

First Annual Delaware State University Research Conference

Building the Foundation to Impact Health Outcomes

Health Policy Opening Remarks
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- I am delighted to join you for Delaware State University's First Annual Research Conference, to share some of the Joint Center for Political and Economic Studies' (Joint Center) work on health policy and health care reform and to serve as Moderator of this panel
 - I am especially pleased to share this platform with the Honorable Margaret R. Henry, Chair of the Delaware State Senate's Health and Social Services Committee, as well as the Honorable Michael A. Barbieri, Chair of the Delaware House of Representatives' Health and Human Development Committee
 - I am looking forward to their remarks and will introduce them more formally at the close of my own
- Research plays a pivotal role in providing the framework for shaping policy proposals and informing policymakers of the possible outcomes linked to different policy options
- Founded in the wake of the Voting Rights Act in 1970 with significant support from the Ford Foundation, the Joint Center is the only freestanding think tank focused primarily on the concerns of American Americans and communities of color
- The Joint Center continues to uphold its mission of improving the socioeconomic and health status of these communities through high quality research and policy recommendations
- I know that earlier this morning, Dr. Thomas A. LaVeist delivered the keynote address on the role, which Historically Black Colleges and Universities (HBCU's) can play in advancing 21st century research on health services

- Dr. LaVeist and two of his colleagues recently carried out very important research for the Joint Center on the costs of racial and ethnic health disparities in the United States.
- The Joint Center released Dr. LaVeist's study, *The Economic Burden of Health Inequalities in the United States*, on September 17th during a Health Reform Briefing at the National Press Club
 - This briefing featured **Secretary Kathleen Sebelius** from the U.S. Department of Health and Human Services, Dr. LaViest and other researchers, and three U.S. Members of Congress, including Majority Whip James Clyburn (D-SC), Representative Bobby Rush (D-IL) and Delegate Donna Christensen (D-VI).
- I have some copies of the study's *Executive Summary* with me but you will also find the same information on the Joint Center's website at: www.jointcenter.org
- Using data from existing federal health surveys, Dr. La Veist and his co-researchers found that between 2003 and 2006, health inequalities for U.S. people of color cost more than **an extra \$50 billion dollars a year**
 - These **direct medical costs** over the 4-year period of the study amounted to a **TOTAL of \$229.4 billion dollars**
 - Please keep in mind that this \$230 billion dollar price tag incurred between 2003 through 2006 reflects only the **excess costs** associated with **health inequalities**
 - In other words, if you **eradicate health inequalities**, these **excess costs would disappear**
- For **African Americans** alone, the direct medical expenditures due to health inequalities over the four-year period was **\$135.9 billion dollars**

- Thus, **eliminating health inequalities** for African Americans and other people of color is not only the just and moral thing to do, it is the **most cost-effective thing to do** to restore the nation's fiscal health
- Now, let me say a few words about the **indirect costs** that result from health inequalities
 - These include the **indirect costs of illness** such as lost productivity, lost wages, absenteeism, use of family leave for avoidable illnesses, and lower quality of life, as well as
 - The **indirect costs of premature deaths**, which are:
 - Forgone wages, lost tax revenues, benefits and services for families of the deceased and lower quality of life for family survivors
- The researchers calculated that the **indirect costs that result from health inequalities** add up to **more than a trillion dollars** from 2003 through 2006
- When you add the direct and indirect costs of health inequalities together, the **GRAND TOTAL** is more than \$1.24 trillion dollars
 - This study noted that this figure of **\$1.24 trillion dollars** over a four-year period is more than the annual gross domestic product (**GDP**) of **India** – the **world's 12th largest economy**
- **Who is paying** this \$1.24 trillion dollar bill? **ALL of us are**, in our federal, state and local tax bills as well as bills for doctor visits, prescription drugs and medical procedures
- Yet eliminating racial health inequalities will do more than put the nation's fiscal house in order
- It will also **improve health status** and outcomes **for people of color**, from cradle to grave
- Let me give you some information on why we especially need to improve health status and outcomes for **African Americans**

