

**A RECOMMENDATION REPORT FROM
THE HHS ADVISORY COMMITTEE ON MINORITY HEALTH (ACMH)**

**A Federal Health Equity Commission
Will Promote the Public's Health and
Ensure Health Equity in Health Care Reform**

**A Statement of Principles and
Recommendations**

March 2010

Submitted to

**U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Office of Minority Health**



**A FEDERAL HEALTH EQUITY COMMISSION WILL PROMOTE THE
PUBLIC'S HEALTH AND ENSURE HEALTH EQUITY IN HEALTH CARE
REFORM**

**A STATEMENT OF PRINCIPLES AND RECOMMENDATIONS
U.S. Department of Health and Human Services
Advisory Committee on Minority Health (ACMH)**

Submitted

**Through
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To
Kathleen Sebelius, Secretary,
U.S. Department of Health and Human Services**

March 2010

Advisory Committee on Minority Health: Section 1707 of the Public Health Service Act, as amended, by the Minority Health and Health Disparities Research and Education Act of 2000, P. L. 106-525 authorizes the establishment of an Advisory Committee on Minority Health. The Committee also is governed by provisions of Public Law 92-463, as amended (5 U.S.C. Appendix 2), which sets forth standards for the formation and use of advisory committees. The Act directs the Advisory Committee on Minority Health to advise the HHS, through the Deputy Assistant Secretary for Minority Health, on improving the health of racial and ethnic minorities and on the development of the program activities of the Office of Minority Health.

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EXECUTIVE SUMMARY

The Advisory Committee on Minority Health (ACMH) urgently recommends that the President and Congress take steps to establish a ***Federal Health Equity Commission (FHEC) that will focus on eliminating health disparities and achieving health equity for all. The FHEC will provide the national focus and authority necessary to achieve sustainable progress toward achieving these two goals critical to preserving our nation's health and security.***

In accordance with Dr. Martin Luther King's acute observation that injustice in health is the most shocking and most inhumane inequality, the FHEC will effectively (1) elevate health disparities issues to the status of civil rights concerns, (2) recognize that all US residents have the right to an equal opportunity for a healthy life and to equitable treatment by the US health care system, and (3) establish health equity as the standard for personal and public health.

The FHEC will ensure that the main indicators of health care reform success be defined by how well the reformed health care system responds to the health needs of the least visible and influential, improves the health of minority and vulnerable communities, eliminates health disparities, and achieves health equity for all.

The ACMH recommends the following criteria for establishing the Federal Health Equity Commission:

- Federal Health Equity Commission will be comprised of seven members who will serve four year staggered terms. Each commissioner will be appointed by the president, and subject to Senate confirmation. As a prerequisite, commission members will have extensive health equity and health disparities experience and expertise.
- The FHEC director and general counsel will be career Senior Executive Service positions. The FHEC director will be provided with adequate funding and staff.
- The FHEC will investigate and monitor the progress of health equity and the elimination of health disparities, and whether equal opportunity for a healthy life exists or is restricted/limited/constrained. The Commission will have effective authority to call upon any agency of the executive branch for assistance.
- The FHEC will have the authority to hold hearings across the country to assess how much progress has been made in achieving health equity and eliminating health disparities, and in providing all minority and vulnerable populations with equal opportunities to live a healthy life.
- The FHEC will have enforcement authority, similar to those mechanisms currently identified in Title VI, to direct federal grants and contracts to be contingent and comply with relevant standards/requirements associated with a commitment to eliminate health disparities and achieve health equity.

The ACMH also notes that health insurance reform is necessary, but it is not sufficient to eliminate health disparities, and urges that the FY2011 federal budget provide substantial support for health equity including strong support for critical functions implementing the reauthorized Office of Minority Health, and expanded funding for community- and prevention-oriented programs.

I. Context for Second 2009 Report of the Advisory Committee on Minority Health

In preparing this Second Report to the Secretary of Health and Human Services (HHS), the HHS Advisory Committee on Minority Health (ACMH) is keenly aware that present public debate, media coverage, and federal legislative activity concerning health reform have yet to focus on the impact of reform on this nation's minority and other vulnerable communities. Since 1998, the ACMH has endeavored to carry out its charge to advise "the Secretary on ways to improve the health of racial and ethnic minority populations, and on the development of goals and program activities within the Department."

With this important charge and the newly passed health reform legislation in mind, the ACMH again insists that the quality and success of health reform initiative must be measured and assessed by more substantive measures in addition to increased access to insurance and improved financing or cost control. ***The most important indicators of health reform success must consider how well the reformed US health care system responds to the health needs of the least visible and influential in our society, improves the health of minority and vulnerable communities, and eliminates health disparities.***

This Committee's First 2009 Report to the Secretary proposed 14 Principles for Minority Health Equity in Health Care Reform to ensure that the legislative and administrative processes would meet the health care needs of minority communities by creating the impetus and infrastructure to eliminate health disparities.¹ Noting that the US history of intractable health inequities requires systematic vigilance/oversight, and corrective action, the Committee also proposed three overarching recommendations to ensure ongoing application of the Minority Health Equity in Health Care Reform Principles:

- The Administration and the Congress shall take steps to develop and establish a Federal Health Equity Commission (akin to the Federal Civil Rights Commission) that will focus on eliminating health disparities in the US. The Health Equity Commission will provide the stature necessary to begin to achieve sustained progress toward the elimination of health disparities/inequities.
- In the meantime, all health care reform commissions, committees, and working groups – whether federal or state or local governmental and legislative, public or private think-tank/NGO, must take steps to include sub-committees that address health disparities/inequities, minority health equity, and workforce diversity. It is equally important that these entities take meaningful steps to ensure diversity reflective of communities served in their leadership, membership, and staffing.
- The 14 Principles for including Minority Health Equity in Health Care Reform should be thoroughly addressed in writing by all entities noted above. These reports must be delivered to the HHS Secretary and the Federal Health Equity Commission if such entities receive public funding or support.

