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**Testimony to the Subcommittee on Health in the House Ways and Means
Committee on
Addressing Disparities in Health and Healthcare:
*Issues for Reform***

**By Congresswoman Donna Christensen
Tuesday, June 10, 2008**

Thank you very much, Chairman Rangel and Mr. Stark, and ranking member Mr. Camp for holding this historic and critically important hearing on an issue of grave concern. I also want to thank my colleague, Congresswoman Stephanie Tubbs Jones, for her leadership – as a member of this subcommittee – on health disparity elimination.

My colleagues and I in the TriCaucus have been seeking a hearing on this issue for a long, long time, and our expectations were heightened when Democrats came back into the majority. Today this important Subcommittee has answered our call and the call of millions of people of color, those in rural America and the territories who bear a disproportionate burden of disease.

Issues of health disparities have loosely come up during past hearings held by this committee, but to the best of my knowledge, this is the first Health Subcommittee hearing focusing solely on health disparities.

On behalf of my colleagues in the Congressional Black Caucus and joining those in the TriCaucus and the millions of racial and ethnic minorities who are in poorer health and have worse health care because of these disparities, I sincerely thank and applaud you!

As a physician and as the Chair of the Congressional Black Caucus Health Braintrust, I am encouraged by the fact that lawmakers, on both sides of the aisle and in both chambers, are engaging in thoughtful discussions about health care reform and widely recognize the need for it. In this regard, the most pressing point I want to leave

with this Subcommittee today is that health disparity elimination must be an integral component of – and **not** an accessory to – the dialogue and resulting legislative solutions.

Contrary to the belief of many who resist the ideas of addressing anything that has to do with racial and ethnic health disparities, their elimination is not only about improving the health of these groups. Because our health and the kinds of health care we often have to seek late in illnesses for which we often have no coverage or ability to pay, health disparities affect the quality of healthcare of everyone else, as was clearly demonstrated in a series of reports from the Institute of Medicine a few years ago.

The elimination of health disparities would also finally raise the shameful health standing of this rich and technologically advanced country vis a vis the other nations of the world. In fact, we rank 41st in the world in terms of maternal mortality and despite having more neonatologists and neonatal intensive care beds per person than Australia, Canada and the United Kingdom, our infant mortality rate is higher than any of those countries and that of some others considered undeveloped.

A major factor leading to our lower health rankings is our failure to close the gaps in health care and health outcomes that have a disproportionate and detrimental impact on African Americans and other racial and ethnic minorities, as well as on rural populations. For example:

- the African-American infant mortality rate is more than twice that of whites, even when comparing women of similar socioeconomic status; and
- African-American women are nearly four times more likely than white women to die during childbirth or from pregnancy complications.

This and other similarly alarming statistics have existed for far too long and this Democratic-led Congress needs to take steps now to end these tragic gaps once and for all! This hearing is a good first step; passing the disparity provisions of CHAMP would be another.

Health or the lack of it does not exist in a vacuum. The lack of universal coverage is a known major driver in the health disparities we see today. So, too, are the social determinants of health -- race and ethnicity, gender, geography, the built and natural environment, education, discrimination and others which numerous studies confirm have a direct and indirect impact on the health and well being of millions of Americans. Therefore, reforming the healthcare system is not enough. We must also fix the social and physical environments which fuel and support their continued existence.

And because this is also clearly a justice issue, we must also ensure that efforts to reform our nation's health care system prioritize the achievement of health equity by focusing on and addressing the social determinants of health and the differences in insurance status – which, are at the root of health inequity.

We are pleased that issues of health disparities were addressed during the development and successful passage in the House of H.R. 3162 – the CHAMP Act – which included sound provisions which bolstered data collection across the Medicare program, expanded access to culturally and linguistically appropriate care, and instituted several demonstration projects to address the root causes of health disparities within the Medicare population.

While that great success unfortunately was short-lived, it nonetheless was a victory that laid yet another row of bricks on the path to health equity that my colleagues in the TriCaucus and I have been building for the past four congresses through the introduction of our health disparity elimination bills.

H.R. 3014, is the latest bill which was introduced in the first session of 110th Congress by Congresswoman Solis and attempts to hone in on the root causes of *all* health disparities, not just racial and ethnic, but also gender and rural disparities. When we developed this bill, we did so with broad input, both on and off the Hill, and intentionally thought about health disparity elimination in a comprehensive manner.

