and legal context, and to discrimination. The IOM report confirmed that "cultural and linguistic competence" is essential to helping close the gaps in mortality and morbidity.

Ethnic and racial disparities in healthcare have been well documented in recent decades across a broad range of medical conditions. Differences have been noted in health outcomes, which include quality of life, mortality, and appropriateness of care. Despite all that is known regarding health disparities, little improvement has been made, and racial and ethnic minorities continue to be disproportionately affected by illness and disease due in part to an inadequate understanding of cultural differences.

It is our belief that we have collected enough data and that action should be taken now to move toward an agenda that will eliminate disparities. The following should be taken into consideration as strategies are developed.

The 2003 "**National Healthcare Disparities Report**" developed by the Agency for Healthcare Research and Quality (AHRQ) offered a comprehensive tool to measure access and use of healthcare services by various populations. The NHDR provides seven key findings to policymakers, clinicians, health system administrators, and community leaders who seek to use this information to improve healthcare services for all populations:

1. Inequality in quality persists
2. Disparities come at a personal and societal price
3. Differential access may lead to disparities in quality
4. Opportunities to provide preventive care are frequently missed
5. Knowledge of why disparities exist is limited
6. Improvement is possible
7. Data limitations hinder targeted improvement efforts

Findings in this report can help target efforts more effectively to improve quality and reduce disparities. In its ***2005 National Healthcare Quality and Disparities*** report released on January 9, 2006, AHRQ reported that access to care for African Americans was narrowing. Improvements were observed among non-Hispanic Whites and Non-Hispanic Blacks relative to blood pressure control. Yet, cardiovascular disease is the number one killer of African Americans. Only 40 percent of those diagnosed with diabetes have their HbA1c under optimal control (<7 percent). Blacks with diabetes are more likely than Whites to have their total cholesterol under control. Only 70 percent of those diagnosed with diabetes had their blood pressure under control. Rates of late-stage breast cancer decreased more rapidly from 1992 to 2002 among black women (169 to 161 per 100,000 women) than among white women (152 to 151 per 100,000), resulting in a narrowing disparity. Yet, Black women had higher rates of advanced stage breast cancer than White women in 1992, 1993, 2002. Over 12 million children ages 2–19 years old are overweight, 20% are African American.

The Behavioral Risk Factor Surveillance System (BRFSS), a random telephone survey conducted by state health department and the CDC; and the National Health and Nutrition Examination Survey (NHANES) 1999–2002 found that Blacks had the highest prevalence of hypertension, the highest self-report prevalence of diagnosed diabetes and the highest rate of hospitalizations for stroke. The basic philosophy of this program was to collect data on actual behaviors, rather than on attitudes or knowledge, that would be especially useful for planning, initiating, supporting, and evaluating health promotion and disease prevention programs.

The Uninsured

Over 47 million Americans are uninsured and millions lack adequate care. Communities of color have a higher incidence of chronic diseases, cardiovascular disease, diabetes, cancer, violence and HIV/AIDS, leading to high rates of morbidity and mortality. African Americans accounted for 47 percent of AIDS cases in 2005. 20 million Americans have diabetes; it is estimated that 20 million Americans have undiagnosed diabetes. 2.7 million African Americans aged 20 and older have diabetes. African Americans develop diabetes at 1.6 times the rate of whites. Diabetes

is the leading cause of kidney failure and African Americans are more likely to suffer from kidney disease. According to the Centers for Disease Control and Prevention, the incidence of diabetes is expected to double by the year 2050 and healthcare costs associated with diabetes exceeded $132 billion in 2002.

Insurance Coverage

Even more distressing are those individuals who have insurance coverage and continue to experience healthcare disparities. In a recent report from the Families USA Foundation it was revealed that insurance companies in most states are not required to provide health coverage to individuals with pre-existing conditions. This results in insurance companies refusing to pay for needed services that treat common conditions. Individuals are denied coverage and are left with large medical bills they can not pay many ending up in bankruptcy. Employer sponsored health coverage is the major vehicle for the purchase of health insurance for most people. This employee benefit is on the decline and coverage is out of reach for many Americans due to cost. According to Families USA upon completion of their 50 state surveys it is time for the Federal Government to step in and curb the harmful abuse by insurance companies. Citizens of this country are devastated by debilitating illness and disease they should not have to tolerate abuse by the insurance industry.

Study after study provides evidence of the devastating effects on the quality of life of people of color due to healthcare disparities. The staggering statistics related to these disease states are only a snapshot of the continuing pain and suffering, let alone the economic impact that continues to plague our communities. While advances in prevention, diagnosis and treatment, particularly through biomedical research and technology, offer incredible promise for improved health and delivery of care, for a good number of this Nation's citizens, this dire state of health continues.