This Second ACMH Report proposes an expanded delineation of authority for the FHEC, its establishment is based on an informed operational framework that was previously recommended to ensure the elimination of health disparities.

We recommend and urge that the Federal Health Equity Commission be created to assume the legal authority, as well as becoming the nonpartisan leader and integrator, for strategies and initiatives to promote and achieve health equity in the US. The FHEC will provide the national focus necessary for sustainable progress toward achieving two goals – eliminating health disparities and achieving health equity – that are critical to preserving the US health and security.

The Federal Health Equity Commission would catalyze and facilitate fundamental change in the US paradigm by defining what it means to be healthy, and how health is attained and maintained. Given the mounting and compelling evidence that a wide range of socioeconomic factors determine health status (i.e., the social determinants of health SDOH), the FHEC could marshal the interdisciplinary resources and the collaboration across sectors and jurisdictions necessary to achieve health equity for all.

The FHEC would lead concerted efforts on fundamental health equity issues such as (1) the importance of prevention and primary care to health promotion, (2) the need to create health-producing communities and equal opportunities for healthy lives, and (3) the critical role of cultural competency in ensuring that all communities benefit equally from the US health care system.

This Report offers an organizational and operational framework for the FHEC, and provides specific guidance for creating the FHEC including: (1) seven members who will serve four-year staggered terms, be appointed by the president, and be subject to Senate confirmation; (2) authority to hold hearings and seek support from federal agencies; (3) authority to enforce compliance with health equity standards; (4) capacity to establish standards for eliminating health disparities and achieving health equity; and (5) capacity to lead and catalyze all federal level work on health.

The ACMH emphasizes that health insurance reform is necessary but not sufficient to achieve minority health equity. ***Consequently this Report also highlights critical issues related to equitable funding in the FY2011 federal budget and in the health care reform bill.*** These issues include: (1) increased funding for public health, community health, and special populations; (2) increasing funding for OMH and NCMHD; and (3) increased funding for health services research focused on eliminating health disparities in the US health care system and assessing reform efforts using health equity measures.

Lastly, this Report acknowledges the important work of the Federal Interagency Management Team (FIMT) that includes all departments relevant to the social determinants of health such as transportation, housing and urban development, veteran affairs, education, agricultural, commerce, and labor, and the environmental protection agency. The FIMT should strengthen and coordinate with FHEC all federal leadership to achieve health equity, as well as support the work of the FHEC on a wide range of health disparities issues. The FIMT should maintain

representative, meaningful, and responsive consultation with all minority, vulnerable, and marginalized communities comparable to the existing consultation protocols currently in place at HHS.

II. Protecting the Public's Health Requires a Federal Health Equity Commission

In its July 2009 Recommendation Report to the HHS Secretary, ACMH urgently recommended the creation of the FHEC, citing the long US history of health disparities, the lack of effective strategies to ameliorate these disparities, and recent compelling evidence that health disparities are worsening.

As understanding of the current health care reform legislation evolve, ACMH notes that present public debate, media coverage, and federal legislative activities concerning health care reform have yet to focus on the impact of health care reform on this nation's minority and other vulnerable communities.

Given the very troubling absence of minority health and health disparities awareness, this Second ACMH Report again urgently recommends creation of the FHEC, and proposes that it assume expanded authority to lead strategic efforts and initiatives to promote and achieve health equity for all US residents. Pervasive challenges to health equity, quality, and safety for minority communities demand national policy leadership.

In accordance with Dr. Martin Luther King's piercing observation that injustice in health is the most shocking and most inhumane inequality, FHEC would effectively (1) elevate health disparities to the status of civil rights concerns, (2) recognize that all US residents have the right to an equal opportunity for a healthy life and to equitable treatment in the US health care system, and (3) establish health equity as a quality measure for personal and public health applicable to all health care systems.

In this section, we briefly summarize the need for the FHEC as outlined in the July 2009 Report as well as the proposed scope of the FHEC authority and activities. We then highlight a few structural and operational considerations for the FHEC.

US Health Disparities and Inequities are Pervasive, Persistent, Growing, Deadly

Health and health care disparities have disproportionately affected minority communities across the US health care system. Despite the 2003 Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, and the issuance of numerous and compelling reports on health disparities by other prestigious entities, the 2008 National Healthcare Disparities Report shows that gaps in health status remain the same or are worsening with severe consequences.² Minority communities (i.e., Blacks, Hispanics, American Indians/ Alaskan Natives, some Asian Americans and Native Hawaiians and Other Pacific Islanders) continue to be vulnerable communities that are disproportionately poorer, uninsured or underinsured.³ Minority communities continue to disproportionately experience higher morbidity and mortality rates for disabling chronic diseases such as diabetes, kidney disease, heart disease,

and cancer.⁴ A recent analysis of 1991 to 2000 mortality data concluded that, if mortality rates of African Americans had been equivalent to those of whites in this time period, then approximately 886,000 deaths would have been averted.⁵ Minority communities are disproportionately affected by conditions adverse to health including living in unhealthy environments with fewer health care facilities and health care professionals and less emphasis on wellness.⁶

Even with the increased attention and advances in the quality of care, hundreds of studies have documented substantial gaps in the US health care system in access, quality of care and health outcomes by race, ethnicity, socioeconomic status, and gender.⁷ Notable examples include surgical outcomes, access to ambulatory services, and outcomes for heart disease and certain cancers.⁸ African-American women are 67 percent more likely to die when diagnosed with breast cancer.⁹ Hispanics with HIV are almost 30 percent less likely to receive protease inhibitors during treatment;¹⁰ poor individuals score lower on 11 of the 17 core measures of quality care than high-income individuals;¹¹ African Americans wait two times as long for kidney transplantation;¹² women are less likely to receive evidence-based testing and treatment for heart disease than men.¹³

