

**TESTIMONY OF JIN HEE LEE**  
**NOVEMBER 2, 2007**

*Before the New York State Departments of Health and Insurance*

*Public Hearing*  
*Increasing Access to Health Insurance Coverage*  
*and Moving Toward Universal Healthcare Coverage:*  
*Defining the Goals and Identifying the Steps*

Thank you for giving me this opportunity to speak on the issue of health care reform with the goal of ensuring access to quality and affordable health care services for all New Yorkers. My name is Jin Hee Lee, and I am a Staff Attorney at New York Lawyers for the Public Interest, a civil rights law firm based here in Manhattan. New York Lawyers for the Public Interest has three main program areas: disability rights, environmental justice, and access to health care. I am here to speak on behalf of our Access to Health Care Program, which advocates against racial and ethnic discrimination in New York City's health care system.

First, I would like to commend all of the panelists for convening this hearing and taking on the challenge of expanding coverage for New York's uninsured and underinsured. Insurance coverage has unquestionably been a barrier to care for thousands of immigrants and people of color, and is an essential step in reforming our health care system. However, if New York is truly serious about health care reform, it must incorporate two additional key elements that, thus far, have not played a significant

role in these discussions. These key elements are: (1) addressing racial and ethnic health disparities; and (2) implementing some form of community-based health planning.

### *Racial and Ethnic Health Disparities*

The racial and ethnic disparities in both access to health care and health outcomes have been well documented by numerous sources. The Institute of Medicine's landmark report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, made the express finding that "[r]acial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable."<sup>1</sup> Likewise, a report issued by the State Department of Health just this past September, is replete with evidence of racial and ethnic disparities. Just one example is a comparison of premature death rates by race: Black and Latino New Yorkers die prematurely at almost double the rate of White New Yorkers; Asians' premature death rate is 1½ times greater than Whites.<sup>2</sup>

The New York City Department of Health and Mental Hygiene has also documented the severe health disparities in New York City. For example, Black males, on average, live 6 years less than their White counterparts.<sup>3</sup> Citywide, the infant mortality rate of Black infants was almost three times higher than White infants.<sup>4</sup> "If the infant mortality rate among African Americans decreased to that of Whites, nearly 200 fewer babies would die each year."<sup>5</sup>

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<sup>1</sup> Institute of Medicine of the National Academies, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (2003) (hereinafter "IOM Report") at 12, 19.

<sup>2</sup> New York State Department of Health, *New York State Minority Health Surveillance Report* (Sept. 2007) at 21.

<sup>3</sup> New York City Department of Health and Mental Hygiene, *Health Disparities in New York City* (2004) (hereinafter "Health Disparities in NYC") at 7.

<sup>4</sup> *Id.* at 15.

<sup>5</sup> *Id.* at 18.

But the disparities are not just limited to health outcomes. There is also a disparity in the distribution of health care resources that fall along racial lines. From 1995 to 2005, 8 out of 12 hospital closures in New York City occurred in communities of color.<sup>6</sup> In some cases, more than 90% of the patients using those hospitals were African American, Latino, or Asian.<sup>7</sup> In just the past two years, my office has worked with no less than seven separate communities fighting the closure of seven New York City hospitals that are or had been serving medically underserved areas.<sup>8</sup>

A case in point is the area of Central Brooklyn—a community that is more than 90% Black or Latino, and has some of the worst health statistics city or statewide.<sup>9</sup> Yet, despite the obvious need for health care services, in just four years, Central Brooklyn has lost two hospitals, OB-GYN services at a third hospital, prenatal services at a fourth hospital, 13 hospital outpatient clinics, a federally-funded health center, and at least two WIC centers.

While insurance coverage may significantly reduce some health disparities, it will not solve the entire problem. Research clearly demonstrates that racial and ethnic disparities continue to exist even among those with private health insurance or Medicare.<sup>10</sup> In fact, Black and Latino residents of New York City are far more likely

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<sup>6</sup> Opportunity Agenda, *Dangerous and Unlawful: Why Our Health Care System is Failing New York Communities and How to Fix It* (2006) at 6.

<sup>7</sup> *Id.*

<sup>8</sup> Baley Seton Hospital (Staten Island), St. Joseph's Hospital (Queens), and St. Mary's Hospital (Brooklyn) closed as part of the bankruptcy proceedings of St. Vincent's Catholic Medical Centers. Mary Immaculate Hospital (Queens), which had also been part of the St. Vincent's network, was sold to Caritas Health Care, Inc. to avoid closure, but is currently experiencing financial instability and another risk of closure. Both New York Westchester Square Medical Center (Bronx) and Victory Memorial Hospital (Brooklyn) were ordered to close by the Commission on Health Care Facilities in the 21st Century.