Demographics

According to a recent IOM report the U.S. healthcare system is not prepared for the influx of baby boomers that will be entering the healthcare system. The current system is difficult to navigate there are issues with staffing ratios, mandatory overtime, bed closures and patient safety issues. The U.S. is experiencing a shortage of nurses, which are more severe in certain areas than others. The Department of Labor estimates that the number of vacancies for RNs will be 800,000 in 2020.

Nursing Shortage

The National Black Nurses Association was founded because of inequities in healthcare that existed. Healthcare disparities are not new to us. Black nurses are the pulse of the community and are confronted with the devastation of disparities in our communities on a daily basis. Out of 2.7 million nurses in the U.S., Black nurses represents 4.9%.

We are faced with barriers preventing minority students from being admitted to and completing nursing school. We must increase the pipeline of minority students. We cannot close the healthcare disparities gap without nurses. More efforts must be focused on workforce diversity and ensure that all areas of the healthcare delivery system are reflective of the populations served. This can be accomplished by ensuring that cultural competence is an integral component of curriculums. The lack of ethnic minority representation in the healthcare system limits a healthcare professional's access to those who may be able to provide information about the cultural groups they represent.

There are fundamental questions that remain unanswered that need to be addressed to reform the healthcare system if our Nation is to eliminate healthcare disparities:

- What is being done to expand health insurance coverage for the uninsured?
- How is the latest biomedical research and technology being used to help close the disparities gap?
- Why are African Americans less likely to get the expensive, newer treatments?
- How can more vigorous intervention research, occurring in clinical and community based settings, be funded to produce critical findings that underpin evidenced based practice?
- How will the education and training at health professions institutions help to improve the access, and quality of healthcare services to communities of color?
- What are the strategies to recruit and retain nurses and other health professionals to help reduce and eliminate healthcare disparities?
- Can a comprehensive health disparities bill like that introduced by Representative Elijah Cummings (D–MD) and other Members of Congress change our Nation's healthcare infrastructure to eliminate racial and ethnic healthcare disparities? Elements of such legislation seek to ensure quality healthcare; expand

access; strengthen accountability; implement the IOM study recommendations; enhance the Office of Minority Health, Office for Civil Rights and the National Center on Minority Health and Health Disparities; support and empower communities in their efforts to eliminate health disparities; improves workforce diversity; reduce diseases and related complications from HIV/AIDS to asthma; and improve racial, ethnic and primary language data collection, use and monitoring.

Thank you, Mr. Chairman, for the opportunity to present written testimony. The National Black Nurses Association and the 150,000 Black nurses we represent look forward to working with you on this issue in the future.

Statement of National Business Group on Health

The National Business Group on Health (The Business Group) commends the Congress for including a hearing on disparities in health and access to care as part of its ongoing health reform hearing series and thanks the Committee for the opportunity to submit this statement for the record.

Background:

The Business Group, representing over 300 large employers that provide health coverage to more than 55 million U.S. employees, retirees and their families, is the nation's only non-profit, membership organization devoted exclusively to finding innovative and forward-thinking solutions to large employers' most important healthcare and related benefits issues. Business Group members are primarily Fortune 500 and large public sector employers, with 63 members in the Fortune 100.

Starting in 2007, the Office of Minority Health (OMH) at the U.S. Department of Health and Human Services and the Business Group have agreed to co-sponsor the National Partnership for Action for Eliminating Racial and Ethnic Disparities in Health (NPA); a multi-faceted, national effort led by the OMH at the community, business, state, regional, and national levels.

The goal of the partnership is to reduce racial and ethnic disparities in healthcare by 1) improving employers' awareness of the causes and consequences of disparities, and 2) changing employers' healthcare purchasing strategies in health insurance, wellness programs, etc. to reduce the impact that racial and ethnic disparities have on employees' and employers' health and healthcare costs.

Overall Goal:

The National Business Group on Health supports the reduction and ultimate elimination of healthcare disparities among covered employees.

Problem:

Research has shown that disparities occur regardless of insurance status. A difference in the quality of healthcare resulting from disparities received by insured populations is a problem. Simply providing insurance for employees does not guarantee equitable healthcare will be provided.

Effect on Employers:

Aside from addressing healthcare disparities among employees because it is the right thing to do, employers recognize that healthy employees are the foundation for successful business. Improving and maintaining the health status of employees is essential to producing high-quality, goods and services, which, in turn increases shareholder value.

Solutions:

The National Business Group on Health/OMH partnership has created the Racial/Ethnic Health Disparities Advisory Board, whose subcommittees consisting of members from academia, business leaders, and experts in the field of healthcare disparities are responsible for defining elements of data collection, communication and the business case for addressing healthcare disparities.