Additionally, we developed the bill with respect to and following the key recommendations that came out of the groundbreaking 2003 Institute of Medicine (IOM) “Unequal Treatment” report. As such, we have a bill that is and should continue to be championed as a foundation upon which health care reform – the type of reform that is cognizant of and thus meets the health and health care challenges of millions of racial and ethnic minorities, women and rural populations – exists and occurs.

The Health Equity and Accountability Act includes provisions – some which fall under the jurisdiction of this subcommittee – to bolster and strengthen every aspect of our nation’s health care system. It smartly addresses cultural and linguistic competence, data collection, accountability and evaluation, workforce diversity, improvements in health care services and the expansion of health care access.

Because we recognize the pivotal role that the issues addressed in the provisions in H.R. 3014 – provisions that not only complement, but expand upon those in the CHAMP Act – must continue to play in health care reform efforts, my colleagues from the TriCaucus and I are addressing these issues here today, despite the fact that not every provision falls under your jurisdiction, because they are necessary to raise in a forum focusing on both health care reform and health disparities as a needed component of that reform.

That said, we will address a handful of issues addressed in our bill in an effort to continue to impress their importance not only in efforts to eliminate health disparities, but also to truly achieve health care reform in a manner that resonates with all Americans.

I am not providing statistics in my presentation. The witnesses on the next panel – the very research experts whose incredible work drives and informs our efforts on the

Hill – will provide a detailed overview of the extensiveness of health disparities and the compelling data that cannot and should not be ignored. Additionally, they – save one who continues to insist that race plays no role in the face of a mountain of information to the contrary -- will aptly highlight that racial and ethnic minorities, overall, are more likely than whites not only to lack adequate, reliable access to quality health care, but also are in poorer health and are more likely to die from preventable causes and during their most productive life years. We in the first panel will highlight several key provisions of HR. 3014.

The first issue I want to raise is the need for health workforce diversity.

At the outset, let me say that the only way to truly achieve cultural and linguistic competency in health care is to increase – and dramatically so – the number of health providers at all levels. Health workforce diversity does and will play a crucial role in health disparity elimination.

Studies indicate that racial and ethnic minority health care providers – all providers, including physicians, nurses, dentists, pharmacists, hospice care providers, community health workers, ophthalmologists and social workers, as well as health care executives – are more likely than their white counterparts to serve racial and ethnic minorities and other underserved communities.

Additionally, racial and ethnic minority providers are more likely than white providers to be able to bridge gaps – particularly as it relates to the dynamics of the patient-provider relationship – because the existing gaps are those that simply must be lived and cannot be adequately taught from a textbook. Yet important programs – such as Title VII and Title VIII programs – as well as funding to the institutions, such as the Historically Black Colleges and Universities – which together bolster the diversity in our nation's health care workforce have been woefully under-funded.

The sad fact is that racial and ethnic minority providers are grossly under-represented across all aspects of the U.S. health care system. In fact, according to the Sullivan Commission Report:

- Together, African Americans, Hispanic Americans, and Asian Americans and American Indians make up about one-third of the U.S. population, but only 9 percent of the nation's nurses, 6 percent of its physicians, and 5 percent of dentists.
- Similar disparities exist in the faculties of health professional schools. For example, racial and ethnic minorities make up less than 10 percent of baccalaureate nursing faculties, 8.6 percent of dental school faculties, and only 4.2 percent of medical school faculties.

The larger health care reform dialogue, therefore, must include discussions and solutions to ensure that these important programs and institutions receive the funding that they need to meaningfully contribute to the needed health reform by ensuring that

our nation's health care workforce – on all levels – mirrors our nation's growing racial and ethnic diversity. Not only will greater diversity in the health care workforce boost positive health benefits, but it also will help ensure more prudent spending of precious health care dollars.

Without diversity within our nation's health care system and among our nation's health care executives, researchers and health policy makers, the racial, ethnic, and gender nuances that are known to have a direct and indirect impact on health care decisions and thus health care and health status will remain under-addressed. As a result, millions of innocent, hard-working Americans will suffer poorer health outcomes and a lower quality of life and will continue to be at greater risk for premature, preventable death during their most productive life years.

Hopefully someone on the next panel or in the question period will raise the issue of disparate CMS reimbursements in different zip codes, as has been alleged by African- American physicians working in minority communities, as well as the need for low-interest loans for start-up practices, loan forgiveness and tax incentives for providers serving in high health disparity communities. Save loan forgiveness programs; they are not addressed in HR.3014, but we anticipate another bill which will address these also important issues.

My next issue is accountability.