Asian American and Pacific Islander women have low rates of cancer screening including mammograms and Pap tests. According to Kagawa-Singer and Pourat (2000), in the US, 26% of Chinese, 21% of Japanese, 28% of Filipinos, 50% of Koreans, and 68% of Asian Indians (all over the age of forty) had never had a mammogram. Twenty percent of Asian American women over the age of eighteen have never had a Pap test, and among those who have, one out of seven has not had the test within the past three years.¹⁴ When mortality rates are used as the indicator of health outcomes, American Indians and Alaska Natives face a disadvantage relative to Whites at each stage of the life span, with persistent disparities in infant mortality, life expectancy, and mortality from a variety of conditions including chronic diseases.¹⁵

Even when care is received, minority status is a harbinger for patient safety related to communications concerns. Despite Title VI requirements,¹⁶ language differences between patients and their health care providers continue to impede health care delivery to many minority patients because appropriate language interpreter services are not available. Untrained, *ad hoc*, or lack of language interpreter services for minorities with limited English proficiency has resulted in an average of 31 mistakes per visit among these patients.¹⁷ Extensive research has shown that the delivery health care services associated with life threatening conditions such as asthma, diabetes, and hypertension is often misunderstood by minority patients.¹⁸

FHEC Will Demand and Catalyze National Action to Eliminate Health Disparities

The FHEC will be a catalyst, as was the Civil Rights Commission in the civil rights movement, for concerted mobilization of resources to achieve governmental regulations and policies to eliminate health disparities. The FHEC will provide the ongoing opportunity for re-examining the standards that govern federal financial assistance to

health care entities and health programs. New standards can incorporate requirements comparable for compliance with Title IV civil rights mandates.

The FHEC will provide needed leadership for developing a legal and policy framework for expediting progress toward eliminating health disparities. This framework will aim to achieve health equity as well as health care reform by focusing upon community, public health, prevention-oriented, environmentally-sensitive strategies to eliminate health disparities through recognition that problems associated with health disparities are local, and do not confine themselves to a single discipline. Health reform premised on health equity principles can contribute to both the health of minority communities and the health of the nation by promoting more K-12 science programs in minority-populated areas to lay the foundation for an increasingly diverse health care workforce.¹⁹

The FHEC will participate in designing and implementing strategic policies fundamental to eliminating health disparities such as (1) the importance of prevention and primary care to health promotion, (2) the need to create health-producing communities and equal opportunities for healthy lives, and (3) the critical role of cultural competency in ensuring that all communities benefit equally from the US health care system.

The FHEC will also catalyze fundamental change in the US paradigm by defining what it is means to be healthy, and how health is attained and maintained. Given the mounting and compelling evidence that a wide range of socioeconomic factors determine health status, the FHEC will marshal the interdisciplinary resources and the collaboration necessary across sectors and jurisdictions to eliminate finally health disparities.

FHEC Will Elevate Social Determinants of Health as Critical to Health Status

The need to recognize and understand the link between the social determinants of health (SDOH) and health status/health disparities in minority and vulnerable populations is increasingly well-accepted in academic, research, policy, and legislative circles.²⁰ Consensus among leading researchers, policymakers, and public health officials around the world has been coalescing that eliminating health disparities requires addressing the SDOH as well as ensuring access to quality medical care services. Policies and organizational practices that improve the environments in which people live, work, learn, and play are powerful tools in reducing disparities and improving the social and economic contexts that shape health.²¹

The World Health Organization (WHO) Commission on Social Determinants of Health underscored the urgent need for ameliorative action on health equity issues in their landmark 2008 Report. As the WHO notes: “[I]nequities in health [and] avoidable health inequalities arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.....Social justice is a matter of life and death.”²²

The WHO Commission found that the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life.

The WHO concluded that: “This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries.”²³

FHEC Will Catalyze National & State Leadership Needed to Achieve Health Equity

The Federal Health Equity Commission will ensure that social and economic inequities among racial, ethnic, and other marginalized groups, as well as the inequities in access and quality experienced by these groups in the US health care system, are recognized as a key, significant underlying factor behind most health status inequities.²⁴ Racial, ethnic, and financial discrimination and segregation perpetuate and deepen these gaps. The evidence is growing and compelling in support of the trenchant observation that “the most important number for assessing a US resident’s health status is that person’s zip code.”²⁵ A comprehensive health care reform plan must address these social and environmental factors, and hold accountable providers who do not reach a level of care that takes into account patient characteristics and communications effectiveness.²⁶ The cumulative consequences of the status quo will be unhealthy behaviors and unsafe living environments with continued poor health outcomes and higher costs.²⁷

The FHEC expanded vision in this report will specifically accomplish the following:²⁸

- Establish a national commitment to eliminate health inequities for minority communities (i.e., Blacks, Hispanics, American Indians/ Alaskan Natives, some Asian Americans, and Native Hawaiians and Other Pacific Islanders) and to recognize the right to equal opportunity for a healthy life for all minority and vulnerable communities and elevate health equity to the level of civil rights concerns.
- Create a vital platform for action by acknowledging the problem of health inequity, by ensuring that health inequity is measured and monitored.
- Lead and coordinate public efforts to establish health equity surveillance systems for routine measuring and monitoring of health inequity and the social determinants of health.

- Act as a resource for legislators, public officials and policymakers to promote policy addressing health inequities and evaluate the health equity impact of legislation, policies, regulations, and programs.
- Establish and enforce health equity standards for measuring, monitoring, evaluating and correcting progress toward achieving health equity for all US residents.