- Seventeen years ago – **in 1992** – the Joint Center published what was at that time a pioneering document – *A Health Assessment of Black Americans* – which included noteworthy findings on black men’s and women’s health
- Although it is hard to believe, it was **not until 1985** that the U.S. Department of Health and Human Services (HHS) published an official report on Black and Minority Health
- The Office of Minority Health at the U.S. Department of Health and Human Services (HHS) was established the following year, **in 1986**
 - Moreover, the National Institutes of Health (NIH) **did not adopt a policy that urged the inclusion of people of color and women in its clinical health research trials until** two years later, **in 1987**
 - Three years later – **in 1990** – NIH established the first Office of Research on Women’s Health
- Moreover, **Congress did not mandate the inclusion of people of color and women in all NIH-supported clinical research studies until 1993**
- NIH is still attempting to overcome ongoing barriers to the recruitment of people of color and women as clinical research subjects
 - One of the most pressing of such barriers is the continued **lack of racial and ethnic diversity among health researchers and practitioners**
 - This lack of diversity is one of the reasons why **it is imperative** for students at Delaware State University and other HBCUs to become engaged in conducting health services research
 - Please allow me a few moments to sketch out the parameters of heart disease in the U.S. in order to buttress my message on the importance of HCBU involvement in health research

- According to a new study reported in the September 16th issue of the *Journal of the American Medical Association*, **black patients who suffer cardiac arrest in a hospital setting are much less likely to survive** than white patients

- Although **survival after having a cardiac arrest** in a hospital setting is historically low, **survival rates for blacks were significantly lower, at 25 percent** versus 37 percent for whites
 - That amounts to a **12 percent absolute difference in survival**

- According to lead researcher Dr. Paul Chan, a cardiologist at St. Luke's Mid-America Heart Institute in Kansas City, this **12 percent absolute difference in survival** is larger in terms of a racial disparity than survival disparities for any other medical condition
 - Although much of this disparity is believed to result from the hospitals in which black patients receive care, there are other factors at play
 - We need to investigate these other factors

- Some **32% of African Americans have high blood pressure (hypertension) – a leading risk factor for heart disease** -- compared to 22.5% of whites in 2007
 - African Americans are 1.5 times as likely as whites (non-Hispanic) to have high blood pressure
 - In other words, African Americans have more severe high blood pressure than whites and hence, a higher risk of heart disease
 - Moreover, when you add obesity, smoking, high blood cholesterol levels or diabetes, the risk of heart attack or stroke increases several times

- **AFRICAN AMERICAN MEN are 30% more likely to die from heart disease** than white (non-Hispanic) males, according to 2005 data on the Office of Minority Health's website

- And the **disturbing disparity between heart-related death rates for black** males and white males in this country is not only stubbornly persistent, it **also applies to females**

- Starting in 1997, the Joint Center has been publishing the **Women of Color Health Data Book**.
 - Our 3rd Edition of this Women’s Health Data Book was released in 2007
- As highlighted in the latest data-book, **AFRICAN AMERICAN WOMEN** are:
- **More likely to be obese**, another leading risk factor for heart disease, (along with Mexican American and Native Hawaiian women) than women of other racial or ethnic groups;
 - **Two out of every three black women were obese** between 1999 – 2001;
- **More likely to have sedentary lifestyles** than women of other racial or ethnic groups;
 - **55 percent of black women** reported they had **sedentary lifestyles** between 1999 – 2001, which means they did NOT engage in light physical activities for 10 minutes at a time;
- **More likely to have high blood pressure** (hypertension) – a leading risk factor for heart disease – than women of other racial or ethnic groups;
- **More likely** (black adult females, males and children) **to have elevated lead levels in the blood** – which is associated with high blood pressure – than people of other racial or ethnic groups (except Mexican Americans);
- **More likely to die of heart disease** than women of other racial or ethnic groups;
- **More likely to die of diabetes-related causes** than women of other racial or ethnic groups;
- **More likely to have a shorter life expectancy** (along with American Indian and Alaskan Native women) than women of other racial or ethnic groups;
- Equally as alarming in the Joint Center data-book are some of the **health indicators for BLACK ADOLESCENT FEMALES**, who are:

