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November 2, 2009

President Barack Obama
The Honorable Nancy Pelosi, Speaker of the House
The Honorable John A. Boehner, Republican Leader
The Honorable Charles B. Rangel, Chairman, Committee on Ways and Means
The Honorable David Lee Camp, Ranking Member, Committee on Ways and Means
The Honorable George Miller, Chairman, Committee on Education & Labor
The Honorable John Kline, Ranking Member, Committee on Education & Labor
The Honorable Henry Waxman, Chairman, Committee on Energy & Commerce
The Honorable Joe Barton, Ranking Member, Committee on Energy & Commerce
The Honorable Edolphus Towns, Chairman, Committee on Oversight & Government Reform
The Honorable Darrell Issa, Ranking Member, Committee on Oversight & Government Reform
The Honorable John Spratt, Chairman, Committee on the Budget
The Honorable Paul Ryan, Ranking Member, Committee on the Budget

DELIVERY VIA FACSIMILE AND EMAIL

Dear Mr. President and Distinguished Members of Congress:

The undersigned members and supporters of the National Health Equity Coalition (NHEC), a policy and advocacy network committed to the elimination of racial and ethnic health disparities and the achievement of health equity, write to express our disagreement with the analysis of health workforce provisions in the America's Affordable Health Care Choices Act (H.R. 3200) presented by the U.S. Commission on Civil Rights in their October 9, 2009 letter. We are shocked and disappointed that some commissioners chose to interpret as potentially discriminatory provisions that were designed to create a culturally-competent health workforce and improve access to health care and public health professionals. It should be noted that only five of the eight members of the Commission signed the letter.

The October 9th letter alleges that provisions in the bill¹ that give preference in awarding grants or contracts to health professional training programs with a "demonstrated record of training individuals who are from underrepresented minority groups or disadvantaged backgrounds" would not help increase access to care or quality of care among racial and ethnic minority populations experiencing health disparities. It states that simply "[i]ncreasing access to high-quality physicians—whatever their race or ethnicity—and removing the obstacles they face in obtaining high-quality services for their patients is the way to mitigate health disparities." Unfortunately, the Commissioners who authored the letter failed to appreciate the complexity of issues impacting access to and quality of health services among racial and ethnic minority groups² or the evidence of the effect of a diverse health professions workforce on reducing health disparities.

¹ America's Affordable Health Care Choices Act of 2009, H.R. 3200, 111th Cong. § 2213(d)(2), 2214 (e)(2), 2215 (d)(2), 2232(d)(2). 2009.

² See, e.g., CERD Working Group on Health and Environmental Health. *Unequal Health Outcomes in the United States: Racial and Ethnic Disparities in Health Care Treatment and Access, the Role of Social and Environmental*

Improving Diversity among Health Professionals Will Reduce Health Disparities

The critical importance of increasing diversity and cultural competency among health professionals to improve health outcomes for underserved racial and ethnic minorities is supported by a large body of research.³ The Commissioners' letter fails to acknowledge this and relies instead on questionable publications while misrepresenting others. Several key studies omitted from the Commissioners' considerations are worth noting:

- In 1999, the U.S. Commission on Civil Rights issued a two volume report, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality*, based on a comprehensive review of the U.S. Department of Health and Human Services (HHS) from a civil rights perspective. This report reached conclusions that are directly contrary to the letter produced by members of the same commission ten years later. The 1999 report documented "striking disparities in the health status of minorities and non minorities" and cautioned that while critics often cite behavioral habits as culprits in health disparities, these account for only a "modest portion of health disparities." Significantly, the report stated that "a major finding of the research conducted here is that clearly more minorities are needed as health care professionals."⁴
- The Sullivan Commission on Diversity in the Workforce's 2004 report, *Missing Persons: Minorities in the Health Professions*, is also notable. The Sullivan Commission was composed of national experts in health, education and law, and chaired by Dr. Louis W. Sullivan, former Secretary of HHS, from 1989 to 1993. The Commission conducted an exhaustive 18-month review of the pertinent literature and invited testimonials from stakeholders around the country. It found that health professionals from racial and ethnic minority groups are more likely to serve racial and ethnic minority and lower-income populations. In fact, they disproportionately serve minority patients in general, not just patients from their own racial and ethnic groups. There is an even stronger association between caring for underserved communities and race than between caring and socioeconomic background. The report concluded: "The fact that the nation's health professions have not kept pace

Determinants of Health, and the Responsibility of the State. A Report to the U.N. Committee on the Elimination of Racial Discrimination; 2008. (The report lists a variety of causes of racial health disparities in the U.S., including unequal access and treatment; social and community level determinants of health; and the health effects of race-based discrimination, bias and prejudice).