<sup>9</sup> Central Brooklyn's health outcomes in almost all areas, including heart disease, diabetes, HIV, mental illness, substance abuse, cancer, asthma, and birthweight, are worse than the Brooklyn borough or the city as a whole. See New York City Department of Health and Mental Hygiene, Central Brooklyn Community Health Profile (2006) (hereinafter "Central Brooklyn Profile").

<sup>10</sup> Health Disparities in NYC at 22; see also Bowen Garrett et al., "Racial and Ethnic Differences in Insurance Coverage and Health Access and Use," The Urban Institute (April 2006) at 27 ("[I]nsurance

than Whites to have diabetes even if they are at the same income levels.<sup>11</sup> The cause of these disparities is multi-faceted and complex. The Institute of Medicine report has found that disparities may partially result from “[b]ias, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers . . . .”<sup>12</sup> Other studies have noted the physiological effects of living with racism and the attendant stress factors,<sup>13</sup> the varying levels of quality depending on where care was received,<sup>14</sup> and lower trust in health care providers, particularly among African Americans.<sup>15</sup> Still others have cited language barriers as one of the most significant causes of health disparities.<sup>16</sup>

These racial and ethnic disparities are both unacceptable and illegal. Regulations promulgated under Title VI of the Civil Rights Act of 1964 expressly forbid facially neutral policies or procedures that have the “effect” of discriminating on the basis of race,

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coverage is at best a partial explanation for differences in access and use” of health care.); Michelle M. Doty et al., “Health Care Disconnect: Gaps in Coverage and Care for Minority Adults,” The Commonwealth Fund Issue Brief (Aug. 2006) at 7 (“Insurance alone does not ensure equal access and equal care. Having a regular doctor is important as well, in terms of timing and receipt of preventative care.”); Glenn Flores et al., “Racial and Ethnic Disparities in Early Childhood Health and Health Care,” *Pediatrics* (Feb. 2005) (hereinafter “Disparities in Childhood Health”) at 191 (“[N]onwhite children were almost twice as likely not to be referred to specialists by health care providers, even after adjustment for insurance coverage, health status, and other relevant covariates.”); Arlene S. Bierman et al., “Addressing Racial and Ethnic Barriers to Effective Care: The Need for Better Data,” *Health Affairs* (May/June 2002) (“Racial and ethnic disparities in health outcomes have been observed among persons with similar health insurance, within the same system of care, and within the same managed care plan.”); David R. Williams et al., “Understanding and Addressing Racial Disparities in Health Care,” *Health Care Fin. Rev.* (Summer 2000) at 75 (noting “racial differences in the receipt of major therapeutic procedures for a broad range of conditions even after adjustment for insurance status and severity of disease”); Cynthia G. Golen et al., “Maternal Upward Socioeconomic Mobility and Black-White Disparities in Infant Birthweight,” *Am. J. Pub. Health* (2006) (finding mothers’ upward socio-economic mobility to improve birthweight of White infants significantly, but have substantially weaker correlation for Black infants).

<sup>11</sup> Health Disparities in NYC at 15.

<sup>12</sup> IOM Report at 12, 19.

<sup>13</sup> See, e.g., Fleda Mask Jackson, “Race, Stress, and Social Support: Addressing the Crisis in Black Infant Mortality,” Joint Center for Political and Economic Studies Health Policy Institute (2007).

<sup>14</sup> See Romana Hasnain-Wynia, et al., “Disparities in Health Care Are Driven by Where Minority Patients Seek Care,” *Arch Intern Med.* (June 25, 2007).

<sup>15</sup> See Chanita Hughes Halbert, et al., “Racial Differences in Trust in Health Care Providers,” *Arch Intern Med.* (Apr. 24, 2006).

<sup>16</sup> See, e.g., Jose J. Escarce, “Racial and Ethnic Disparities in Access to and Quality of Health Care,” The Synthesis Project (Sept. 2007) (noting studies that find largest disparities to be between Whites and Spanish-speaking Latinos); Disparities in Childhood Health, at 191 (Latino parents “cite language problems as the greatest barrier to health care for their children.”)

color, or national origin.<sup>17</sup> Accordingly, the State has an affirmative obligation to remedy racial and ethnic health disparities, which can finally be addressed in New York as part of a larger health care reform package.

The State of Massachusetts serves as an example of what can be done to begin to address racial and ethnic disparities in an overall effort to achieve universal health care coverage. Without endorsing the specific form of universal health care chosen by Massachusetts, it is important to note how disparities reduction became an integral part of its health care reform.<sup>18</sup> For example, state legislation in Massachusetts created a Health Disparities Council and also included disparities reduction in determining health care quality, hospital rate increases, and hospital and community health worker performance reviews.<sup>19</sup> Currently pending before the Massachusetts Legislature is “An Act Eliminating Racial and Ethnic Health Disparities in the Commonwealth,” which would, among other things, establish an Office of Health Equity to oversee statewide efforts to eliminate disparities, publish disparities report cards and impact statements, and coordinate the collection, analysis, and dissemination of data concerning race, ethnicity, and primary language.<sup>20</sup> I submit to you that New York can exceed the efforts of Massachusetts and any other jurisdictions that are currently addressing racial and ethnic disparities in health care.