The need for this level of overarching leadership is evident in a recent report by EuroHealthNet, and the International Union on Health Promotion and Education (IUHPE) that identified six priority areas for capacity-building to address the SDOH and to improve health equity.²⁹ IUHPE officials note that: “Achieving equal opportunities for health and strong health outcomes for everyone in society, and leveling up the health gradient is an ambitious and complex goal that requires knowledge and action in a wide range of areas. This goal cannot be achieved by the health sector alone, but is a shared responsibility across sectors and involves building partnerships and capacities at the organizational level and across government.” Capacity building must go beyond simply training or providing technical assistance and must involve assisting people to gain the knowledge and experience that is needed to solve problems, implement change, build effective actions and reach sustainability.³⁰

US Civil Rights Commission Lessons Learned for FHEC Structure and Authority

Given the position of the Advisory Committee on Minority Health that health equity must be viewed within the established bundle of civil rights, guidance from the history and experiences of the US Civil Rights Commission (CRC) may be beneficial.³¹ The March 2009 report – ***Restoring the Conscience of the Nation*** - assessed the history of the Civil Rights Commission, the Commission’s current status, and the implications for the Commission’s reauthorization.³²

The summary description in ***Restoring the Conscience of the Nation*** of the CRC suggests potential parallels with the proposed FHEC role and authority vis-à-vis health equity. Established by the Civil Rights Act of 1957, the bipartisan, independent Civil Rights Commission initially investigated and documented attempts to prevent access to the voting booth. The CRC eventually had three primary goals: (1) to gather facts that would lay the foundation for civil rights legislation; (2) to stimulate action by Congress and the executive branch; and (3) to shine a spotlight on discrimination and segregation across the country. The Commission served as the “conscience of the nation,” supplying the Civil Rights Division in the Department of Justice with the evidence to justify use of federal enforcement to protect civil rights.

Restoring the Conscience of the Nation also examined the CRC’s recent history of inaction and partisanship and its current structure as well as assessed the CRC’s capacity to carry out its mission, and made several specific recommendations designed to reinstate and reinvigorate the Commission’s stature and authority to provide critically needed leadership on civil rights.³³

Guided by these recommendations, the ACMH offers the following recommendations for establishing the Federal Health Equity Commission:

- FHEC will have seven members who will serve four year staggered terms. Each commissioner will be appointed by the president, and subject to Senate confirmation. As a group, the Commissioners will have recognized expertise in and personal experience with a) racial and ethnic health disparities, b) health care needs of vulnerable and marginalized populations, and c) health equity as a vehicle for improving health status and health outcomes. The Commission will have effective authority to call upon any agency of the executive branch for assistance.
- The FHEC staff director and general counsel will be career Senior Executive Service positions. The FHEC director will be provided with an adequate funding and staff. The FHEC staff will have recognized expertise in and personal experience with a) racial and ethnic health disparities, b) health care needs of vulnerable and marginalized populations, and c) health equity as a vehicle for improving health status and health outcomes.
- The FHEC will have the following ex-officio members to ensure coordination, collaboration, and integration with the federal executive branch: Director of the Office of Minority Health, Director of the National Center for Minority Health and Health Disparities (Institute for Minority Health and Health Disparities), Chair of the Federal Interagency Management Team, and Chair of the Advisory Committee on Minority Health.
- A health equity rights unit will be created as part of the Government Accountability Office to focus on monitoring federal agency compliance with and enforcement of federal health equity rights.
- The FHEC will investigate and monitor progress toward health equity and the elimination of health disparities, and whether equal opportunities to live a healthy life are restricted/limited/constrained based on health history, insurance claims history, race, national origin, religion, gender, age, disability, income, SES class, sexual orientation, or gender identity.
- The FHEC will have the authority to hold hearings across the country to better understand the landscape of progress toward health equity and the elimination of health disparities, and the status of equal opportunity to live a healthy life in various regions of the country for all minority and vulnerable populations. Based on these hearings, and other information, the FHEC will have the responsibility to make policy recommendations to the President and Congress. The FHEC will retain the authority to subpoena witnesses to participate in such hearings.

- The FHEC will have enforcement authority, similar to those mechanisms currently identified in Title VI, to mandate that all federal grants and contracts be contingent on compliance with requirements dictated by a commitment to eliminate health disparities and achieve health equity

III. Equitable Funding in Federal Budget and Equity in Health Care Reform Bill

The continuing lack of adequate federal funding to support strategies to promote public health and eliminate health disparities highlights the need for public leadership, such as the FHEC. This concern is extant in the federal FY2010 budget and in the passed health reform bill. Prevention and wellness commitments must be strengthened in health care reform with a particular emphasis on primary care and preventable chronic diseases. The importance of equity in access and availability vis-à-vis public health services cannot be overstated. Community health funding must be a part of all federal expenditures, and include comprehensive approaches and investments into public health and addressing health disparities including how to accomplish language outreach and access for communities of color and for the vulnerable.

Critical provisions have been outlined in the health care reform bill that could begin to build the basis for achieving equity at a policy level. These provisions include, but are not limited to the following.

- The Reauthorization of the Office of Minority Health. By reauthorizing and expanding its function with appropriate levels of support, OMH ensures that there is a national plan of action to eliminate disparities and achieve health equity.
- The health disparity provisions within the health care reform bill that (1) expand prevention and wellness activities, (2) strengthen and diversify the health care workforce, (3) support community programs and community health workers, (4) implement quality assurance mechanisms including language access services, and (5) mandate the disaggregation of data by race and ethnicity.
- The Reauthorization of the Indian Health Care Improvement Act. By making this law permanent, Congress demonstrates honoring its trust responsibility to Tribes regarding health care and continues to support Tribal leaders directing the delivery of health care services to Indian people.

