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**Congressional Testimony**  
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**Committee on Ways and Means**  
**U.S. House of Representatives**

**Addressing Disparities in Health and Healthcare: Issues for Reform**

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

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

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

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

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

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

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

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

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

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

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

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

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

- Among Blacks (12% of the general population), 57% were privately insured, 18% were on Medicaid/public programs, and 26% were uninsured (*Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis, March 2007*);
- Among adults aged 19-64 who are uninsured:
  - 54% reported no regular source of care
  - 26% postponed seeking care due to cost
  - 23% needed care but did not get it
  - 23% could not afford prescription drugs (*Kaiser Commission on Medicaid and the Uninsured analysis of 2006 NHIS data*).

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

The following data should raise an appropriate alarm:

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

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

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

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

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

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

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

- In 2004, Black physicians made up **3.3%** (30,598) of physician population;
- The overwhelming majority of physicians graduating from U.S. allopathic medical schools are White. Blacks, Hispanics/Latinos, and Native Americans comprise only 6.4% of all physicians graduating from U.S. allopathic medical schools;

- Diversity in the physician workforce contributes to increased access to health care for the underserved, increased satisfaction in patient care, and expanded options for patient care (*American Medical Colleges Diversity in the Physician Workforce: Facts & Figures 2006*).

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

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

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

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

### **Taking the Long View**

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

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

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

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