Appropriate collection and utilization of racial and ethnic data to close the gaps in healthcare disparities is essential. Additionally, communicating data findings and health messages are key factors to reduce disparities. The Racial/Ethnic Health Disparities Advisory Board will be presenting strategies for addressing both of these factors to employers with an updated Analysis Paper of the business case for why employers should address healthcare disparities among their employees. We also support the current efforts of Congress to improve the ongoing data collection, measurement, and evaluation of healthcare disparities by the Federal Government.

A current survey by a Business Group member company found that employers are collecting race and ethnicity data as required under law and using this data to actively measure quality. Another Business Group member is using race and ethnicity data as evidence of corporate responsibility to its investors,[1] while others are using this data to highlight, and promote the diversity of their workforces.[2,3]

The National Committee for Quality Assurance (NCQA) is also leading efforts to reduce healthcare disparities through the Recognizing Innovation in Multicultural Healthcare award program to publicly recognize health plans that have implemented initiatives to ensure culturally and linguistically appropriate services and reduce healthcare disparities. In addition, the Health Research & Educational Trust has created a healthcare disparities toolkit with information on how to collect racial/ethnic data and how to use this data.

Again, the Business Group appreciates the opportunity to submit this statement for the record. As one of the largest purchasers of healthcare, large employers are often the driving force to change and improve our nation's healthcare system and can play a key role in the elimination of healthcare disparities. The National Business Group on Health looks forward to working with Members of the committee, the Congress and to continuing our existing partnership and collaboration with OMH to address the role of large employers in eliminating healthcare disparities and their repercussions on the health and well being of the American workforce.

Statement of National Council of Urban Indian Health

Introduction: On behalf of the National Council of Urban Indian Health (NCUIH), our 36 member clinics, and the 150,000 American Indian/Alaska Native patients that we serve annually, I would like to thank the Health Subcommittee for this opportunity to submit testimony on "Addressing Disparities in Health and Healthcare: Issues for Reform." The Native American community suffers the highest rates of health disparities of any minority group. Moreover, Congress has repeatedly recognized over the decades the staggering health disparities suffered by the First Americans. Congress was first horrified into action by these health disparities in 1927 when Congress passed the Snyder Act. In 1976 Congress renewed their dedication to end these disparities with the Indian Healthcare Improvement Act, and again in 1986 and in 1992. Now the Native American community waits for the House of Representatives to again renew their pledge to eradicate the alarming health disparities suffered by the Native American Community by passing H.R. 1328, the reauthorization of the Indian Healthcare Improvement Act. With all the legislation passed one would think that the health disparities and barriers to access suffered by American Indians and Alaska Natives would have been ended or at least ameliorated and yet these disparities persist.

Current Health Disparities Levels: Native Americans continue to face the highest levels of health disparities for all races combined. The infant mortality rate is 150% greater for Native Americans than that of Caucasian infants.[1] For a quick comparison, the rate of Sudden Infant Death Syndrome for Native American infants is the same as for infants in Haiti. American Indians and Alaska Natives are 2.6 times more likely to be diagnosed with diabetes than the general population.[2] Native Americans suffer higher mortality rates due to "accidents (38% higher than the general population rate), chronic liver disease and cirrhosis (126% higher), and diabetes (54% higher)."[3] Native peoples ages 15 to 34 constitute 64% of all suicides nationwide. American Indians and Alaska Natives are only 1% of the general population.[4] As a recent example, in the past 12 months there have been 213 suicide attempts on the Rosebud Sioux reservation. That is at least one suicide attempt a

[1] General Motors. 2005/06 Corporate Responsibility Report. 2006. Available at *http://www.gm.com/corporate/responsibility/reports/06/700—social/700—na.html#minhourly*; Verizon. Press Kits: Work Force Development. 2007. Available at *http://newscenter.verizon.com/kit/diversity/workforce.html*

[2] Wal-Mart. Employment and Diversity Fact Sheets. 2008. Available at *http://www.walmartfacts.com/FactSheets/*

[3] IBM. Workforce Diversity. Government Requirements. 2004. Available at *http://www.ibm.com/ibm/responsibility/people/diversity/government-requirements.shtml*.

[1] *Trends in Indian Health 2000–2001*, Indian Health Service, 2002.

[2] *Indian Healthcare Improvement Act Fact Sheet*, National Indian Health Board, 2008. *See also, Unnatural Causes: Is Inequality Making Us Sick?* PBS Documentary, 2008.

[3] *The Health Status of Urban American Indians and Alaska Natives*, Urban Indian Health Institute, 2004.

[4] 2006 National Survey on Drug Use and Health: National Findings

day. Alcohol-related deaths in general were 178% higher than the rate for all races combined.[5] Native Americans also have the fastest transition between diagnosis and death for HIV/AIDs and most forms of cancer.[6] Urban Indians share fully these health disparities as the 2000 U.S. Census found that over 60% of self-identified Native Americans live in urban areas.