Substantially increased resources for the OMH and the NCMHHD are urgently needed. The high costs associated with health disparities and health inequities justify and demand increased resources for NCMHHD and OMH – less than 1% of NIH budget is allocated to agencies to address health disparities issues. Given this history, ACMH strongly supports implementing the NCMHD to an Institute status and expanded funding. Moreover, the new Institute on Minority Health and Health Disparities must be funded and authorized to develop, direct, and execute a coordinated national research strategy on health disparities and health equity.

A critical priority for such a coordinated national strategy is as noted above: measuring, monitoring, and assessing the impact and consequences of efforts to improve the current reality of poor public health and health disparities. But as an equally important responsibility, this strategy must consistently address health care reform and its impact upon communities of color and the vulnerable now and in the future. This work must be designed to assess implications for these communities, but in addition, the implications, challenges, and barriers to providers serving these communities. By elevation to a national institute, the NCMHHD can implement a coordinated strategy to establish standards for research quality and comprehensiveness to ensure that health services and health policy researchers investigate the fundamental roles played by SDOH and health equity in health outcomes, health status, health care provisions, and equitable access to quality health care services.

The strategy can also serve as an important proving ground to critically examine comparative effectiveness research (CER) as a key tool in evaluating minority health issues. Without more, and given the lack of data on minority populations, current conceptions of CER could inadvertently overlook or shortchange minority community assessment efforts. The coordinated national strategy can highlight specific data needs and include revisiting morbidity and mortality data collection issues to ensure that social behavioral health issues and SDOH outcomes are included. Further, through a national institute and grant processes, study design and implementation to ensure cultural competency and inclusion of minority communities can occur. Such efforts can create a standard of CER that appropriately and adequately ensures that race and ethnicity become routine characteristics to be studied and assessed.

Finally, with respect to funding of providers who represent the sharp end of public health and disparities in minority and vulnerable communities, a substantial increase in funding for the National Health Service Corps must be established to support health care professionals who commit to (1) careers in primary care and family practice, (2) practicing in poor, underserved, vulnerable, and minority communities, and (3) careers in policy and research focused on eliminating health disparities and achieving/promoting health equity. Such an increase would represent a meaningful budget expression of commitment to eliminating health disparities.

IV. Federal Interagency Management Team Will Be a Critical Partner for FHEC

ACMH acknowledges the important work of the Federal Interagency Management Team (FIMT). Acting as operational arm of the National Partnership for Action to End Health Disparities (NPA), ACMH strongly recommends that the FIMT have the authority to ensure that all federal agencies effectively pursue the common goal and priority for health equity.

ACMH recommends that the FIMT:

- Emphasize the multi-dimensional and multi-sector partnerships to address elimination of health disparities and promotion of health equity. Because racial,

ethnic, and financial segregation and inequality are the foundation for inequitable health care in the US, FIMT must promote the goal to break down silos of federal departments with responsibilities that bear on wide range of SDOH and social determinants of health equity.

- Be the primary point of coordination, support, communication, policy and legislation development, legal and moral enforcement, etc. between the executive branch and the FHEC.
- Begin to address the critical reality that the federal government is not equipped to deal with, and indeed will not become equipped to deal with public health emergencies that pose fundamental threats to homeland security (e.g., H1N1/A) unless/until substantial progress is achieved toward eliminating health disparities and achieving health equity.³⁴
- Adopt the existing consultation protocols currently in place at HHS as the framework to maintain representative, meaningful, and responsive consultation with all minority, vulnerable, and marginalized communities. This approach will also catalyze this standard of representation on key commissions, boards and other groups created by health reform legislation and thereby involve these communities in implementing policies and strategies to eliminate health disparities.³⁵
- Provide a critical forum for national health care leaders, particularly those from safety net organizations who have long advocated for considering and acting upon all areas that contribute to addressing particular health and health care issues through the development and management of community partnerships that extend beyond personal health care services.³⁶ This approach has led to substantial improvements in health status for the vulnerable populations.
- Ensure that cultural competency be understood as an overarching approach to access and services delivery that benefits all citizens, as well as an important opportunity to address behavioral health issues and emergency response as significant and critical unmet needs for minority communities, since communities of color experience disproportionate rates of depression, substance abuse, etc. as well as stigma of seeking assistance.³⁷ These causal factors include 1) differences in insurance coverage and sources of coverage, 2) the inequitable distribution of health care resources and 3) aspects of the clinical encounter, including cultural and linguistic barriers in health care systems and the interaction of patients and providers
- Ensure that health care providers establish cultural competency as an essential skill set necessary to promote health care quality. Note also that FIMT can support health care reform goals of an overarching commitment to cultural competency to ensure quality and safety in health care for all populations using standard evidence-based principles. Health services research designs

assessing impact of health care reform must account for cultural competency issues such as the use of alternative treatments and traditional healing practices.

V. Conclusion

In its July 2009 Report, the ACMH urgently recommended the creation of a Federal Health Equity Commission citing the long US history of health disparities, the lack of effective strategies to ameliorate these disparities, and compelling evidence that health disparities are worsening.³⁸ Given the very troubling lack of visibility of minority health and health disparities issues during the 2009 health care reform debates, the ACMH again urges creation of a FHEC with broad authority for eliminating health disparities and achieving health equity. The FHEC must also have enforcement authority to mandate that all federal grants and contracts funding be contingent on compliance with new health equity standards comparable to current Title VI mechanisms.

The FHEC will also ensure that the quality and success of health reform initiatives, now and in the future, are assessed by indicators that consider how well the reformed delivery system responds to the health needs of the least visible and influential in our society, improves the health of minority and vulnerable communities, and eliminates health disparities. This assessment will include the challenges of public health emergencies and disasters that pose threats to homeland security.

