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Congressional Testimony
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Committee on Energy and Commerce
U.S. House of Representatives

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

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

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

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

NMA Has Always Been Concerned About Disparities

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

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

Early Advocate for Medicare

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

The National Health Disparities Report

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

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

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

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

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

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

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

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

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

The following data should raise an appropriate alarm:

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

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

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

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

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

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

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

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

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

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

H.R. 3014 AND RELATED LEGISLATION

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

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

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

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

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

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

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

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

Taking the Long View

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

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

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

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