These health disparities are the direct result of continuing social and economic inequality that lead to disparities in healthcare accessibility. The idea that health disparities are the direct result of health inequality is not a new idea[7] and in the Native American community its existence is well documented.[8] Lifting the Native American community out of the abyss of inequalities that impact their health and dramatically shorten their life requires Congress to stand by the treaty promises and the passed legislation. It requires addressing the chronic underfunding of IHS programs, the lack of culturally competent providers, and the poor social determinants of health. The following testimony will address each of these problems from the urban Indian provider prospective.

Lack of Funding: As this Subcommittee knows the Urban Indian Health Program has been under sustained attack from the Administration. The UIHP has been zeroed out of the President's proposed budget for FY 2009. This is the third attempt by the Bush Administration to eradicate the Urban Indian Health Program under the false assumption that the UIHP provides duplicitous services. This assumption not only ignores the trust responsibility of the Federal Government to provide healthcare to Native Americans regardless of where they reside[9], it also ignores the health inequalities suffered by AI/AN. Zeroing out the UIHP program would have a devastating impact not only on the 36 urban Indian clinics dedicated to serving urban Indians, it would also be extremely damaging to the Tribes as they would be the ones absorbing the nearly 200,000 patients served annually.

Fortuitously for the UIHP, Congress vehemently disagrees with the Administration's views and has rejected each and every attempt by the Administration to kill the program.[10] However, constantly fighting for even baseline funding necessary to maintain the clinics limits the UIHPs ability to expand services to meet the growing needs of the patient population—a population that is itself rapidly growing. Although urban Indian health clinics are able to leverage two non-IHS dollars for every IHS dollar received—making a program a very sound investment—the constant threat of elimination from the Bush Administration places the 36 clinics in a difficult situation. Clinics report that it is difficult to obtain necessary loans for facilities repair and expansion, that they have problems recruiting and retaining necessary personal, and that they are unable to expand programs needed by their patient population. Urban Indian health clinics have done impressive things with limited resources from significantly reducing the rates of diabetes in their patient populations to decreasing suicide attempts and relapse of addictive behaviors. However, these services are only the bare minimum of what the patient population needs and what the Urban Indian Health Program could provide if time, energy, and resources were not constantly drained by the need to fight the Administration's attack on the program's very existence.

It is difficult to determine whether or not the urban Indian health clinics reside in areas that follow the so-called 80–20 rule, which says that 80% of the medical costs for an area are driven by 20% of the population because the urban Indian population tends to be highly fluid, transitioning between reservation and urban centers with increasing frequency.[11] The UIHP does not have the funds to do an appropriate needs assessment study of this shifting population to even determine what needs are driving the costs. There hasn't been a needs assessment done for the urban Indian population since the early 1980s. The most recent estimates done by the Indian Health Service suggests that the urban Indian clinics are currently funded at 22% of the need, and that was the need rates calculated in 1981.

The most recent regulations promulgated by the Centers for Medicaid and Medicare services are also badly damaging to the financial security of the Urban Indian Health Program. As will be discussed in a later section, nearly one in four Indians living in urban centers live in poverty and nearly half live below the 200% of the

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[5] ibid

[6] fn 1.

[7] See Reducing Health Disparities, presentation by Dennis Raphael, PhD Dec 14th, 2006 http://video.google.com/videoplay?docid=-4129139685624192201&hl=en last accessed 6/23/2008.

[8] fn 2.

[9] Senate Report 100–508, Indian Healthcare Amendments of 1987, Sept. 14, 1988, p. 25.

[10] See House Report 109–46, House Report 110–187, and Senate Report 109–275.

[11] "[The] patterns of cross or circular migration on and off the reservations make it misleading to suggest that reservations and urban Indians are two well-defined groups," *United States v. Raszkiewicz*, 169 F.3w 459, 465—7th Cir. 1999.

Federal poverty level.[12] This means that the UIHP sees a high number of Medicaid patients. The patients are often what are classified as 'complex patients' meaning they suffer from chronic disease, and often multiple, co-morbid, chronic diseases.[13] The regulations on case-management and outpatient hospital services significantly undercut the financial stability of many urban Indian health clinics as States' limit services available in their State Medicaid plans.[14] Urban Indian health clinics are better able to weather the damage of these regulations than many other clinics, assuming that their base funding through IHS continues and is no longer under attack. However, the combined impact of these regulations and the attack on the UIHP funding by the Administration, if both are successful, would mean the complete shutdown of nearly all 36 clinics across the country, leaving the UIPH potential patient population of 939,588 Native Americans without primary care.

Recommendations:

- Restoration of the Urban Indian Health Program in the FY 2009 Budget, and continued funding of the program.[15]
- Repeal of the CMS regulations related to case management services[16] and redefinition of Medicaid outpatient hospital services.[17]
- Appropriate funds to conduct a full needs assessment for the urban Indian community.

