Testimony of
Majority Whip James E. Clyburn
before the Health Subcommittee of the
House Energy and Commerce Committee
HR3014 the Health Equity and Accountability Act of 2007.
June 24, 2008

Good morning,

I want to offer my sincerely thanks to Chairman Pallone and Ranking member Nathan Deal for allowing me to testify in strong support of HR3014 the Health Equity And Accountability Act of 2007. I also want to acknowledge the tireless work of our Congressional Tri-caucus in particular the health chairs Representatives Donna Christensen, Hilda Solis, and Madeleine Bordallo.

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

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

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

Consider this statistics:

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

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

- These differences could be attributed to delaying care: 32% of Latinas and 32% of African American women report delaying or foregoing care in the past year, as

did 15% of white women. Women report several reasons for delaying care, including cost, lack of insurance, and competing family or work responsibilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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