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<sup>17</sup> 45 C.F.R. § 80.3(b)(2).

<sup>18</sup> For a brief overview of Massachusetts’ health care reform, see “Confronting Disparities while Reforming Health Care: A Look at Massachusetts,” Minority Health Initiatives at Families USA (June 2007).

<sup>19</sup> *Id.*

<sup>20</sup> *Id.*

### Community-Based Health Planning

Another important element to include in health care reform is the implementation of community-based health planning. Though far from perfect, the Health Systems Agency (“HSA”) provides a precedent for what such planning might look like in New York State. Since it was defunded in 1996, there has been absolutely no comprehensive community health planning across the state, and the consequences have been disastrous.

I would like to return to what has happened to Central Brooklyn to illustrate this point. In its last report, New York City’s HSA concluded that neighborhoods in Central Brooklyn, such as Crown Heights, Bedford-Stuyvesant, and East New York/Brownsville, were “Priority 1” areas because they were experiencing the most severe health problems and needed the most funding and resources.<sup>21</sup> However, it is clear that the health status in these neighborhoods has only deteriorated since the loss of the HSA. The Bedford-Stuyvesant and Crown Heights Service areas have been designated “Medically Underserved Areas” by the federal government since 1993. The federal government has likewise designated Bedford-Stuyvesant, Crown Heights, and East New York as “Health Professional Shortage Areas” with respect to primary care providers. Rates of deaths or hospitalizations from diabetes, heart disease, cancer, HIV, substance abuse, asthma, and mental illness far exceed that of the entire city or borough.<sup>22</sup>

In the context of these health disparities, the closure of St. Mary’s Hospital in 2005 serves as the perfect case study on why we need community-based health planning. At the time of its closure, St. Mary’s detoxification beds were at 105.8% capacity, and the emergency room had seen 60,000 visits in the preceding year. Although five of

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<sup>21</sup> Health Systems Agency of New York City, “A Framework for Primary Care Needs Analysis in New York City,” (Sept. 1993).

<sup>22</sup> Central Brooklyn Community Health Profile, at 6-13.

St. Mary's seven outpatient clinics were transferred to Kingsbrook Jewish Medical Center, less than two years later, all but one have closed. Moreover, the property owner of one of these recently closed clinics in Brownsville informed us that the space had undergone a \$2.5 million renovation within the prior two years. That clinic space will soon be demolished to make way for a supermarket.

The loss of these health care resources has severe implications. In 2004, the infant mortality rate (deaths per 1000 live births) in Brownsville was 12.2; in Flatbush it was 7.4. Compare these rates to areas in Manhattan, such as the Upper East Side, with infant mortality rates as low as 2, or even the citywide rate of 6. If the current trend of health care disinvestment continues unchecked, we can only expect infant mortality and other health outcomes to worsen in what has already become a veritable health crisis.

A lesson to be learned from the health crisis in Central Brooklyn is the need for community-based health planning that includes meaningful participation from and accountability to community stakeholders. With the leadership of Ngozi Moses of Brooklyn Perinatal Network, a coalition of community partners is currently trying to save two of the four clinics recently closed by Kingsbrook. Yet, their involvement in the future of these clinics should have been sought from the very beginning. If we are truly serious about connecting patients to care for long-term cost effectiveness, we cannot continue closing hospitals and clinics in medically underserved communities, only to follow up with a letter in the mail or a flyer posted on a shuttered clinic window. The State must ensure that health care resources are distributed in a thoughtful and comprehensive manner that is fully accountable to the community residents affected by its decisions.

In summary, New York Lawyers for the Public Interest makes the following recommendations with respect to health care reform in New York:

1. Develop and implement a coordinated system of collecting and reporting data on patients' race, ethnicity, and primary language at various points of interaction with providers in order to identify areas of disparities;
2. Develop and implement a comprehensive, statewide effort to reduce racial and ethnic disparities that includes financial incentives for disparities reduction;
3. Develop and implement a transparent and public process of deliberation prior to the approval of any hospital or clinic closure—whether voluntary or involuntary—that includes an opportunity for public comment and a meaningful review of the closure's impact on the neighboring community; and
4. Develop and implement a fully-funded, community-based health planning agency that is independent of special interest groups, comprised of a wide array of experts and interested stakeholders, and charged with the responsibility to collect and report data, conduct localized needs assessments, and make binding recommendations regarding the distribution of health care resources.

Thank you for the opportunity to present this testimony. We at New York Lawyers for the Public Interest look forward to working with all of you on these very important issues for the common goal of ensuring quality health care for all New York residents, regardless of race, ethnicity, or national origin.