Culturally Competent Care: One of the single largest barriers to care, and largest reasons for continuing health inequality, is the lack of culturally competent care available to not just Native Americans, but all minorities. Patients treated without necessary cultural sensitivity and understanding suffer worse health outcomes, are more likely to have a relapse, and more likely to have a serious medical crisis.[18] Culturally competent care is not a luxury, but a necessity if we are going to be serious about reducing the health disparities and health inequality faced by all minorities.

Cultural competency for Native Americans means the provider must not only be aware of the larger historical and cultural context of the patient, but also be aware of the specific culture of that patient's tribe. Each tribe has its own language and belief systems, which forms the structure of values within which the provider must be able to speak in order to achieve good health outcomes. Native American patients have a greater tendency to distrust non-Native providers as their history is replete with instances where the health provider has actually been the deliverer of illness and ultimately death.[19] Providers, when dealing with Native American patients, have consistently found that placing the needs of the patient in the framework of family needs and responsibilities, as opposed to individual needs, leads to greater compliance health and medicine regimens.[20]

Culturally competent care is one of the major reasons that the Urban Indian Health Program can not seriously be considered duplicitous with other Federal programs such as the Community Health Centers.[21] The Urban Indian Health Program is currently the only source of culturally sensitive care for Native Americans living in urban centers. However, the UIHP, like IHS as a whole, has difficulty finding healthcare providers with the appropriate cultural knowledge. The growing lack of primary care providers from obstetricians to RNs is well documented. What has not been well documented, or even significantly explored, is the lack of culturally competent health providers. Only recently have there been serious discussion regarding

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[12] fn 3.

[13] The general trifecta of chronic disease suffered by urban Indians is diabetes, heart disease, and hypertension. These three disease reinforce the symptoms and debilitating impact of the others. Fn 3.

[14] *See generally The Administration's Medicaid Regulations: State-by-State Impacts*. Committee on Oversight and Reform, March 2008.

[15] The suggested restoration level for UIHP in the FY 2009 budget is 40 million. *Views and Estimates*. Senate Committee on Indian Affairs. Febuary 2008.

[16] The case management regulation was published December 4, 2007 at 72 Federal Register 68007.

[17] The redefinition of outpatient hospital services was published September 22, 2008 at 73 Federal Register 9685.

[18] *See* fn 1.

[19] *Broken Promises: Evaluating the Native American Healthcare System.* Civil Rights Commission. 2004

[20] *Invisible Tribes: Urban Indians and Their Health in a Changing Worlds*. Urban Indian Health Commission. 2007

[21] The National Association of Community Health Clinics has consistently supported the Urban Indian Health Program, and have declared in Congressional testimony and letters of support.

paying for on-the-job training in cultural competency within CMS.[22] More important, from the perspective of NCUIH, are programs that encourage Native Americans and minorities to enter into the health professions. Not only enter into the health professions, but return to their communities to provider care.

Current proposed changes by the Health Resources and Services Administration (HRSA) to the classification and methodology of the health professional shortage areas (HPSA) and medically underserved areas/populations (MUA/P) are concerning as it could have an damaging impact on rural health providers and the providers with a largely minority patient populations. The proposed change to the classification and methodology does not include a calculation for determining the cultural competency of the providers available. Any potential change to the HPSA and MUA/P classifications must also include an analysis of the cultural competency of the health providers of that area for the patient population that they serve.

Recommendations:

- Increase the number of scholarships available to minority students that not only encourage them to enter into the health profession, but to return to their communities. Programs such as the Indian Health Professions Scholarships (P.L. 94–437, section 104), Indian health Service Loan Repayment Program (P.L. 94–437, section 108), and the Health Professions Recruitment Program for Indians (P.L. 94–437, section 102). It is not enough to simply encourage minority students to enter into the health professions; there must also be a financially viable way for them to return to their communities.
- Include cultural competency of health providers as a metric for determining classifications such as HPSA and MUA/P.
- Include cultural competency as a requirement for government health programs and grants, such as 330 CHC grants, SAMHSA provider grants, and similar programs.

Social Determinates of Health: As the health professionals become more alarmed at the growing and irrefutable health disparities between the general population and minorities, rich and poor, urban and rural, greater amounts of research have been dedicated to determining the social determinants of health. The results of this research are not surprising. Poverty, homelessness, social and physical isolation are all key indicators of health inequality. The differences between the general population and minorities, particularly Native Americans, in living conditions are directly linked in the extreme differences in health status. It is an enormous social injustice that those with the greatest living disparity also suffer the greatest health disparity. It is an even greater injustice when one realizes that the group living with the greatest disparities across the board from education, purchasing power parity, and health are the Native Americans.

