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Testimony of

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On behalf of the

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Mr. Chairman and members of the Committee, thank you for the opportunity to discuss the critical importance of diversity in the health professions, and specifically the health professions training programs at the Health Resources and Services Administration (HRSA).

I am Dr. John E. Maupin, President of the Morehouse School of Medicine (MSM) in Atlanta, Georgia. MSM is one of only four Historically Black medical schools in the country, and one of twelve (12) Historically Black health professions institutions that compromise the Association of Minority Health Professions Schools (AMHPS). Historically, this small number of schools have collectively trained 50% of the African American physicians and dentists in this country, 60% of African American pharmacists, and 75% of African American veterinarians. Many have called our institutions a national resource, and they are correct. These schools go a long way in making the healthcare workforce look like America. I want you to know that it is not lost on me that I am making this statement to your committee in February, Black History Month. I think this is as appropriate time as any to have a discussion about health disparities in America, and hopefully we can agree on a legislative solution. Mr. Chairman, I understand that the Historically Black institutions are not the only ones who are combating health disparities. I have provided the committee with a list of all institutions which were able to compete well for the key programs which support the training of minority health professionals, when those programs were funded more robustly.

In 1997, then as President of Meharry Medical College (MMC) in Nashville, Tennessee, I testified before this Committee, and discussed the challenges of health disparities in America. There have been some improvements, thanks to the work this Committee did to reauthorize, restructure, and empower certain programs that created and strengthened a pipeline of minority health professionals. Those health professionals have dedicated themselves to serving in the areas where they are most needed—rural and urban medically underserved communities. The diversity cluster of the Title VII health professions training programs: Minority Centers of Excellence (COE), Health Careers Opportunities Program (HCOP), Scholarships for Disadvantaged Students (SDS), and Faculty Loan Repayment Program are the programs that made the training of a diverse healthcare workforce possible, and they are the lifeblood of institutions like Morehouse School of Medicine, Meharry, and our sister institutions at AMHPS. Unfortunately, the funding for these programs was dramatically cut in Fiscal Year (FY) 2006, and the programs have struggled to regain that funding. Shortly, I will explain the unique mission of our small set of institutions, the reason why the aforementioned programs are so important, and what this committee can do to make sure we continue to produce quality primary care health professionals.

The Health Status of Minorities

Mr. Chairman, in 2005 the Centers for Disease Control and Prevention (CDC) still claimed that "non-Hispanic blacks bear a disproportionate burden of disease, injury, death, and disability." It is still fair to say that African Americans and other minorities suffer a disproportionately low health status when compared to their non-minority counterparts in our country. In a 1985 landmark study conducted by the U.S. Department of Health and Human Services, The HHS Secretary's Task Force Report on Black and Minority Health, confirmed this national problem. Allow me to share updates on some of the highlights from that report:

- African American infants are nearly two and one-half times more likely to die before their first birthday than white infants
- African Americans are twice as likely to die from stroke as Caucasians. The rate of first strokes in African Americans is almost double that of Caucasians
- African Americans who died from HIV-AIDS had approximately 11 times as many age-adjusted years of potential life lost before age 75 years per 100,000 population as non-Hispanic whites. African Americans also had substantially more years of potential life lost than non-Hispanic whites for homicide (nine times as many), stroke (three times as many), prenatal diseases (three times as many), and diabetes (three times as many)
- Cancer is the second leading cause of death for African Americans
- Only 56% of African Americans have private health insurance coverage. Medicaid covers an additional 21%, but almost one quarter (23%) are uninsured. The uninsured rate for African Americans is more than one and a half times the rate for white Americans
- 24.7% of African American families lived below the poverty level, including 46% of African American children

Mr. Chairman, if improving upon these health disparities is a national priority, the need for an aggressive federal commitment to address these problems still very much exists.

The Need for Strengthening and Funding Federal Health Professions Training Programs

The national priority to improve the health status of minorities, by doing so all Americans, rests in large part on our ability to train competent and dedicated individuals to serve our nation's underserved and disadvantaged areas. Currently, Mr. Chairman, even though African Americans represent about 13% of the U.S. population, only 2-3% of all physicians, dentists, pharmacists, veterinarians, and allied health professionals are African Americans. There is also a wide body of research demonstrating that language, communication patterns, socioeconomic barriers, and diverse health/disease belief systems play a major role in eliciting history, establishing diagnoses, obtaining the help and cooperation of family and friends, and influencing the patients' compliance with a recommended course of treatment. There are also ethnic and racial differences in response to drugs and how diseases manifest themselves. Therefore, federal heath professions training programs support targeted to institutions that significantly influence the number of underrepresented minorities practicing in these areas is critical not only to addressing issues of access to care but to the quality of healthcare provided as well.

Every credible study ever conducted demonstrates that an individual who comes from a disadvantaged background or underserved area is much more likely to serve in an underserved area as a health professional. Increasing the numbers of health professionals that serve in underserved areas can and does improve health status. Many of the health professions training and institutional support programs being reviewed today have, and continue to have a dramatically positive impact on the ability of our schools to train the health professions workforce that will serve in underserved areas and improve the health status of disadvantaged and minority populations. Those programs have a positive impact when they are well funded.

The Role of Historically Minority Institutions in Training African American Health Professionals

Collectively, the goal of historically minority institutions has been to train African Americans to serve in medically underserved areas. As demonstrated by the figures outlined in the opening part of my statement, this small contingent of schools has been hugely successful in accomplishing this mission. Yet, in spite of our proven success in training minority health professionals, our institutions endure a financial struggle that is inherent in our mission to train disadvantaged individuals to serve in underserved areas. That is why we say that MSM, like Meharry and our other sister institutions, is a private institution with a public mission.