Critical to health disparity elimination and also to health care reform is establishing accountability and evaluation as well as on coordination of effort. If we – as a nation – took the necessary steps to ensure that across all federal agencies and offices with health oversight and that issues which affect health equity had a designated office of minority health or an office of health disparities, then efforts to not only measure, but to propose and implement solutions to close health care gaps would become a reality.

In the Health Equity and Accountability Act, we not only work to strengthen and expand those existing entities – such as the Office of Minority Health at the Department of Health and Human Services and the National Center on Minority Health and Health Disparities at the National Institutes of Health – but we also propose the creation of Offices of Minority Health within the Centers for Medicare and Medicaid Services, the Food and Drug Administration, as well as to create an Office of Health Disparities within the Office of Civil Rights at the Department of Health and Human Services.

The creation of these offices will help ensure that federal efforts – and as important, federal resources – to achieve health equity not only remain on the national health care reform agenda, but also are coordinated as efforts to eliminate health disparities are launched. Additionally, these offices – though they will require an initial outlay of resources – would surely generate a positive return on investment; an investment that we should make today to improve the health, health care and health outcomes of millions of Americans today.

Lastly I want to address the need for community centered and comprehensive approaches to eliminating health disparities.

Our proposal for Health Empowerment Zones, which enjoy broad and strong support in the health advocacy community, should resonate in this Committee which created Economic Empowerment Zones in the 90's. They are included in the Health Equity and Accountability Act (H.R. 3014), as well as in a standalone bill – the Health Empowerment Zone Act.

This provision leverages not the expertise at the community level as it pertains to health disparities, but also the all existing resources – across all federal agencies -- available to implement health disparity elimination efforts. This rationale – one that not only fully engages all sectors of communities most affected by health disparities, but also defers to those communities – with technical assistance from the Department -- to develop a plan with solutions that mirrors the direction that myriad health disparity elimination studies have recommended. Fully engaging the communities most affected is essential! Not doing so, I believe, is the chief reason prior efforts have been unsuccessful.

As I close my testimony, I want to stress that I – along with my colleagues – fully understand that health disparity elimination, in many ways, is like the final match of any World Cup Final, in that if you keep shooting, you eventually score. So, that is the strategy we have and will continue to employ, because we are here to play for the season and not just the game.

That said, we have another game before us that could guarantee a victory for the season. There is a Medicare package that we all have been discussing and debating for many months. In this package, there are opportunities to reduce health disparities, but what hangs in the balance is our foresight and willingness to allow good politics and sound research to guide us toward great policy. While this package focuses on only a few of the several health disparity elimination issue areas, it is, nonetheless critically important and has an enormous impact in our collective efforts to not only achieve health equity, but to further the health care reform debate. So, as we move forward with this latest round of Medicare legislation, we must do so with an emphasis on strengthening our nation's successful Medicare system.

And, this must include ensuring that health disparity elimination within the Medicare population is at the forefront of our objectives. Doing so means that we must ensure that as the health and quality of health care for those with end-stage renal disease – a disease that has a disproportionate impact on African Americans – are adequately addressed with legislation that reflects the data suggesting that one size does not, in fact, fit all.

Additionally, while my position remains that it is bad policy to begin legislating medical practice, which has always been referred to as an art because of the uniqueness of every doctor-patient relationship, regardless of the disease entity, if this

Subcommittee and the Committee decides to move forward with legislation, I urge doing so with provisions that are cognizant of the differences between small and large dialysis facilities, and the fact that myriad factors – including race, ethnicity and geography – directly affect not only the volume of patients served, but the needs of those patients. Further, we hope that you will do so carefully and in a manner that focuses solely on provisions that allow for the case-by-case adjustments necessary to preserve the health and wellness of the millions of Americans – a disproportionate number of who are African American, other racial and ethnic minorities or members of rural communities – who will be most affected.

In closing, I, again, thank Chairman Rangel, Mr. Stark and everyone else who made this hearing possible. I know that the issue of health disparities is a difficult one to address, not because it is not important, but because health disparities are rooted in so many factors – some of which are overtly health and health care related, but others that are rooted in realms that tread in areas that are not well understood and others that bring out personal biases – such as race and ethnicity, gender, geography, education, and geography.

That said, I sincerely applaud your leadership and welcome future discussions as we proceed to bring about health care reform, on how we can work together to ensure that eliminating all racial, ethnic, gender and geographical disparities and achieving health equity are championed as components of our collective goals and objectives for the future.

It is only through proceeding in this comprehensive way that we will not only help all Americans achieve wellness, but also bring reform to a system in crisis and stop the skyrocketing costs of health care.

Thank you!