



# FIRST FOCUS

*MAKING CHILDREN & FAMILIES THE PRIORITY*

## TESTIMONY OF BRUCE LESLEY, PRESIDENT, FIRST FOCUS

HOUSE COMMITTEE ON ENERGY AND COMMERCE  
SUBCOMMITTEE ON HEALTH

HEARING ON THE HEALTH EQUITY  
AND ACCOUNTABILITY ACT (H.R. 3014)

JUNE 24, 2008

Good morning Chairman Pallone, Ranking Member Barton, and members and staff of the Health Subcommittee. I am Bruce Lesley, President of First Focus, a bipartisan children's advocacy organization dedicated to making children and families a priority in federal policy and budget decisions.

I appreciate the opportunity to testify today in support of the *Health Equity and Accountability Act* (H.R. 3014), legislation aimed at reducing health disparities by improving access to health care, research, and education on the diseases and illnesses that are having a disproportionate impact on minorities.

The issues you are considering today have not only been of great professional interest to me – through my work on Capitol Hill and for the National Association of Children's Hospitals – they are also deeply personal to me because I grew up in El Paso, Texas, and I started my professional career working for a public hospital just a few miles from the US-Mexico border.

At Thomason Hospital in El Paso, the medical staff provided care to a largely Hispanic patient population that also included American Indians from the Tigua Reservation. While Thomason had an excellent medical, resident, and nursing staff that came from all across the country and from around the world, many had little knowledge or understanding of the region and its diverse cultures. Many could not speak Spanish and few took the time to learn even the most basic of phrases to communicate in any depth with patients since they were only going to be in the region for a few years.

Sadly, despite the high quality of care provided at Thomason, the health disparities among patients were obvious – some were rooted in poverty, some due to the educational level of heads of household, some due to lack of basic health care coverage or reasonable access to primary care, and some due to cultural and ethnic bias on the part of the medical staff.

There is much that can and should be done to improve health care delivery systems in this country in order to ensure better quality and appropriate care for all people, regardless of their race, ethnicity, cultural heritage or economic status. I am grateful that you are exploring these issues today and want to make the committee aware that First Focus fully supports the *Health Equity and Accountability Act*. It is an important and timely proposal and it is our hope that passage of this bill will put our nation on the critical path toward reducing and eliminating disparities for all Americans across the health care spectrum.

Let me stop for a moment and tell you a little bit about my organization. First Focus is a national, bipartisan advocacy organization focused on advancing stronger federal policy and investment to improve the lives of our nation's children. Our policy work focuses on health, education, child welfare, and family economics and the Federal budget. In all of our work, we are committed to giving voice to children and families who slip through the cracks, those who are often overlooked or marginalized in research, programs, policy, and access to care. On the health front, our core mission is to improve health care access and quality for all of our nation's children.

Unfortunately, as First Focus Advisory Board member and pediatric expert Dr. Glenn Flores has noted, very little attention to health disparities has been directed at children. According to Flores, "...in a recent report on disparities by the Agency for Healthcare Research and Quality, there were more than three times as many disparity measures for adults as there were for children and only 15% of measures were child specific, and in the Institute of Medicine's comprehensive health disparities monograph, only 5% of studies addressed disparities in children."<sup>1</sup>

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<sup>1</sup> Glenn Flores and Sandra C. Tomany-Korman, "Racial and Ethnic Disparities in Medical and Dental Health, Access to Care, and Use of Services in U.S. Children," *Pediatrics*, Vol. 121, Number 2, February 2008.

However, we do know that minority children typically fare far worse than white children across the spectrum of health outcomes. From infant mortality, obesity, and dental care to asthma, diabetes, and environmental illnesses, minority children have higher rates of disease and more limited access to care than the non-minority population. As Dr. Flores adds, "...minority children in America often face a 'triple threat' of greater risks of suboptimal medical and oral health status, impaired access to medical and dental care, and lower receipt of prescription medications and essential medical and dental services."<sup>2</sup>

**The statistics are startling, for example:**

- African-American children are almost 60 percent more likely than white children to have an unmet medical need.<sup>3</sup>
- Latino children are more than 31.2 times more likely than White children to lack a regular place to receive health care.<sup>4</sup>
- Elevated blood-lead levels are four times as common in Black children (3.5 percent) as in White children (0.9 percent).<sup>5</sup>
- Emergency department visit rates for African-Americans are 2 to 4 times higher than that of whites (21/100 for African-Americans versus 4/1000 for whites) as are asthma hospitalizations (and deaths).<sup>6</sup>
- Asthma hospitalization rates are 240 percent higher for non-Hispanic black children than whites.<sup>7</sup>
- The rate of asthma among Latino children is two and a half times higher than among non-Hispanic white children.<sup>8</sup>
- The incidence of Type 2 diabetes is rising faster among American Indians and Alaska Native children and young adults than in any other ethnic population and is 2.6 times the national average.<sup>9</sup>
- Non-Hispanic white children were more likely to have had a dental contact in the past six months (63%) than non-Hispanic black children (47%) or Hispanic children (47%).<sup>10</sup>
- Latino preschoolers—the fastest growing population of children in the United States—experience 2.5 times more tooth decay than white children.<sup>11</sup>

Such disparities cannot be explained away as just a matter of socioeconomic differences. Poverty or educational attainment alone cannot account for the vast differences in outcomes for minorities and whites. A number of scholars, including Acevedo-Garcia, have noted that “Infant mortality rates decline as mothers’ education level rises for all racial and ethnic groups, but education does not erase

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<sup>2</sup> Ibid.