Urban Indians suffer greater rates of poverty, homelessness, unemployment, and social isolation than the general population.[23] These disparities translate into health disparities that are difficult for any one provider, or set of providers, to seriously address.[24] Rather, in order for the underlying causes of the health disparities to be seriously addressed there must be a comprehensive rethinking of Federal health and social policy towards Native Americans. The clustering of disadvantage—meaning Native Americans suffer unemployment, poverty, poor housing, and poor health outcomes all at once—means that there must be a coherent attempt to address those problems as part of the continuum of inequality as opposed to approaching each problem individually.

From the health provider perspective this means transitioning from a medical crisis model of care to a wellness model of care that involving dealing not only with the immediate illness but also the underlying social causes. This would require a shift in Federal payment policy for programs such as Medicare and Medicaid from incremental payment scale to an episodic payment plan. It would also mean a focus on developing a medical home for the patients rather than the current split between primary care, specialty care, mental health, and social services. Developing a medical home means employing the 'medical pod' method organizing health professionals. These proposed changes are discussed below.

The current payment method under Medicaid and Medicare, unless the patient is considered a 'complex patient,' pays providers in 15 minute increments. Generally speaking those 15 minutes are 'sticky,' meaning that Medicaid and Medicare pay an

[22] There was very limited discussion regarding a potential payment code regarding culturally competent care.

[23] *See* fn 3, fn 20.

[24] *See generally* fn 7.

increasingly smaller percentage of the cost the longer the appointment takes. If a patient has been classified as a 'complex patient,' meaning that the patient has multiple conditions, or a complex chronic disease, then the entire episode of treatment is paid for. It is a good thing that CMS has moved towards a complex patient code, but if we are to be serious about reducing health disparities we want to address chronic disease and illness before the patient becomes diabetic, develops heart disease or hypertension. The National Council of Urban Indian Health would encourage broadening the complex patient code to include those who are in the preconditions for chronic disease. It is difficult, if not impossible, to explain the significant life style changes that must happen when someone is diagnosed as pre-diabetic in order to prevent the onset of diabetes in a single 15 minute appointment. Changing the patient codes to expand the definition of complex patient would give providers the necessary time with their at-risk patients before they become patients with chronic illness.

There has been a great deal of discussion regarding the development the medical home model of care within the United States. A medical home means that the patient receives all of their care except complex specialty care for advanced illness through a single provider. This model increases communication between the healthcare professionals involved in the patient's care, increases patient involvement, and increases compliance with the health regimen developed by the health professionals. When the medical pod method is employed in conjunction with medical home model social workers and similar professionals become involved in the care of patients, increasing their health outcomes. These professionals close the loop in patient care to ensure that the patient continues implementation of the health regimen outside the healthcare delivery setting. Social workers also bringing in the social aspects of health: unemployment, poverty, poor housing. Addressing these issues through the healthcare lens increases the likelihood the patient will have a good health outcome.

Recommendations:

- Broaden the definition of 'complex patient' for Medicaid and Medicare payment codes.
- Encourage the transition to a medical home by allowing billing of social services and case management to Medicaid and Medicare.
- Encourage the use of the 'medical pod' method of care.

Statement of Papa Ola Lokahi

Aloha Chairman Stark and Members of the Subcommittee on Health. Thank you for the opportunity to provide a statement on addressing the on-going and increasing health disparities which our nation's population is experiencing. My name is Hardy Spoehr, Executive Director of Papa Ola Lokahi (POL), the Native Hawaiian Health Board. My comments will be primarily focused on health disparities in the Native Hawaiian population.

Native Hawaiians, like American Indians and Alaska Natives, are Indigenous Peoples of the United States. The Native Hawaiian population comprises a little over 400,000 people with the majority still being resident in the State of Hawai'i. It is important to note, however, that today Native Hawaiians live in every state of the nation. The 2000 Census identified:

Where Native Hawaiians Live

State of Hawai'i	**Number**	**Percent**
County of Kaua'i	13,511	
City and County of Honolulu	153,117	
County of Hawai'i	43,010	
County of Kaua'i	30,017	
Total, State of Hawai'i	**239,655**	61%
Continental United States		
(by HRSA Region)		
Southwest Region (excluding Hawai'i)	85,754	
Northwest Region	42,247	
Southeast Region	18,258	
Northeast Region	15,248	
Total, Continental U.S.	**161,507**	39%
Total, Native Hawaiians	***401,162***	100%

Source: 2000 U.S. Census

The top ten Congressional Districts with Native Hawaiian residents are:

Hawai'i—2nd District	162,128	Washington—9th District	2,521
Hawai'i—1st District	77,527	Washington—6th District	2,237
Nevada—1st District	3,464	California—7th District	2,045
Nevada—3rd District	3,451	California—10th District	1,957
California—13th District	2,972	Alaska—0 District	1,878

