

For Immediate Release
September 26, 2007
9:30 A.M. EST

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Civil Rights And Medical Leaders Call For Social Justice In Health Care

"Of all forms of inequality, injustice in health care is the most shocking and inhumane."

Dr. Martin Luther King, Jr.

Washington, DC—"Everybody knows that the U.S. healthcare system is inadequate. We are here to remind the nation that it is also unfair," said Gary A. Puckrein, PhD, at a press conference today in Washington. "The system continues to treat the White majority in this country as the norm while it neglects the rest of the population in every aspect of health care, from research through end-of-life care."

The press conference — entitled "The Healthcare Quality Crisis in America: A 21st Century Civil Rights Priority!" — featured a blue-ribbon panel of speakers, including Mohammad Akhter, MD, MPH¹; Hon. Donna M. Christensen²; Rev. Tyrone Crider³; Gerald DeVaughn, MD⁴; Rev. Jesse Jackson⁵; Elizabeth Ofili, MD, MPH⁶; Rev. Al Sharpton⁷; Rev. Charles Steele, Jr.⁸; Hilary O. Shelton⁹; and Richard Allen Williams, MD¹⁰.

"We are free, but not equal," said Rev. Jackson. "The struggle to increase life options continues. Without equality in healthcare, we will continue to have high infant mortality, short life expectancy, and great health disparities."

Minority populations in the United States are struggling to survive a pervasive health crisis, but investment in their health remains disproportionately low. Private health insurance plans spend about twice as much per person on White patients as they do on Black or Hispanic patients. Disparities in the quality of healthcare provided through public programs, such as Medicare and Medicaid, have been well documented, and differences in income and education do not explain the existence or persistence of this inequitable treatment. Particularly troubling are the delays by Medicare, Medicaid, the Department of Veterans Affairs, and other federally sponsored programs in adopting new treatment modalities for Black patients with chronic heart failure, causing needless suffering and death.

"Healthcare is the next battleground for civil rights", said Mr. Steele. "It is imperative that we inform our people. It is about a racial divide, as well as between rich and poor. People are being disenfranchised."

Mr. Shelton called for a comprehensive, aggressive approach to ending disparities. He illustrated the magnitude of the problem with statistics that, he noted emphatically, "...are as unthinkable as they are conclusive! African Americans are 23% more likely to die from various types of cancer than Whites. African American and American

Indian/Alaskan Native infant mortality rates are more than 2 times higher than those for their Caucasian counterparts...African American diabetics are more than 3 times more likely than Caucasian diabetics to have a lower limb amputated.”

Other available data sources document that the prevalence of HIV/AIDS in minority communities has reached catastrophic levels, with documented case rates for African Americans and Hispanics that are more than 10 times and 4 times higher, respectively, than those of White Americans. Black patients with kidney disease have a disproportionately high experience with dialysis, and a concomitantly low experience with kidney transplantation.

Dr. Akhter, alluding to the need for the system to accept responsibility for some of the causes of health status and healthcare disparities, stated that, “It’s not the choices that people make, it’s the choices that people have”. Further, he said, “The American medical system was designed in the 30’s to take care of White middle class men only, and that education system is still going to this day”. This systemic bias must be changed, or efforts to create universal access will not bring about the desired improvements.

Dr. DeVaughn used treatment of heart disease as a model for understanding healthcare disparities. “Cardiovascular disease is the #1 killer of all Americans”, he said. “But encouragingly, we have witnessed a positive trend in heart health in America. Between 1994 and 2004 the death rate from coronary artery disease has declined by 33 percent. Kudos for medical science. Unfortunately, African Americans have not enjoyed the same benefit of this science. The cardiovascular death rate in Blacks dropped by only 11 percent. African Americans have twice the incidence of first stroke. And if you’re a Black male, you can expect to live 13 years less than a White female.” The explanation for the disparity in cardiovascular health is complex. Black Americans are diagnosed at a younger age and, when diagnosed, are more progressed, and mortality is higher. The causes of chronic heart failure in Blacks differ from the causes in Whites. During the past 25 years, Dr. DeVaughn noted, African Americans have benefited, but to a lesser degree, from advancements in treatments for congestive heart failure.

“It should be clear to even the non-medical observer that a unique solution is called for,” said Dr. DeVaughn. “A race neutral approach to this entity has not worked, and has been responsible for thousands and thousands of unnecessary deaths.”

Dr. Ofili, Dr. Williams, and Dr. DeVaughn, decried the appalling lack of support for adoption of BiDil, the scientifically-proven therapy that, in clinical trial, resulted in unprecedented improvement in the health status, and in reduced costs of related health care, for African-Americans with chronic heart failure by reducing mortality rates, reducing hospitalizations, and improving overall quality of life. Although the Food and Drug Administration approved BiDil in 2005, the use of BiDil in Black patients with chronic heart failure is still in single digits.

Dr. Ofili expressed particular concern about the daily obstacles that physicians face from drug benefit plans who continue to erroneously advocate for unproven therapies as

substitutes for BiDil. “By ignoring the scientific evidence,” said Dr. Ofili “we are placing our patients at unnecessary risk of premature death and poor quality of life.”

Dr. Williams called upon providers and patients to challenge political candidates about their views on healthcare disparities, including medication access inequities and drug switching. Denial of access to BiDil, and required switching of patients from brand drugs to generics that are not as effective, are a healthcare disparity of the greatest sort, he said.

Rev. Crider spoke of both his commitment to a civil rights framework for the healthcare disparities movement, and the challenges of advocating for the addition of BiDil to formularies across the nation. He praised the linkage of the civil rights, the medical, and the faith-based communities to bring their particular expertise to the civil rights movement for social justice in healthcare.

In support of this civil rights social justice movement, these organizations will work together to conduct a series of initiatives to help build a healthcare research, delivery and financing system that has the capacity to provide optimal care to a diverse America. One of the first is Community HeartBEAT— a national education and advocacy initiative designed to eliminate preventable morbidity and mortality for Blacks/African Americans with chronic heart failure by improving the quality of care provided by physicians, and increasing patients’ awareness of effective treatments. All speakers supported the need for a national plan to redress healthcare inequities.

“Lack of quality healthcare for all Americans, no matter how you got here, is a national issue that needs to be addressed at the national level,” said Dr. Akhter. “You don’t get what you deserve, you get what you demand!”

As noted by Del. Christensen, who has co-sponsored the Health Equity and Accountability Act of 2007, “Quality healthcare for all Americans cannot and will not be achieved until we have a healthcare system that is built upon a foundation of health equity”.

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The National Minority Quality Forum is a not-for-profit, non-partisan organization dedicated to research, education, and advocacy to assure the availability of quality health services for all Americans.

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