The financial plight of the majority of our students has affected our schools in numerous ways such that we are not able to depend on more traditional means of support such as annual gifts and generous endowment contributions. Additionally, the patient populations served by the AMHPS institutions have historically been poor, uninsured and under-insured, therefore our institutions have not generated revenue from the process of much more lucrative patient care at the 40-50% level achieved by majority schools. In other words, as a colleague of mine says, our schools have grateful patients, but not wealthy, grateful patients.

With regard to student financial assistance, there is a desperate need for this Committee to understand that scholarship support is the only way to a health professions education for severely disadvantaged students. Student aid officers tell us time and time again that poor students will not agree to incur debt for tuition cost that is about twice the level of their family's annual household income. The effect of wiping out scholarship support is to ensure that poor people do not become health professionals. Further, that almost guarantees that the poor will not be well served medically.

The very nature of our mission directs us to admit students that do not come from affluent backgrounds. In fact at MSM, 72% of entering MSM are classified as disadvantaged. Because of the lack of a sizable financial base at most historically minority institutions, we are unable to provide scholarship assistance to our students at the same level of other institutions. For example, at MSM:

- Only 25% of the scholarships awarded annually are from endowment funds.
- The remaining 75% are non-endowed scholarships and are funded by sources that are cyclical in nature so that the numbers and amounts of scholarships fluctuate annually and are therefore less stable sources of funding.
- The average annual scholarship award is $9,480, which comprises only one-third of the College's tuition and fees for medical students. More significantly, this average award represents only one-fourth of the total cost of a medical education at MSM.
- Because MSM's scholarships only cover 25% of the educational costs, the students must secure the remaining 75% of the funding from loans. When they graduate, the students have often amassed debt which exceeds the national averages for students entering similar professions.

Therefore, targeted federal scholarship support is crucial to the fulfillment of our missions. Scholarship support is the most important way to assist the health professions education of severely disadvantaged students. The program that accomplishes this is the Scholarships for Disadvantaged Students (SDS).

Health professions training grants, targeted towards our institutions and authorized by this Committee, have helped our schools level the playing field by a small measure. They have also allowed us to continue to address the critical disparity needs. Make no mistake, without such programs as the Minority Centers of Excellence (COE), MSM would be a much different place. Health professions training grant programs represent life blood for our institutions.

However, that lifeblood, like the pipeline of health professionals, has been choked off. In FY 2006, the Congress passed a Labor-Health and Human Services (HHS)-Education Appropriations bill that severely cut the funding stream for the programs that fund our institutions' core activities. The programs cut were COE (funded in FY 2005 at $33.6 million, funded in FY 2008 at $12.773 million), HCOP (funded in FY 2005 at $35.647 million, funded in FY 2008 at $9.825 million), Faculty Loan Repayment Program (funded in FY 2005 at $1.302 million, funded in FY 2008 at $1.266 million), and Scholarships for Disadvantaged Students (funded in FY 2005 at $47.128 million, funded in FY 2008 at $45.842 million). I appreciate the fact that the HELP Committee is an authorizer, but the negative impact of this low level of funding for these programs cannot be understated. In terms of the COE program, the funding level is so low that MSM cannot compete for a grant. MSM is adversely affected by our inability to compete for COE and the low level of HCOP funding which inhibits our outreach efforts towards students in primary education, especially the poor, to show them which math and sciences course to take to begin the road to the health professions. Secondly, MSM boasts the number one rated program in the nation for producing minority medical school faculty. That program, previously funded by our COE grant, is in serious jeopardy of closing. Like MSM, that program is a national and state treasure. It is fair to say that if these programs continue to be funded at these low levels, many of the minority health professions institutions may not exist in their current form, furthering the disparity of minority health professionals. These are the kinds of ramifications that occur when the core funding stream for our programs and institutions are drastically reduced.

This has occurred at a particular sensitive time for the minority health training community. Our institutions face the threat of loss of Graduate Medical Education (GME) funding, financing our residency programs, withdrawn unless the moratorium on the CMS rule is extended.

No matter the vehicle this Committee chooses to reauthorize the diversity cluster of the Title VII health professions training programs—either as a portion of Senator Kennedy's *Minority Health Improvement and Health Disparities Elimination Act* (S. 1576) or a Title VII reauthorization bill—our institutions are in favor of adding an evaluation component to each program. Some criticize these programs for not having enough evidence of effectiveness. Mr. Chairman, our students disproportionately dedicate themselves to practicing in the medically underserved areas. That is a direct result of the programs I mentioned above. Morehouse School of Medicine and its sisters HBCU health professions schools, only 12 in all, have historically trained about half of the black health professionals in the country. I don't know how much more

evidence anyone needs to appreciate the impact of these institutions and the importance of these federal programs in responding to their needs.

Recommendations for the Reauthorization of the Health Professions Training Programs

Mr. Chairman, we urge that the Committee move quickly to reauthorize the Centers of Excellence, Health Careers Opportunities Program, Scholarships for Disadvantaged Students, and Minority Faculty Loan Repayment Program to respond to the unwarranted criticism that it is difficult to link the effectiveness of these programs. Please do incorporate a strong evaluation and data collection component into the reauthorization

We also encourage each member of this Committee to advocate for the full restoration of funding for COE, HCOP, Faculty Loan Repayment, and Scholarships for Disadvantaged Students in the FY 2009 L-HHS Appropriations bill. The full funding of these programs gives institutions like MSM the opportunity to compete and invest in the education of the nation's future health professionals that will actively combat racial and ethnic health disparities in the U.S.

Mr. Chairman, I hope these suggestions are helpful to the Committee. Thank you for the opportunity to present views of the Association of Minority Health Professions Schools and Morehouse School of Medicine.