<sup>3</sup> Children’s Defense Fund, “Improving Children’s Health: Understanding Children’s Health Disparities and Promising Approaches to Address Them,” June 2006.

<sup>4</sup> Ibid.

<sup>5</sup> Children’s Defense Fund, *The Healthy Child Campaign*, 2006.

<sup>6</sup> Christine L.M. Joseph, L. Keoki Williams, Dennis R. Ownby, Jacquelyn Saltzgeber, and Christine C. Johnson, “Applying epidemiologic concepts of primary, secondary, and tertiary prevention to the elimination of racial disparities in asthma,” *The Journal of Allergy and Clinical Immunology*, Volume 117, Issue 2 (February 2006): 233-240.

<sup>7</sup> Analysis of data from the National Hospital Discharge Survey, 2004, by Lara Akinbami M.D., as reported in *Asthma Prevalence, Health Care Use and Mortality: United States 2003-2005* (Hyattsville: National Center for Health Statistics), 2007.

<sup>8</sup> Congressional Hispanic Caucus, “Health and the Environment Task Force Priorities,” June 10<sup>th</sup>, 2008.

<sup>9</sup> <http://www.hhs.gov/news/press/2003pres/fsindian90803.html>

<sup>10</sup> Bloom B, Cohen RA. Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006, National Center for Health Statistics. Vital Health Stat 10(234). 2007.

<sup>11</sup> Congressional Hispanic Caucus, “Health and the Environment Task Force Priorities,” June 10<sup>th</sup>, 2008

the racial gap. African American women with college or graduate degrees face infant mortality rates that are higher even than among white women with less than a high school education.”<sup>12</sup>

While there are many factors that contribute to these grim statistics, chief among them is that minority children face significantly higher rates of uninsurance when compared with white children. Nearly two-thirds, or 64 percent, of the 9 million children in the U.S. who are uninsured belong to a racial or ethnic minority.<sup>13</sup> More specifically:

- Latino children are three times as likely as white children and nearly twice as likely as African-American children to be uninsured.
  - Rates of white children who are uninsured : 7.5 percent
  - Rates of African-American children who are uninsured: 13.4 percent
  - Rates of Latino children who are insured: 21.0 percent<sup>14</sup>

The bottom-line is that we are failing our nation’s children, our next generation of leaders, by denying them the opportunity to fulfill their promise due to the lack of a healthy start in life.

During the debate last year on the reauthorization of the State Children’s Health Insurance Program (SCHIP), Congress focused significant attention on another important data point – that is two-thirds of our nation’s uninsured children are currently eligible for but not enrolled in coverage under SCHIP or Medicaid. The numbers are worse for minority children. More than 80 percent of uninsured African American children and 70 percent of uninsured Latino children appear to be eligible for but not enrolled in public health coverage programs.<sup>15</sup>

The SCHIP legislation that was passed by Congress last year included several provisions that would have helped to improve outreach and enrollment to these populations. We were disappointed that SCHIP reauthorization was not completed last year. We want to highlight for the Committee that Congress must reauthorize SCHIP before March of next year to improve coverage and access to care for our nation’s most vulnerable children.

As you know, one of the most pressing issues facing our nation’s poorest children is the looming implementation of the SCHIP directive issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007. By limiting states’ abilities to tailor SCHIP programs to meet the needs of their citizens, the directive will cut off or limit coverage for scores of children from working families who play by the rules, work hard, and do their best to provide for their kids. Without a doubt, the rolls of uninsured children will grow further if Congress does not take action to stop the implementation of this directive. We urge Congress to take quick action to ensure that no child in America is denied health care as a result of this short-sighted administrative action.

It is fair to say that we are very concerned that our nation is headed in the wrong direction when it comes to its investments in children and their healthcare. In the last few years, we have taken serious steps backwards when it comes to addressing health disparities and improving health care access and outcomes.

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<sup>12</sup> Dolores Acevedo-Garcia, et al, *Unequal Health Outcomes in the United States: A Report to the U.N. Committee on the Elimination of Racial Discrimination*, January 2008.

<sup>13</sup> U.S. Census Bureau , “Table H108. Health Insurance Coverage Status and Type of Coverage by Selected Characteristics for Children under 18 (All Children): 2006,” *Current Population Survey 2006*.

<sup>14</sup> Robert Wood Johnson Foundation, “Covering Kids and Families: The State of Kid’s Coverage,” August 9th, 2006

<sup>15</sup> Urban Institute analysis of data from the U.S. Census Bureau’s Current Population Survey, 2004, as reported in *Going Without: America’s Uninsured Children* (Washington: Robert Wood Johnson Foundation, August 2005).