Endnotes

¹ US Department of Health and Human Services Advisory Committee on Minority Health ***Ensuring that Health Care Reform Will Meet the Health Care Needs of Minority Communities and Eliminate Health Disparities A Statement of Principles and Recommendations***. July 2009.
http://minorityhealth.hhs.gov/Assets/pdf/Checked/1/ACMH_HealthCareAccessReport.pdf

² 2008 National Healthcare Disparities Report (NHDR). Agency for Healthcare Research and Quality At pages 7-8 Magnitude and Patterns of Disparities Differ Among Various Populations Improvements in preventive care, chronic care, and access to care have led to the elimination of disparities for some priority populations in areas such as mammograms, smoking cessation counseling, and appropriate timing of antibiotics. ***At the same time, many of the largest disparities have not changed significantly. The 2008 NHDR demonstrates/reports that the biggest gaps in health care quality for Blacks, Asians, AI/ANs, Hispanics, and poor populations that were reported in the 2005 NHDR continue to be the biggest gaps more than three years later in 2008. The 2008 NHDR can be used to identify the most important gaps in care as well as improvements for priority populations. For Blacks and Asians, 60% of the core measures used to track access remained unchanged (gap stayed the same) or got worse (gap increased). For Hispanics, 80% of core access measures remained unchanged or got worse. For poor populations, 57% of core access measures remained unchanged or got worse.***

The complete picture of disparities is different for each population. An analysis of each population allows targeting of resources and efforts to improve care and narrow the gaps in care for racial and ethnic minorities and poor populations. For Blacks, large disparities remain in new AIDS cases despite significant decreases. The proportion of new AIDS cases was 9.4 times as high for Blacks as for Whites. Hospital admissions for lower extremity amputations in patients with diabetes and lack of prenatal care for pregnant women in the first trimester are the largest disparities for Blacks observed in the 2008 NHDR.

For Asians, disparities remain in timeliness of care. Asians were more likely than Whites to not get care for illness or injury as soon as wanted. For AI/ANs, disparities remain in prenatal care. AI/AN women were twice as likely to lack prenatal care as White women. Also, AI/AN adults were less likely than Whites to receive colorectal cancer screening. For Hispanics, large disparities also remain in new AIDS cases despite significant decreases. The rate of new AIDS cases was more than three times as high for Hispanics as for non Hispanic Whites. For poor people, disparities remain in communication with health care providers. The percentage of children whose parents reported communication problems with their health providers was nearly four times as high for poor children as for high income children. Poor adults were also more than twice as likely not to get timely care for an illness or injury.

The “biggest gaps” are defined as those quality measures with the largest relative rates between Whites and racial and ethnic minorities and between high income and poor individuals. For example, a relative rate of 4.0 means that this population was four times as likely as the White population to be hospitalized for pediatric asthma. This analysis is presented in Table H.1.”

³ Ibid.1 Pages 14-15. Financing and reimbursement policies must redirect resources to minority and vulnerable communities who have always experienced a disproportionate lack of access to the health care system and disproportionately poor health status. Communities of color experience significant disparities relative to whites in both coverage and access. These growing gaps are not unexpected given that the increase in the numbers of the uninsured has been more dramatic in communities of color than in nonminority communities. The crisis of health insurance disproportionately hurts low-income families and communities of color in no small part because health insurance in the United States remains linked to employment. Higher-paying jobs tend to offer more comprehensive health benefit packages, while lower-paying jobs – jobs disproportionately occupied by people of color – tend to offer only limited health benefits, if offered at all, that are often accompanied by high cost-sharing arrangements with employees. The Kaiser Family Foundation 2009 Update State Health Facts/Key Health and Health Care Indicators by Race/Ethnicity and State shows the glaring/breathtaking health disparities for minority populations for infant mortality rates, diabetes-related mortality rates, annual AIDS case rate, percent living in poverty, and percent uninsured.

See also: Addressing Racial and Ethnic Health Care Disparities Testimony to the House Energy and Commerce Committee, Health Subcommittee Brian D. Smedley, PhD. Health Policy Institute Joint Center for Political and Economic Studies. The Kaiser Family Foundation 2009 Update State Health Facts/Key Health and Health Care Indicators by Race/Ethnicity and State, April <http://www.kff.org/minorityhealth/upload/7633-02.pdf>. James C, Thomas M, Garfield R, and Lillie-Blanton M. *Key Facts: Race, Ethnicity & Medical Care*. Kaiser Family Foundation, January 2007. Institute of Medicine *Hidden Costs Values Lost Uninsurance in America* Washington DC National Academy Press 2003. *The Society and Population Health Reader: Volume I Income Inequality and Health* Eds. Kawachi, I., Kennedy, BP, Wilkinson, RG. The New Press New York City. 1999.

⁴ James C, Thomas M, Garfield R, and Lillie-Blanton M. *Key Facts: Race, Ethnicity & Medical Care*. Kaiser Family Foundation, January 2007.

⁵ Woolf SH, Johnson RE, Fryer GE, Rust G, and Satcher D. 2004. The health impact of resolving racial disparities: An analysis of US mortality data. *American Journal of Public Health*, 94(12): 2078-2081.

⁶ US Commission on Civil Rights Briefing on Health Disparities June 12, 2009 Testimony by Rubens J. Pamies, M.D., FACP Vice Chancellor of Academic Affairs, Dean of Graduate Studies, & Professor of Internal Medicine University of Nebraska Medical Center, Omaha, Nebraska.