Source: 2000 U.S. Census

Health Disparities and Native Hawaiians

Native Hawaiians along with other Pacific Islanders are identified by the U.S. Census Bureau as one of six racial and/or ethnic populations within the United States. These designations are in federal statutes and Executive Branch policy directives and serve as a basis for relative socio-economic comparisons in the United States. These comparisons also influence funding levels for various federal programs targeting socio-economic disparities in and among the various populations. As a specific population, Native Hawaiians have serious health disparities which trace their root causes back to times of contact with foreigners during the 18th and 19th centuries. The severity of these disparities continues and have been enumerated in proposed reauthorization legislation for the Native Hawaiian Healthcare Improvement Act.

In a study by Johnson, Oyama, and Le Marchand entitled "Hawaiian Health Update" (1998) and funded by POL, five major findings were identified which remain valid today:

1. That when reviewing the mortality trends since 1910, Native Hawaiians have experienced the highest mortality rates of any ethnic group in Hawai'i and have had among the lowest life expectancy of all groups in the population.
2. That Native Hawaiian life expectancy at birth has ranged from five to ten years less than the overall population average.
3. That Native Hawaiians have higher age-adjusted morbidity rates for hypertension, asthma, diabetes and heart conditions than the total population.
4. That the "years of productive life lost" by Native Hawaiians is the highest of any ethnic group in Hawai'i.
5. That cancer mortality rates for Native Hawaiians, particularly females, are among the highest in the United States. Death rates for Native Hawaiian women are 70% higher than for all women in Hawaii.

The extent of health disparities is clearly evident in Hawai'i State health data which, it is assumed, is similar for Native Hawaiians living on the Continental United states.

Underlying Causes of Death in Hawai`i
2004 Resident Deaths by Ethnicity of Decedent
(age-adjusted rates/100,000) Source: DOH – Hirokawa,R 5/2006

Cause of Death	Native Hawaiians	Total State Population	
Cancer	**218.3**	**145.4**	50% ↑
Diabetes Mellitus	28.9	13.2	119% ↑
Heart disease	305.5	164.3	86% ↑
Cerebrovascular Dz	75.6	46.0	64% ↑
Other Circulatory diseases (incl: HPT and atherosclerosis)	20.6	14.1	46% ↑
Chronic Lower Resp Dz	31.6	20.8	52% ↑
Nephritis, Nephrotic Syn and Nephrosis	26.9	11.2	140% ↑

Higher than Total State

Prevalence of Risk Factors

Risk Factor	Native Hawaiians		Total State
Cigarette Smoking^**	33.8	61%↑	21.0
Diabetes^**	7.2	24%↑	5.8
Overweight (25<=BMI<30)**	38.1	6%	36.0
Obese (BMI>=30)**	37.5	119%↑	17.1
Hypertension^	15.0	13%↑	13.3
High Cholesterol^	12.2	9%↓	13.3

^2001 HHS Data Report – Papa Ola Lōkahi
** 2002 BRFSS Data – Department of Health

In general, the current status of Native Hawaiian health can be summarized in five major points:

1. There is a general lack of awareness nationally about Native Hawaiians and Native Hawaiian health status and related issues.

2. There is indifference by the general Hawai'i population to Native Hawaiian health.
3. There is a general lack of acceptance of Native Hawaiian-specific data among federal agencies in the national arena where resources are allocated.
4. There is a general lack of cultural competency and understanding of Native Hawaiians in the providing of healthcare services, teaching and education, and in conducting research.
5. There is under representation of Native Hawaiians in health, allied-health, and research professions.

Data is critical to determining how best to move in the future. A number of federal agencies have not fully implemented the reporting requirements mandated by Office of management and Budget in 1998 and continue to use an antiquated 'Asian Pacific Islander' (API) or 'Asian American Pacific Islander' (AAPI) identifier instead of the required disaggregated 'A' (Asian), 'AA' (Asian American) and 'NHOPI' (Native Hawaiian and Other Pacific Islander) or "NHPI" identifiers. The result is that often in national health studies and reports, the national health status trends, or health profiles, for Native Hawaiians and other Pacific Islanders is not apparent because it is masked by the larger Asian component.

Papa Ola Lokahi strongly recommends that the Congress reviews the untimely implementation of Office of Management and Budget (OMB) policy and clearly states that health and related data needs to be collected, analyzed, and reported in accordance with OMB Circulars and Directives including its "revisions to the standards for classification for Federal data on race and ethnicity," dated October 30, 1997, and codified as 62 FR 58782–58790; its Bulletin No. 00–02 dated March 9, 2000; its Working Group Report dated December 15, 2000; and its memorandum for the President's Management Council dated January 20, 2006, entitled "Guidance on Agency Survey and Standardized Information Collections." All of these have to do with collecting and reporting data specifically for Native Hawaiians and other Pacific Islanders.