- **Less likely to participate in any form of physical activity**, be enrolled in a physical education class or play on a school sports team – a precursor to a sedentary lifestyle – than adolescent females of other racial or ethnic groups;
- **More likely to be overweight** than adolescent females of other racial or ethnic groups;
 - Both these factors present high risks for the development of adult heart disease
- The **enactment of comprehensive health reform legislation is absolutely imperative** if we are **to eliminate** the current **health inequities facing African Americans** and other people of color
 - The **results of these inequities are now well documented in the higher premature death and disease rates among African Americans**
 - **Secretary Kathleen Sebelius** of the U.S. Department of Health and Human Services called these higher rates of premature death and diseases among African Americans **“quite stunning and shocking”** at the Joint Center’s briefing
 - She further emphasized that **“although we have become better at measuring these inequities, we have made little progress in reducing them”**
 - She also **pledged her personal commitment – as well as President Obama’s -- to eliminating such health inequities**
- I have only given a few examples of the **many “shocking and stunning” health disparities** that Secretary Sebelius was referring to at the recent Joint Center Health Reform Briefing
- These **inequities include serious and significant financial barriers** that prevent access to quality health care services, from time-sensitive treatment options to preventive care aimed at curbing a wide range of chronic and debilitating illnesses
- Clearly, **reducing these health disparities and enacting comprehensive health care reform is a top priority for President Obama, Secretary Sebelius** and the entire Obama Administration

- **Now it is up to Congress to send President Obama a health reform bill**, which he can sign into law
- On September 17, 2009, at the Health Reform Briefing at the National Press Club, the Joint Center also released a report entitled ***Congressional Health Care Reform Proposals: Potential for Advancing Health Equity in America***, conducted by Dr. Dennis P. Andrulis, Associate Dean for Research at Drexel University’s School of Public Health
- This report **compares the specific health equity provisions** in the **pending health reform bills** in the U.S. Congress
 - Again, I have a copies of the **Executive Summary** of this report with me
 - You can also access this summary as well as the report in greater detail on the Joint Center website, which I’ll repeat once again -- www.jointcenter.org
- The **bills analyzed in this report** include the health reform proposals voted out of the **U.S. House Committees on Ways and Means, Energy and Commerce, and Education and Labor** – also known as the “Tri-Committee” proposal – as well as the proposal voted out of the **U.S. Senate Health, Education, Labor and Pensions (HELP) Committee**
- The **U.S. Senate Finance Committee** is slated to finish work on its proposal in the coming days
 - However, Senators Rockefeller (D-WV) and Wyden (D-OR) are withholding their support for the bill in its current form
 - Senator Rockefeller wants to see a public option established
 - Senator Wyden wants to see more done to hold down insurance premium costs and ensure accountability of insurance companies
- Let me start by summarizing a few of the most important **provisions aimed at reducing health inequities common** to both **Tri-Committee** and the **Senate HELP Committee** proposals, as follows:

KEY ELEMENTS which the U.S. House **Tri-Committee** share in common with the bill passed out of the U.S. **Senate Committee on Health, Education, Labor and Pensions (HELP)** include:

- **Adopting health insurance reforms** aimed at **expanding coverage and affordability for low-income** racial and ethnic minorities and others, which make them more likely to:
 - lack coverage
 - delay or forgo care due to its expense
 - face medical debt
- **Creating exchanges or gateways** for individuals and employers to compare and purchase health insurance
- **Expanding access to Medicaid and federal support** for Medicaid services
- **Creating a new public plan** (option) to compete with private insurance plans
- **Prohibiting insurance exclusions** or rate variations for **pre-existing conditions**
- **Expanding the affordability of health coverage, especially for low-income racial and ethnic minorities**
- **Improving access** to health care for **diverse communities**
- **Increasing support for community health centers**, which remain a major source of care for low-income African Americans and other people of color
- Providing **grants to increase the number of primary care providers**
- Ensuring **adequate funding for scholarships and loans supporting professional programs in underserved areas**
- Underscoring the importance of **cultural and linguistic competence** in public programs as well as **support for cultural competence training** for health professionals
- Providing federal support for **evidence-based research and community strategies to reduce health inequities**, which include:
 - Comparative Effectiveness Research (CER)
 - Evidence-based community prevention,
 - Grants for testing community-centered medical home programs
- **Developing standards to collect and report health data by race**, ethnicity, and language, with an emphasis on quality measures detecting health inequities

