

**Testimony before the
House Committee on Energy and Commerce
Subcommittee on Health**

H.R. 3014, Health Equity and Accountability Act of 2007

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

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

The point I would like to emphasize today is that efforts to improve the health of minorities will be most successful when they target the factors associated with socioeconomic disadvantage that predispose individuals to poor health and suboptimal care.¹ Such disadvantage is not limited to racial or ethnic groups.

Before turning to practical interventions that can be deployed within the health care domain – and, indeed, there are many -- it is important to acknowledge that the clinical setting represents only one of many realms that contributes to health. This recognition helps frame reasonable expectations of interventions that originate at the level of the healthcare system.

Socioeconomic Basis of Health – “Upstream” Factors

In a larger, social context it appears that educational attainment is one of the strongest predictors, if not the strongest predictor, of adult health.² Failure to complete high school in the United States is associated with a considerably higher likelihood of developing many chronic diseases before the age of 65 years.³

Why does education create most of the association between higher social status and higher health status? The mechanisms are complex and not fully understood but scholars generally believe that good education enables children to develop self-control, problem-solving dispositions, and not least, a sense of future. As adults, those who are well-educated feel more in control of their lives; they have more opportunities to obtain decent

jobs, jobs with health benefits, more autonomy, and financial security to help cushion setbacks. They are better informed about health matters (including new technological innovations) and tend to have a more positive view of the benefits of such interventions. Also, better educated individuals tend to be part of social networks that reinforce their healthy life styles norms.

The elements of “social capital” briefly summarized above serve to motivate individuals to invest in themselves (e.g., to refrain from smoking and excessive alcohol consumption, to exercise, observe diet, make use of preventive and primary care, consume care in a timely manner, and so on. And the healthier people they are, the more energetically they can advance occupationally; the less likely they are to suffer depression). Thus, the benefits of early education are all encompassing and cumulative.⁴

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

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

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

Facilitating Engagement

Establish continuity of care with same provider - Patients who see the same doctor from visit to visit have the opportunity to establish a rapport with him or her (which, in turn, will lead to better adherence with treatment regimen and conscientiousness about self-care).⁵

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

Expand the average length of the doctor visit – Doctors must be able to spend sufficient time with each patient – more than the standard fifteen minutes, at least – in order to

elicit patients' concerns (including complaints about side-effects), needs, values, and preferences.

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

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

Cultural sensibility - Practical accommodations can help health providers care for low-income patients of any race or group. These include translation services and education of medical staff about local anthropology such as healing customs, dietary patterns, and commonly used remedies.

Take the example of black pediatrician Lynn Smitherman and colleagues, who wrote a 2005 paper in *Pediatrics* entitled, "Use of Folk Remedies Among Children in an Urban Black Community: Remedies for Fever, Colic and Teething." On a radio show she explained that she wrote the paper because she hadn't heard of any of the remedies—her mother and grandmother did not use any of these treatments with her when she was a child—and assumed that many of her colleagues might not be familiar with them either.¹

The importance of local customs was made compellingly clear in an account of the ... Perhaps one of the most compelling ethnographic accounts of the diabetes epidemic in East Harlem, New York City (Spanish Harlem) that appeared in the *New York Times* ("Living at the Epicenter of Diabetes – Defiance and Despair," January 10, 2006). Similarly, many black trainees or physicians may not be any more aware of certain folk beliefs than whites.¹

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

The reporter quotes a resident of East Harlem saying:

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

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

Finally, the mere grind of being poor, the overwhelming personal and family and occupational problems, the social disruption and instability, and the lack of safety nets, pushes self-care into the background. The importance of watching one’s diet, exercising, checking blood glucose, quitting smoking or drinking, is surpassed by more pressing daily realities. Add to this a higher likelihood of clinical depression, demoralization, and stress in this group and the risk of non-adherence multiplies.⁶

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

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

Foster health literacy to facilitate adherence with treatment and to facilitate patient self-management and sense of control– A patient’s accurate understanding of the nature of his illness and the purpose of various therapies and, perhaps most important, some sense of control over his condition, is essential to self-care and treatment adherence. An important new study from an economist at Columbia University documented that differences in patient self-management trigger a racial mortality gap even when access and treatment for chronic heart failure are equalized. The authors estimate that targeting compliance patterns could reduce the black-white mortality gap by at least two-thirds.⁷

It is important to assume a balance and avoid putting all the emphasis on the clinician. As Theodore Pincus, professor of medicine at Vanderbilt University and expert in rheumatoid disease, has noted, “Emphasis on the predominant role of health professionals rather than patient actions in health outcomes may also distract from powerful health-promoting activities.”⁸ He describes a self-help course for patients with rheumatoid arthritis that led to a reduction in pain and physician visits, resulting in savings that were 10 times the cost of the course. The patients' improved sense of control over their illness through self-management rather than knowledge or changes in behavior explains the improved outcomes. “Patient education programs directed at reduction of feelings of helplessness and improved self-efficacy may result in considerably greater cost containment and better outcomes in chronic diseases than do current efforts to restrict medications and visits to specialists,” he writes.

Common Sense Local Innovations – Consider other meaningful interventions:

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

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

Again, it is vital that healthcare systems have the flexibility to respond to the patients they serve. The National Association of Community Health Centers, for instance, offers examples of innovations, including collaboration between a community health center and a local YWCA in Massachusetts which enabled patients with diabetes to exercise (with resultant improvement in diabetic control).⁹

Conclusion

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

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

¹ For a comprehensive review, see Jonathan Klick and Sally Satel, *The Health Disparities Myth* (Washington, DC: AEI Press, 2006). Online at http://www.aei.org/books/bookID.847/book_detail.asp.

² Angus Deaton, “Policy Implications of the Gradient of Health and Wealth,” *Health Affairs*, vol. 21, no. 2 (March/April 2002), pp. 13-30.

³ Theodore Pincus et al, “Social Conditions and Self-Management Are More Powerful Determinants of Health than Access to Care,” *Annals of Internal Medicine*, vol. 129, issue 5 (September 1998), pp. 406-411. Online at <http://www.annals.org/cgi/content/full/129/5/406>.

⁴ John W. Lynch et al, “Cumulative Impact of Sustained Economic Hardship on Physical, Cognitive, Psychological, and Social Functioning,” *New England Journal of Medicine*, vol. 337, no. 26 (December 1997), pp. 1889-1895. For a good summary, see Barak D. Richman, “Behavioral Economics and Health Policy: Understanding Medicaid’s Failure,” *Cornell Law Review*, vol. 90, no. 3 (2005).

⁵ Chanita H. Halbert et al, "Racial Differences in Trust in Health Care Providers," *Archives of Internal Medicine*, vol. 166, no. 8 (April 2006), pp. 896-901.

⁶ Bruce S. McEwen BS and Teresa Seeman, "Protective and damaging effects of mediators of stress," in Nancy Adler et al, eds., *Socioeconomic Status and Health in Industrial Nations: Social, Psychological, and Biological Pathways* (New York: New York Academy of Science, 1999).

⁷ Emilia Simeonova, "Doctors, Patients, and the Racial Mortality Gap: What Are the Causes?" Columbia University working paper, November 2007. Online at <http://www.columbia.edu/~es2085/research/jmpaper.pdf>.

⁸ Pincus, et al.

⁹ National Association of Community Health Centers, "Studies on Health Centers and Disparities," May 2008. Online at

http://www.nachc.com/client/documents/HC_Disparities_Studies_5.08.pdf, http://www.nachc.com/client/documents/H C_Disparities_Studies_5.08.pdf