⁷ Prevention Institute and The Joint Center for Political and Economics Studies Health Policy Institute. *Reducing Inequities in Health and Safety through Prevention* March 2009.

http://preventioninstitute.org/documents/HealthEquityMemo_031709.pdf Every year, hundreds of thousands of people die in the United States from preventable illnesses and injuries. These illnesses and injuries disproportionately impact communities of color and lower wealth communities.¹⁰ Low-income populations and people of color do not experience different injuries and illnesses than the rest of the population; they suffer from the same injuries and illnesses, only more frequently and severely. For example:

- Compared to Whites, American Indians and Alaska Natives are 2.3 times more likely to have diagnosed diabetes, African Americans are 2.2 times more likely, and Latinos are 1.6 times more likely.
- Among African Americans between the ages of 10 and 24, homicide is the leading cause of death. In the same age range, homicide is the second leading cause of death for Hispanics, and the third leading cause of death for American Indians, Alaska Natives, and Asian/Pacific Islanders.
- Homicide rates among non-Hispanic, African-American males 10-24 years of age (58.3 per 100,000) exceed those of Hispanic males (20.9 per 100,000) and non-Hispanic, White males in the same age group (3.3 per 100,000).
- Native Americans have a motor vehicle death rate that is more than 1.5 times greater than Whites, Latinos, Asian/Pacific Islanders, and African Americans.
- Poverty is associated with risk factors for chronic health conditions, and low-income adults report multiple serious health conditions more often than those with higher incomes.
- The average annual incidence of end-stage kidney disease in minority zip codes was nearly twice as high as in non-minority zip codes.
- Premature death rates from cardiovascular disease (i.e., between the ages of 5 and 64) were substantially higher in minority zip codes than in non-minority zip codes.
- Education correlates strongly with health. Among adults over age 25, 5.8% of college graduates, 11% of those with some college, 13.9% of high school graduates, and 25.7% of those with less than a high school education report being in poor or fair health.

⁸ Agency for Healthcare Research and Quality. *National Healthcare Disparities Report, 2008*. Rockville, MD.

⁹ Joslyn S & West M. Racial Differences in Breast Carcinoma Survival. *Cancer*, 88(1): 114-123, 2000.

¹⁰ Stone V, Steger KA, Hirschhorn LR, Boswell SL, et al. *Access to treatment with protease inhibitor (PI) containing regimens: is it equal for all? Int Conf AIDS*, 12: 834, 1999.

¹¹ Ibid.8.

¹² Louis O, Sankar P, Ubel P. *Kidney Transplant Candidates' Views of the Transplant Allocation System*. *J Gen Intern Med*, 12(8): 478-484, 1997.

¹³ Kim C, Hofer TP, Kerr EA. Review of evidence and explanations for suboptimal screening and treatment of dyslipidemia in women: a conceptual model. *J Gen Intern Med*, 18: 854-63, 2003.

¹⁴ Tanjasiri, SP, and Nguyen, T. "The Health of Women" in *Asian American Communities and Health*. Eds. Trinh-Shevrin, C, Islam, NS. Rey, MJ. Jossey-Bass, 2009, p. 143.

¹⁵ Trends in Indian Health 1998-1999. Available at: <http://www.ihs.gov/PublicInfo/Publications/index.asp> 2005.

¹⁶ Language barriers should not be a problem in receiving/providing appropriate health care due to requirements under Title VI of the 1964 Civil Rights Act as well as in a Presidential Executive Order, which indicates the federal requirement that patients needing language interpreter services are entitled to one during their health care visit without cost to them. See Liang BA. Limited English and Health Proficiency: A Call for Action to Promote Patient Safety for Vulnerable Populations. *J Patient Safety*; 2007;3(1):3-5. Glasser BL, Liang BA. Hearing without

understanding: A proposal to modify federal translation guidelines to improve health care for citizens with limited English proficiency. *J Health Law*. 2002;35(4):467-492.

¹⁷ 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.

¹⁸ Williams MV, Baker DW, Parker RM, Nurss JR. Relationship of functional health literacy to patients' knowledge of their chronic disease: A study of patients with hypertension or diabetes. *Arch Int Med*. 1998;158:166-72.

Patients with limited English proficiency have tremendous problems accessing appropriate and effective medications, understanding medication instructions, and recognizing medication side effects Liang BA. Patient safety and the drug benefit: Reducing the risk of medication errors. In: *Proceedings of the Mini-Conference on Health Literacy and Health Disparities*. White House Conference on Aging, Chicago, IL: American Medical Association & BlueCross BlueShield Association, July 21, 2005: 28-32. Andruilis DP, Goodman N, Pryor C. *What a Difference an Interpreter Can Make*. Boston: The Access Project, April 2002.

The problems of not having access to trained language interpreters and of experiencing health care with limited English proficiency have been and will likely be even more problematic in the near and long term. This is likely to be the case because of the increasing number of Americans who do not speak English or who do not speak English well enough to communicate effectively with their providers. According to the 2003 U.S. census, over 47 million adults (approximately 14% of the U.S. population) speak a language other than English at home. Furthermore, English literacy in the U.S. is an issue affecting all groups; yet, minorities bear the brunt of this issue. According to the National Adult Literacy Survey (NALS), 15% of whites, but 35% of Asian Pacific Islanders and 52% of Latinos reach only NALS level 1; that is, they cannot enter background information on a Social Security application, cannot find an intersection on a street map, and cannot locate two pieces of information in a sports article. US Census Bureau. *The Foreign-Born Population in the United States: 2003*. Washington, DC: US Department of Commerce, Economics and Statistics Administration; 2004. Kirsch I, Jungeblut A, Jenkins L, et al. *Adult Literacy in America: A First Look at the Results of the National Adult Literacy Survey*. Washington, DC: National Center for Education Statistics, US Department of Education; 1993.

¹⁹US Commission on Civil Rights Briefing on Health Disparities, June 12, 2009, Testimony by Rubens J. Pamies, M.D., FACP Vice Chancellor of Academic Affairs, Dean of Graduate Studies, & Professor of Internal Medicine University of Nebraska Medical Center, Omaha, Nebraska.