- **Beyond these common elements, each bill has distinct provisions** to eliminate racial and ethnic inequities in access, affordability and quality of health care, as follows:

TRI-COMMITTEE PROPOSAL also focuses on:

- **Establishing national priorities and strategies for reducing health disparities** in consultation with the HHS Office of Minority Health
- **Emphasizing linguistic competence in public programs** by means of support for research and payment to on-site interpreters under Medicare
- **Expanding health care services at** freestanding birth centers, dialysis centers, school-based health clinics, public health clinics and other **community sites**

HELP PROPOSAL also focuses on:

- **Providing support for reducing inequities in oral health care** and outcomes by means of a 5-year national public education campaign and grants for school-based oral health programs
- **Supporting the development and evaluation of cultural competence programs**, which include curricula for medical education and the establishment of an online clearinghouse and self-assessment models for health care providers
- **Emphasizing the social determinants of health** and the cross-sector approach by means of a newly-created National Public Health Council charged with developing health-promoting policies and supporting Health Impact Assessments
- As soon as the Senate Finance Committee votes out its bill, then attention will shift to Senate **Majority Leader Harry Reid** and **House Speaker Nancy Pelosi**, who are in charge of merging their respective health reform legislative proposals and taking them to the floors of the U.S. Senate and U.S. House respectively for votes on passage
- Subsequently, differences between the House and Senate packages must be reconciled in conference proceedings, which result in an agreed upon conference report

- Only once the conference report has been adopted by both the U.S. House and Senate, will the legislation go to President Obama for his signature
 - So we will all have to stay tuned
 - Now, it gives me distinct pleasure to introduce my fellow panelists
 - Starting with The Honorable Margaret Rose Henry, she is the FIRST African American woman elected to serve in the Delaware State Senate
 - As a quick aside, I would like to note that at the start of my career, I worked for the first African American woman elected to the Oregon legislature
 - So I know a little about the challenges that face the first African American female to be elected to the state legislature
 - After earning her Bachelor of Arts degree from Texas Southern University, Senator Henry moved to Delaware in 1970
 - She also holds a Master’s Degree in Community Development and Leadership from Springfield College
 - Currently, Senator Henry is Program Coordinator of the Women’s Center at Delaware Technical and Community College
 - Having played a leadership role in the Delaware human service community for three decades, Margaret Rose Henry has been honored by the Delaware YWCA as the “Woman of the Century”
 - Senator Henry has received numerous other awards, including being honored by the Delaware Bar Association in 2002 as their “Legislator of the Year”
 - Most recently, Senator Henry was inducted into the Delaware Women’s Hall of Fame
- Next, it is a real pleasure to introduce Dr. Michael A. Barbieri

- Representing the 18th District in Delaware’s House of Representatives, Dr. Barbieri earned his Ph.D. in Urban Affairs and Public Policy, with a concentration on health care delivery, at the University of Delaware
- Representative Barbieri also holds a Master’s Degree in Social Work from Temple University as well as a Bachelor of Arts degree from the University of Delaware
 - It is also worth mentioning that during his senior year at the University of Delaware, he was a member of the 1971 National Championship Football Team (Blue Hens)
- In 1991, Dr. Barbieri served as Founder and Director of Strategic Management Initiatives
- In 1993, he also founded a Wilmington-based adolescent substance-abuse treatment program known as “Crossroads of Delaware”
- Representative Barbieri stresses that his work with adolescents has served as the primary motivation for his political aspirations and service
- Of particular relevance to today’s panel discussion, Representative Barbieri has seen the struggle of working parents trying to provide for their children without affordable health care and aspires to change that
- First, I will turn to Senator Margaret Rose Henry, Chairwoman of the Delaware State Senate’s Health and Social Services Committee, for her opening comments
- Next, Representative Barbieri, Chairman of the Delaware House of Representatives’ Health and Human Development Committee, will give his opening remarks
- Following that, I will open up the discussion for Questions and Answers