³ Institute of Medicine. *The Right Thing to Do, The Smart Thing to Do: Enhancing Diversity in the Health Professions*. Washington, DC: National Academies Press; 2001.

Institute of Medicine. *In the Nation's Compelling Interest: Ensuring Diversity in the Health-Care Workforce*. Washington, DC: National Academies Press; 2004.

Cohen JJ, Gabriel BA, Terrell C. The case for diversity in the health care workforce. *Health Aff*. 2002; 21(5):90-102.

Komaromy M, Grumbach K, Drake M, et al. The role of black and Hispanic physicians in providing health care for underserved populations. *N Engl J Med*. 1996; 334(20):1305-10.

Saha S, Taggart SH, Komaromy M, Bindman AB. Do patients choose physicians of their own race? *Health Aff*. 2000; 19(4):76-83.

Saha S, Gupton G, Wimmers PF, Wilkerson L. Student body racial and ethnic composition and diversity-related outcomes in US medical schools. *JAMA*. 2008; 300(10):1135-45.

LaVeist TA, Nuru-Jeter A, Jones KE. The association of doctor-patient race concordance with health services utilization. *J Public Health Pol*. 2003; 24(3-4):312-23.

Cooper LA, Roter DL, Johnson RL, Ford DE, Steinwachs DM, Powe NR. Patient-centered communication, ratings of care, and concordance of patient and physician race. *Ann Intern Med*. 2003; 139(11):907-15.

⁴ US Commission on Civil Rights. *The Health Care Challenge Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality*. Washington, DC: US Commission on Civil Rights; 1999.

with changing demographics may be an even greater cause of disparities in health access and outcomes than the persistent lack of health insurance to millions of Americans.”⁵

- The Health Resources and Services Administration, which administers health professions training grants, found in their report *The Rationale for Diversity in the Health Professions: a Review of the Evidence* that race and ethnic concordance is expected to improve the quality of communication, comfort level and trust between health professionals and patients, particularly regarding primary care. This is especially true for patients with limited English proficiency. As a result, patients increasingly use appropriate care, have greater medical comprehension, adhere to effective programs, and experience better health outcomes. However, language concordance alone does not account for better physician-patient encounters, suggesting that language training is unlikely to serve as a substitute to increasing the supply of minority health professionals.⁶

Evidence that racial biases and stereotypes contribute to a wide array of clinical decisions is abundant and highlights the crucial need for cultural competency training for health professionals.⁷ In fact, the data are so overwhelming that the Liaison Commission of Medical Education, whose accreditation is necessary for medical schools to receive federal grants and participate in federal loan programs, revised its standards in 2008 to require medical schools to “work within their own universities and/or collaborate with other institutions to make admissions to medical education programs more accessible to potential applicants of diverse backgrounds.”⁸ In addition, a host of legislative mandates nationally require or strongly recommend cultural competency training of health professionals.⁹

The Commissioners’ position that “[i]f cultural competence were the problem, one would expect doctors who treat black patients most frequently to provide superior care to black patients, since their extensive experience with black patients would cause them to be on the

⁵ Sullivan Commission on Diversity in the Health Workforce. *Missing Persons: Minorities in the Health Professions*. Washington, DC: 2004.

⁶ Health Resources and Services Administration. *The Rationale for Diversity in the Health Professions: a Review of the Evidence*. Rockville, MD: U.S. Department of Health and Human Services; 2006.

⁷ Smedley BD, Stith AY, Nelson AR. What Health Care Providers Need to Know about Racial and Ethnic Disparities in Health-Care. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Institute of Medicine; 2003.

Alderman AK, Hawley ST, Janz NK, et al. Racial and ethnic disparities in the use of postmastectomy breast reconstruction: results from a population-based study. *J Clin Oncol*. 2009.

Alexander C, Chen E, Grumbach K. How leaky is the health career pipeline? Minority student achievement in college gateway courses. *Acad Med*. 2009; 84(6):797-802.

Einbinder LC, Schulman KA. The effect of race on the referral process for invasive cardiac procedures. *Med Care Res Rev*. 2000; 57 Suppl 1:162-80.

Ezenwa MO, Ameringer S, Ward SE, Serlin RC. Racial and ethnic disparities in pain management in the United States. *J Nurs Scholarsh*. 2006; 38(3):225-33.

Kreatsoulas C, Anand SS. Disparity in outcomes of surgical revascularization for limb salvage: race and gender are synergistic determinants of vein graft failure and limb loss. Nguyen LL, Hevelone N, Rogers SO, Bandyk DF, Clowes AW, Moneta GL, Lipsitz S, Conte MS. *Circulation*. 2009; 119:123-130. *Vasc Med*. 2009; 14(4):397-9.

