United States Senate HELP Subcommittee on Primary Health and Retirement Security
"*Addressing Disparities in Life Expectancy*"
July 21, 2021

Testimony of
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Good morning, Chairman Sanders, Ranking Member Collins, and members of the Subcommittee: I am Dr. William Cooke, a family physician from Indiana. Thank you for the opportunity to speak to you today.

I've spent two decades working to increase health equity in underserved areas of Southern Indiana. That's where I grew up surrounded by poverty, toxic stress, and substance use. Those factors contributed to my grandpa's death in his fifties and my aunt's overdose death at 39. Although my parents escaped that fate, providing my brother and me greater opportunity, our family remains an example of how early deaths profoundly affects life expectancy.

During medical school I was impressed by the investment we've made in research and technology. There's no place on earth better at keeping *sick* people alive.

As a family physician I felt prepared to care for the entire community at my office, regardless of age or condition. At our critical access hospital, I delivered babies, worked in the Emergency Department, and treated critically ill patients.

Even so, nothing could have prepared me for the suffering I found in the nation's heartland. Young people with late-stage diabetic complications, women dying from cervical cancer, and a man with a tumor on his tongue so large he couldn't close his mouth. These encounters made me realize that our healthcare system focuses so heavily on treating *sick* people it fails to promote *healthy* people. As the Surgeon General's report on Community Health and Economic Prosperity indicates, our nation is at a health disadvantage due to inequitable access to vital community conditions that shape health and wellbeing, such as: clean air and water, nutritious food, having safe housing, reliable transportation, a livable wage, and a sense of belonging and civic power. [1]

There are far too many people, like many of my patients, who lack these vital conditions. Children don't choose to be born and raised in these "low opportunity neighborhoods," yet their life chances are diminished all the same.

Life was more comfortable before I recognized these inequities. My discomfort caused me to cling to beliefs I'd been taught about people who were different from me. But close encounters with

real people have taught me that health and prosperity are not solely dependent on effort and choice but are often limited by the resources and opportunities available where they live. After all, people can only make choices from the options available to them.

The greater the inequity the greater the burden of disease, disability, and early death. We must move beyond the passive, *disease*-oriented model of "do no harm" to a proactive, *person*-centered model of "protect from harm." Primary care physicians are uniquely positioned to do just that. Research confirms access to primary care improves health outcomes[2] and life expectancy.[3]

You've heard a lot of bad news. I'd like to highlight some hopeful progress we've made in Indiana.

My community experienced the worst drug fueled HIV outbreak in U.S. history in 2015, but things look different today. Despite having the highest percentage of people who inject drugs living with HIV in the state, we have defied conventional wisdom by boasting the best viral suppression rate in the state. We went from nearly 200 new cases of HIV in 2015 to only having one last year. Although Indiana leads the country in hepatitis C cases, we've decreased our cases by over 75%. We've also seen an explosion of people with substance use disorder enter treatment and recovery, along with fewer diabetic complications, better pain management without the use of opioids, improved prenatal care, reduced hospital admissions, and the list goes on. We did this with no specialists and limited resources. I believe we've reduced the impact of social determinants on our community by getting outside of the four walls of my clinic. A few examples include:

- Mobile, school, and jail based clinics.
- Working with our sheriff and recovery community to respond to overdoses and people in crisis by providing them direct access to treatment.
- Project ECHO enables my team to provide interdisciplinary access to endocrinology, rheumatology, infectious disease, addiction medicine, and women's health.
- Telehealth allows patients greater access to us and their support networks.
- Interdisciplinary teams with diverse lived experiences help patients feel safe accessing care and overcoming barriers.
- Integrating care with Centerstone, a nonprofit behavioral health system.
- Community, recovery, and faith-based partners help meet basic human needs for food, safety, and belonging.

Our fee for service system doesn't reimburse for these interventions, which highlights the need to move towards payment models designed to address health inequities.

Healthcare disasters don't just happen; they develop right before our eyes, unseen or ignored until it is too late.[4] Then, the people who were already suffering are the ones who are harmed most. We must recognize that there is a cumulative effect of every person's health on our nation's health. But by taking on this crisis of health inequities and declining life expectancy now, we can reestablish the United States as the healthiest place in the world to live.

Thank you for the opportunity to discuss this important topic with the committee and I look forward to your questions.

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[1] Community Health and Economic Prosperity: Engaging Businesses as Stewards and Stakeholders—A Report of the Surgeon General, (Atlanta: US Department of Health and Human Services, Centers for Disease Control and Prevention, and Prevention Office of the Associate Director for Policy and Strategy, January 2021), 11, https://www.hhs.gov/sites/default/files/chep-sgr-full-report.pdf

[2] Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q*. 2005;83(3):457-502. doi:10.1111/j.1468-0009.2005.00409.x

[3] Basu S, Berkowitz SA, Phillips RL, Bitton A, Landon BE, Phillips RS. Association of Primary Care Physician Supply With Population Mortality in the United States, 2005-2015. JAMA Intern Med. 2019;179(4):506–514. doi:10.1001/jamainternmed.2018.7624

[4] Cooke, W. 2021. *Canary in the Coal Mine: A Forgotten Rural Community, a Hidden Epidemic, and a Lone Doctor Battle for the Life, Health, and Soul of the People.* Tyndale House Publishers.