²⁰ US Department of Health and Human Services *Call to action: Eliminating Racial and Ethnic Disparities in Health*, 1998. Schulz, A. et al. Racial and Spatial Relations as Fundamental Determinants of Health in Detroit. *The Milbank Quarterly*, 80(4):677-707, 2002. Marmot, M. Social determinants of health inequalities. *Lancet* 2005; 365:1099-1104.

²¹ Prevention Institute <http://preventioninstitute.org/healthdis.html>, Health Equity and Community Health, 2009.

²² World Health Organization Commission on the Social Determinants of Health. (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*, Final Report of the Commission on Social Determinants of Health, available at http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

²³ Ibid.

²⁴ Addressing Racial and Ethnic Health Care Disparities, March 24, 2009, Testimony to the House Energy and Commerce Committee, Health Subcommittee, Brian D. Smedley, PhD, Director, Health Policy Institute, Joint Center for Political and Economic Studies, Washington, DC.

²⁵ *UNNATURAL CAUSES: Is Inequality Making Us Sick?* 2008 <http://newsreel.org/nav/title.asp?tc=CN0212>
California Newsreel <http://newsreel.org/main.asp>.

²⁶ This may be accomplished through using the federal Hospital Compare scores for patient experiences in hospitals. See, e.g., Bryan A. Liang, *Report Cards Key to Health Reform*, SAN DIEGO UNION TRIBUNE, November 19, 2009, at B7 (indicating patient safety is a matter of patient respect and calling upon federal program participation by facilities based on patient experience and communications scores).

²⁷ Ibid.7.

²⁸ Ibid.22. These recommended areas of leadership for the FHEC are adapted from recommendations outlined by the WHO Commission on the Social Determinants in their 2008 report that they deemed necessary to catalyze global action.

²⁹ *Capacity Building - Awareness Raising Actions To address the social determinants of health and to improve health equity 2009* <http://www.health-inequalities.eu/pdf.php?id=68410efc3dbc18f8b1a0ea0e5e1fa4ef>.

³⁰ Ibid.

³¹ The ACMH gratefully acknowledges Deborah A. Reid, JD, Senior Attorney, National Health Law Program in Washington, DC who generously shared her time and expertise. Ms. Reid spent 10 years as senior staff for the US Civil Rights Commission and brought ***Restoring the Conscience of a Nation: A Report on the U.S. Commission on Civil Rights*** to the attention of the ACMH.

³² LeRoy, Catherine. ***Restoring the Conscience of a Nation: A Report on the U.S. Commission on Civil Rights*** Leadership Conference on Civil Rights Education Fund Civil Rights Enforcement Project, March 2009. <http://www.civilrights.org>

³³ Ibid. pages 43-45.

³⁴ ***Integrating Culturally Diverse Communities into Public Health Emergency Preparedness: State of the Nation and Future Directions***. Presentation to Advisory Committee on Minority Health by Dr. Dennis Andrus, Director, Center for Health Equity, Associate Dean for Research, School of Public Health, Drexel University, November 27, 2007.

With support from the Office of Minority Health, Center for Health Equity is developing a web-based National Resource Center on Advancing Emergency Preparedness for Culturally Diverse Communities focused on public health emergency preparedness for culturally diverse communities. The National Resource Center will serve as a comprehensive online database of resources and an information exchange portal to facilitate communication, networking and collaboration in the field. It will feature hundreds of annotated and cross-referenced resources, including but not limited to those that highlight promising and best practices, successful programs, research, training and education curriculum, measurement and evaluation tools and effective emergency risk communication strategies. News, updates and events within the field will also be featured. <http://www.diversitypreparedness.org>.

That the health and well-being of citizens is an important assurance/component of national security is not a new policy. See **RICHARD B. RUSSELL NATIONAL SCHOOL LUNCH ACT** enacted in 1945 and signed into law by President Truman. [As Amended Through P.L. 110–246, Effective October 1, 2008] Quoting from the Preamble: “AN ACT To provide assistance to the States in the establishment, maintenance, operation, and expansion of school lunch programs, and for other purposes. Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, §42 U.S.C. 1751 (That this Act may be cited as the “Richard B. Russell National School Lunch Act”). DECLARATION OF POLICY SEC. 2. §42 U.S.C. 1751 ***It is hereby declared to be the policy of Congress, as a measure of national security, to safeguard the health and well-being of the Nation’s children*** and to encourage the domestic consumption of nutritious agricultural commodities and other food, by assisting the States, through grants-in-aid and other means, in providing an adequate supply of foods and other facilities for the establishment, maintenance, operation, and expansion of nonprofit school lunch programs.”

³⁵ For example, in his Executive Order 13175, President Obama directed the Secretary of HHS to consult with Tribes on health reform policies and regulations. This approach confirms that engaging knowledgeable leaders from the minority and vulnerable communities before policy approaches are evaluated, refined and implemented will ensure that the potential of health care reform to improve the health of all US residents will be achieved.

³⁶ Paul J. Boubulian, S. Sue Pickens, Ron J. Anderson, *Managing the In-Between through Servant Leadership, Building Leadership Bridges 2004*; editors: Nancy S. Huber and J. Thomas Wren, International Leadership Association, 2004.

³⁷ US Department of Health and Human Services Advisory Committee on Minority Health. ***Reducing Health Disparities by Promoting Patient-Centered Culturally and Linguistically Sensitive/Competent Health Care***, submitted to U.S. Department of Health and Human Services Office of Minority Health, Washington, DC; September 8, 2008. Ibid. 1 pages 11-13.

³⁸ Ibid.1 pages 1-4, pages 21-25.