Sabin JA, Rivara FP, Greenwald AG. Physician implicit attitudes and stereotypes about race and quality of medical care. *Med Care*. 2008; 46(7):678-85.

⁸ Liaison Commission on Medical Education. Latest Additions to LCME Accreditation Standards <<http://www.lcme.org/standard.htm>>. Accessed 10/16/09, 2008.

⁹ Graves D, Like R, Kelly N, Hohensee A. Legislation as intervention: a survey of cultural competency policy in health care. *J Health Care Law Pol*. 2007; 10(2):339-61.

average, more culturally competent,” shows a lack of understanding and appreciation for the complex intricacies of cultural-competency training. Such competencies are not merely acquired by treating patients of racial and ethnic minority backgrounds, but demand an open mind, tolerance, humility, a willingness to learn, and participation in both didactic and hands-on training.

Constitutionality of Diversity Provisions in H.R. 3200

The Commissioners’ letter also alleges that giving preference in awarding grants and contracts to health professional training programs that have a demonstrated record of training individuals who are from underrepresented minority groups or disadvantaged backgrounds is tantamount to Congressionally-mandated affirmative action and is likely to be held unconstitutional. They assert that this could cause potential grantees to give preferential treatment to minority applicants and apply less demanding academic standards.

However, the Commissioners fail to note that this preference has existed in statute for health professions training programs since they were last reauthorized in 1998 with the passage of the Health Professions Education Partnerships Act. The Act reads, “[w]ith respect to programs for the training of interns, residents, or physician assistants, the Secretary shall give priority in awarding grants under this section to qualified applicants that have a record of training individuals who are from disadvantaged backgrounds (including racial and ethnic minorities underrepresented among primary care practice or general or pediatric dentistry).”¹⁰

In addition, this preference in awarding grants and contracts would not violate constitutional law because it would not create a preference for minority-owned contractors. In their letter, the Commissioners erroneously rely on the Supreme Court case of *Adarand Constructors v. Peña*¹¹ as a basis for their assertion that this preference is unconstitutional. However, *Adarand* applies to federal preferences in contracting with minority-owned contractors and the provisions in question in H.R. 3200 do not give preference to training programs that are more than 50 percent minority-owned. More importantly, the Commissioners’ letter does not recognize that the use of racial preferences is constitutional if it is narrowly tailored to further a compelling interest (e.g., diversity).¹² Accordingly, the Supreme Court upheld the narrowly-tailored use of race-based policies for graduate school programs in *Grutter v. Bollinger et al.*,¹³ which allows institutions to use race-conscious admissions policies as long as they take into consideration race-neutral alternatives to achieve diversity.¹⁴

The Commissioners also misrepresent the provisions in H.R. 3200 as “offer[ing] subsidies to those [medical] schools that can demonstrate that they have recruited a “sufficient” number of minority members.” In fact, the legislation states that a preference in awarding grants and contracts would depend upon a demonstrated record of *training* individuals who are from underrepresented minority groups and disadvantaged backgrounds. This implies that these institutions would have a success rate of graduating a significant number of individuals from underrepresented minority groups and disadvantaged backgrounds.

¹⁰ Health Professions Education Partnership Act of 1998, 42 U.S.C § 293(k) (1998).

S. Rep. No. 105-220, (1998) (Senate Committee on Labor and Human Resources Report on the Health Professions Education Partnership Act).

¹¹ *Adarand Constructors v. Peña*, 515 U.S. 200 (1995).

¹² *Id.* at 237.

¹³ *Grutter v. Bollinger et al.*, 539 U.S. 306 (2003).

¹⁴ *Id.* at 340.

Moreover, the allegation that this preference in awarding grants and contracts to medical schools would lower academic standards on the basis of race is a gross mischaracterization of decades of interventions spearheaded by the federal government, health professions schools and national professional associations to increase diversity in the educational pipeline. These interventions include mathematics and sciences enrichment programs; pre-health career preparation; pre-matriculation interventions; summer research programs; school partnerships; faculty enrichment, individual and institutional level support; and national and regional campaigns by health professions schools, professional societies, accreditation bodies and the federal government.¹⁵ Diversity efforts do not lower educational standards, but instead contribute to educational achievement.

Conclusion

The pervasiveness and persistence of health and health care disparities in our nation are a serious civil and human rights problem. Moreover, as the proportion of minorities in the U.S. population grows, improving access to and quality of care for these groups would greatly enhance the nation's health and reduce the economic toll associated with inequities in health status and health care. According to a recent report by the Joint Center for Political and Economic Studies, from 2003 to 2006 disparities in health care and health outcomes cost our nation an estimated \$1.24 trillion in excess spending and lost productivity. In those four years, eliminating certain health disparities would have reduced direct health care expenditures by \$229.4 billion.¹⁶ As substantiated by the weight of scientific research, efforts to improve health outcomes for underserved racial and ethnic minorities necessitate increasing diversity and cultural competency among health professionals.