Additionally, Papa Ola Lokahi through its years of operations in Hawai'i and across the nation commends to the Congress its findings:

1. There is no "one-size-fits-all" model for healthcare delivery—each community has its own priorities and ways of doing things. This is applicable to Native Hawaiians living in Hawai'i and to Native Hawaiian and Pacific Islander communities spread across the Continental United States.
2. The health programs that are working in Native Hawaiian communities need to be highlighted, replicated and built upon for continued success.
3. Traditional Native Hawaiian healing and spirituality must be integral components of any major effort to address Native Hawaiian health.
4. Research must be respectful of Native Hawaiian ways and customs.
5. Disease prevention focused on individual responsibility needs to be emphasized in any health program.
6. Physicians, more specifically Native Hawaiian physicians, need to be involved in program development and community interventions.
7. Native Hawaiians who participate in data collection and analysis feel they are part of making the Native Hawaiian community as a whole healthier.
8. When working with Native Hawaiian individuals, health providers need to utilize the strengths of the family—a multi-generational approach.
9. Service providers working in Native Hawaiian communities need to utilize mentors and role models to educate communities and professionals alike.
10. The academic approach to research is often incompatible with Native Hawaiian community approaches and desires.
11. A major effort needs to continue to increase the number of Native Hawaiian health researchers and health and allied-health professionals.
12. An Institutional Review Board (IRB) model controlled by the community in which research is being conducted is an excellent model and tool for monitoring research and ensuring that there is a definable community benefit.

Mahalo for the opportunity to provide these thoughts for consideration.

Statement of Special Olympics International

Testimony on Behalf of Special Olympics

As Senior Vice President of Special Olympics International, I, Stephen B. Corbin, submit this written testimony on behalf of Special Olympics International, to the

record of the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health's hearing of June 10, 2008, "Addressing Disparities in Health and Healthcare: Issues for Reform." Special Olympics provides year-round sports training and athletic competition in a variety of Olympic-type sports for children and adults with intellectual disabilities, giving them continuing opportunities to develop physical fitness, demonstrate courage, experience joy and participate in a sharing of gifts, skills and friendship with their families, other Special Olympics' athletes and the community. Last year, almost 550,000 athletes with intellectual disabilities participated in 20,000 sports competitions across the United States—an average of almost 28 events per day. What began as a sports movement for individuals with intellectual disabilities has evolved into a worldwide movement to improve the health and quality of life of individuals with intellectual disabilities through sports competition and related programs such as our Healthy Athletes Program.

Health issues are of particular concern for those we serve. Like race, ethnic origin, and gender, intellectual disabilities are a life-long phenomenon accompanied by significant health disparities across the lifespan. Similarly, like other members of groups who face health inequity and health disparities, both access to healthcare and quality healthcare are significant issues for individuals with intellectual disabilities. For example, only 1 in 50 primary care physicians has received clinical training to qualify to properly treat the more than 6 million individuals with intellectual disabilities in the United States. Complicating the matter further, there is no reliable source for people with intellectual disabilities and their families to find qualified healthcare providers who are willing to treat their special needs. Few health practitioners want to "deal" with individuals with intellectual disabilities. As a result, when they are able to find healthcare providers willing to see them, the quality of care provided to people with intellectual disabilities is often inferior and inconsistent.

Our research shows that individuals with intellectual disabilities in the United States have poorer health, more specialized healthcare needs, and greater difficulty accessing healthcare services and doctors. For example, in 2006, at the U.S. National Games in Iowa, 1337 Special Olympic Athletes were screened through our Healthy Athletes program. More than 53% of our athletes failed hearing tests. Almost 50% failed vision screenings and were given prescription glasses onsite. Twenty-three percent (23%) were overweight in addition to the 36% who were obese. More than 20% had untreated tooth decay and 38% had diseases of the gums. Some 34% had osteoporosis screenings that indicated a need for further examination.

Though routinely denied access to healthcare, the population of individuals with intellectual disabilities is excluded from current policies that cover the "medically underserved" in the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and other United States Government programs. Individuals with disabilities are not only underserved, they are ill-served. They do not even receive the same benefits, research dollars, and government attention as other individuals who face disparate treatment based on race, gender, and ethnic origin.

Special Olympics has documented that health equity and health status disparities are significant issues for individuals with intellectual disabilities. This Committee can have a dramatic impact as it seeks ways to address disparities in health and healthcare and looks at health disparities as an issue for future healthcare reform. We urge the Committee to: include individuals with intellectual disabilities amongst those with documented disparities in health and access to healthcare; include them amongst the "medically underserved;" and include the health and healthcare needs of individuals with intellectual disabilities in discussions of all aspects of health disparities.

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