In fact, in recent years there have been a host of policy changes that have contributed to and in some instances exacerbated the disparity gap:

**Citizenship Documentation.** For instance, in 2007, CMS imposed citizenship documentation requirements that, according to states, have cut few, if any, immigrant children, but have led to the loss of coverage for thousands of American children, particularly African-American children in desperate need of health care. In an article in the *Lawrence Journal* this past week, the State of Kansas estimates that \$1 million was spent complying with the citizenship documentation requirements that has only stopped one illegal immigrant from getting coverage while denying an estimated 20,000 eligible Kansans health insurance coverage. Republican Senator Majority Leader Derek Schmidt said of the situation, "...[the federal government] ha[s] imposed a bunch of ancillary mandates on states, which are akin to trying to push a wet noodle up a hill with your nose. State taxpayers are picking up the dollars and cents costs of a failed federal policy."

**Funding for Critical Programs, Such as Healthy Start, the Maternal and Child Health Programs, and Health Professions.** Congress has failed to reauthorize the Healthy Start program – a critical initiative working to ensure that women living in communities with high infant mortality rates have access to early prenatal care and infant care. In addition, Congress also has cut funding for Healthy Start and the Maternal and Child Health Block Grant despite the fact that the U.S. infant mortality rate is 25<sup>th</sup> in the world and our maternal mortality rate is 30<sup>th</sup>. We also have cut funding for health workforce programs and the HHS Office of Minority Health, which provide important assistance for getting minority health professionals into medically-underserved neighborhoods.

**Legal Immigrant Health Improvement Act.** Congress has failed to pass legislation that would lift the five-year waiting period for legal immigrants to receive health coverage. A newborn, a child with cancer, a child with diabetes, or a child with a raging ear infection cannot wait five years for health care. Half of our nation's states have responded to this inhumane policy by providing coverage to these children with state funding, but no child should be denied coverage for a period of up to five years.

**American Indian Healthcare.** Although some might suggest that health disparities are related to immigration status, it should be noted that American Indians, the population that has been in this country longer than any other, experience some of the worst health disparities in the nation. Congress should pass the *Indian Health Care Improvement Act* as soon as possible and focus attention on American Indians in all federal programs by, at the very least, doing no harm. Congress has, for example, failed to include American Indian communities as possible grant recipients for meth grants or breast and cervical cancer treatment due to an oversight that took years to fix.

**Medicaid and SCHIP Quality Improvement for Children.** Over the past few years, Congress and the Department of Health and Human Services (HHS) have undertaken numerous efforts to improve quality of care, health disparities, and information technology (IT) in Medicare and the Veterans Administration health system while specifically exempting Medicaid and SCHIP from such improvements, chief among these examples is the President's Executive Order on quality and health IT improvements. Studies at AHRQ, the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH) often fail to address the special circumstances or needs of children as well so that quality improvement and the focused reduction of health disparities for children has largely gone unaddressed in federal policy.

These disparities in access, care, coverage, treatment and outcomes are abysmal and unacceptable. They are highlighted by the fact that on the average day 76 babies die before reaching their first birthday. If we did nothing else, as a society, we cannot let that figure stand.

Importantly, by design, the *Health Equity and Accountability Act* is not just about minority health, as it also recognizes and prioritizes the elimination of gender and rural health disparities. For example, recognizing that minority and rural communities disproportionately are eligible but not enrolled in public programs, you will note that the legislation makes a priority for outreach and enrollment grants to children in both minority and rural communities, and along the U.S.-Mexico border where uninsured rates are the highest in the nation.

For all of these reasons, the *Health Equity and Accountability Act* must be advanced as quickly as possible. While we appreciate all of the efforts by Congress in recent years to enact legislation to address health disparities, these issues have become urgent ones and we cannot let any more time pass without taking critical steps to address them. We applaud the provisions of the bill that would:

- Give states the option to provide coverage under SCHIP and Medicaid for legal immigrant children and pregnant women;
- Provide grants to support community health worker programs which improve enrollment strategies among minority communities, including the use of *promotoras*, to guide families through the enrollment processes;
- Ensure the availability of culturally and linguistically appropriate health care services;
- Require data collection and analysis on disparities;
- Provide grants to increase the number of minority health professionals;
- Support training programs for providers who treat an increasingly diverse patient population; and,
- Improve research and education on diseases that are found to be more prevalent in minority communities.

This is the right bill at the right time. If enacted, it would be an important step forward and would make significant improvements in health care access, research and programs for all racial and ethnic minorities, including children, who, as the data shows, lag behind white children in almost every health indicator. One in every five children in America lives in poverty – one in every five. This bill will not solve all of our problems, but it will be a significant step in the right direction in ensuring that every child has a healthy start in life regardless of family circumstance. That is something that First Focus fights for every day and is why we stand as strong supporters of this legislation.

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Thank you for the opportunity to provide this testimony. I welcome the opportunity to answer any questions you might have.