Historically, racial and ethnic minorities have been underrepresented in the health professions workforce. Following the civil rights movement, schools of medicine, dentistry and nursing have been among the last to enroll minority students and health professional organizations have been among the last to recruit minorities. Since then, enrollment of minority students in health professions schools has increased slightly, but it has not kept up with the growing proportion of minorities in the U.S. population. While African Americans, Hispanic Americans and American Indians make up nearly 25 percent of the U.S. population, they account for only six percent of physicians, five percent of dentists and nine percent of nurses. Diversity is also lacking in the faculties of medical schools, limiting the number of minority leaders and mentors. Minorities make up only 4.2 percent of medical school faculties, 8.6 percent of dental school faculties and 10 percent of baccalaureate nursing faculties.¹⁷

The preference given to training programs with a demonstrated record of training individuals who are from underrepresented minority groups or disadvantaged backgrounds is particularly important because of obstacles individuals from underrepresented minority groups and disadvantaged backgrounds face in affording a medical education. The financial burden of medical school prevents many minorities from pursuing an education in the health

¹⁵ Grumbach K, Coffman J, Rosenoff E, Munoz C, Gandara P, Sepulveda E. *Strategies for Improving the Diversity of the Health Professions*. Woodland Hills, CA: The California Endowment, 2003.

Strelnick AH, Taylor VS, Williams B, et al. Diversity in academic medicine no. 3 struggle for survival among leading diversity programs. *Mt Sinai J Med*. 2008; 75(6):504-16.

¹⁶ LaVeist TA, Gaskin DJ, Richard P. *The Economic Burden of Health Inequalities in the United States*. Washington, DC: The Joint Center for Political and Economic Studies; 2009.

¹⁷ See The Sullivan Commission on Diversity in the Healthcare Workforce.

professions and creates excessive loan and work burdens for those who do.¹⁸ Larger proportions of minorities are low-income and face a greater disadvantage to affording medical school: In 2005, the median income for white families was 39 percent higher than that of African Americans and 29 percent higher than that of Latinos.¹⁹ Since 1984, the cost of a medical education has increased over 300 percent at public schools and 150 percent at private schools. Including living expenses, books and equipment, a four-year medical degree costs approximately \$140,000 at public schools and \$225,000 at private schools. Cost is the number one reason minority students do not apply to medical schools.²⁰

Provisions in H.R. 3200 that recognize the need to increase diversity in the health professions are critical to addressing and eliminating health disparities among racial and ethnic minority and other disadvantaged populations. As stakeholders in the struggle to eliminate racial and ethnic health disparities and achieve health equity, we urge you to support maintaining these provisions in the final health reform bill.

Sincerely,

American Academy of Physician Assistants
American Association of Colleges of Osteopathic Medicine
American Association of People with Disabilities
American Dental Education Association
American Nurses Association
Association of Academic Health Centers
Association of Clinicians for the Underserved
Association of Minority Health Professions Schools
Charles Drew University
Community Health Councils
The Consortium of Social Science Associations
Department of Gerontology, San Diego State University
The Disparities Solutions Center at Institute for Health Policy, Massachusetts General Hospital
Family Voices
Institute for Family Health
La Fe Policy Research and Education Center
Meharry Medical College
Minority Health Institute, Inc
Morehouse School of Medicine
National Asian Pacific American Women's Forum
National Association of Local Boards of Health
National Council for Diversity in the Health Professions
National Health Law Program (NHLP)
National Latina Institute for Reproductive Health
National Physicians Alliance
New York Lawyers for the Public Interest (NYLPI)
Northwest Federation of Community Organizations
Northwest Health Law Advocates
Out of Many, One (OMO)

¹⁸ See The Sullivan Commission on Diversity in the Healthcare Workforce.

¹⁹ DeNavas-Walt C, Proctor BD, Lee CH. *Income, Poverty, and Health Insurance Coverage in the United States: 2005*. U.S. Census Bureau; 2006.

²⁰ Morrison G. Mortgaging our future – the cost of medical education. *N Engl J Med*. 2005; 352(2):117-119.

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*Note: Organizations listed for identification purposes only

cc: The Honorable Harry Reid, Majority Leader
The Honorable Mitch McConnell, Minority Leader
The Honorable Max Baucus, Chairman, Committee on Finance
The Honorable Charles Grassley, Ranking Member, Committee on Finance
The Honorable Thomas Harkin, Chairman, HELP Committee
The Honorable Michael Enzi, Ranking Member, HELP Committee
The U.S. Commission on Civil Rights