“Examining Health Care Workforce Shortages: Where Do We Go from Here?”
United States Senate
Committee on Health, Education, Labor & Pensions

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Chairman Sanders, Ranking Member Cassidy, and members of the Committee, thank you for the invitation to discuss the implications, both immediate and long-term, that the health care workforce shortage has on our nation and, in particular, to communities of color and growing segments of the population located in rural and underserved areas.

Before I begin, I'd like to thank Chairman Sanders for his work to significantly expand the National Health Service Corps, Community Health Centers, and Teaching Health Centers to hire more doctors and nurses of color to underserved areas and boost the Teaching Health Center Graduate Medical Education program to help train more African American primary care physicians. We have a number of Meharry students who are participants in the National Health Service Corps. I'd also like to thank Senator Cassidy and other members of the Senate for passing the John Lewis National Institute on Minority Health and Health Disparities Research Endowment Revitalization Act. This important legislation will provide critical funds to Historically Black Colleges and Universities (HBCUs) to conduct research into and to address minority health disparities.

This important conversation about the effects that the health care workforce shortage has on health care, health outcomes, and thus life opportunities of a growing segment of the U.S. population could not be coming at a more appropriate time. It is certainly not lost on me that we are addressing this critical topic both during Black History Month as well on the 20th anniversary of the National Academy of Medicine's landmark report, "*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care"*, a report that highlighted the startling fact that across similar income and education levels, insurance status, age and even disease type and severity, racial and ethnic minorities, when compared to their white counterparts, often are diagnosed later, and consistently have less access to the most advanced care and treatments, suffer worse health outcomes, and die prematurely. What a fitting time to draw attention to and call for action on the effects of our health care workforce shortage on inequities in health care and on health outcomes.

I have been trained at - and served on the faculty of - some of the world's most prestigious institutions of higher learning. I chose to take the helm at Meharry because of the populations it exists to serve. The reason is because my life - like the lives of so many trained by Meharry and other HBCU academic health science centers - was shaped by health care disparities.

Meharry was founded in 1876, made possible by a donation from a young trader of Scots-Irish descent who was traveling one night through rough terrain in Tennessee when his wagon became mired in a swamp. A Black family came to his aid, giving him food and a place to sleep, and helping him rescue his wagon the next morning. The man said, "I have no money, but when I can, I shall do something for your race." He was as good as his word. In 1876, he and his brothers donated $15,000 - a significant sum at that time - to establish a medical school in Nashville to train Black doctors the white medical establishment would not train, in order to care for former slaves the white medical establishment would not care for. The man's name was Samuel Meharry. The name of the family that helped him remains unknown.

Meharry is the oldest and largest historically Black academic health science institution in the nation, dedicated to educating and training exemplary primary care physicians, dentists, researchers, public health professionals, and health policy experts. As times began to change for the better in the mid-20th century and the American medical establishment began accepting people of color into its ranks, Meharry expanded and amplified its mission across its schools and programs to train medical professionals to serve all of the underserved - those in urban centers where the population is mostly Black, in rural towns where the population is mostly white, in Latino and immigrant communities, and on native American reservations. In fact, four out of every five Meharry physicians and dentists work in underserved rural and urban communities.

The Present Persistent Problem:
Meharry has made major contributions to bolstering the medical, dental, scientific, and public health workforce in America. Approximately 14% of Black medical doctors, 27% of Black dentists, and 15% of Black biomedical scientists in America graduated from Meharry Medical College. Collectively, with other historically Black health professions institutions across the United States, we have educated and trained half of the Black physicians in the country, half of the Black dentists, and 75% of the nation's Black pharmacists and veterinarians. No other set of institutions has such an impressive legacy of accomplishment that is consistent with the national goal of improving the health status of all population groups. As we strive to continue to be the leading producer of diverse health professionals committed to bolstering access to primary care, eliminating health disparities in rural and urban communities, and improving health care quality for all, it is not lost on me that we have a long way to go to close the gaps in our health professions workforce.

A 2021 article in the *Journal of the American Medical Association* highlighted the dearth of underrepresented minorities in many of our health diagnosing and treating professions. Consider, for example, that while White Americans account for 68.7% of Dentists, Black, Native American, and Hispanic Americans account for 4.4%, 0.1%, and 5.7% respectively. Comparatively, Black Americans account for just 5.2% of physicians, with Native Americans accounting, once again, for 0.1% and Hispanic Americans accounting for 6.9%. This is in comparison to the 62.4% of physicians that identify as White Americans. The lack of diversity continues even when considering the other professions at a patient's bedside. For example, while Black Americans account for 4.5% of Physician Assistants, and Native and Hispanic Americans each account for 0.5% and 7.3% respectively, the overwhelming majority of Physician Assistants are White Americans, as represented by the fact that they account for 75.9%.

The dearth of diverse health providers is associated with significant disparities in health care access, quality, and treatments, along with access to critical public health resources. According to the Association of American Medical Colleges, "If underserved populations were to experience the same health care use patterns as populations with fewer barriers to access, the United States would need an additional 102,400 to 180,400 physicians." In addition, a recent research brief by the de Beaumont Foundation found that in the wake of the Covid-19

pandemic, in order to provide a minimum set of public health services to the nation, state and local governmental public health departments need an 80% increase in their workforce. What this percentage equates to in raw numbers, is a minimum of 80,000 more full-time equivalent positions being required to provide adequate infrastructure and a minimum package of public health services. This reality is exacerbated by the fact that in the past decade alone, state, and local health departments lost 15% of their essential staff. Even further, while approximately 54,000 of the additional positions that are needed should be deployed to local health departments, and the remaining 26,000 to state health departments, it is worth noting that the most acute needs are in local health departments that specifically serve fewer than 100,000 people (de Beaumont Foundation, 2021).

The Worsening Future Problem if We Don't Act Now

The United States is in the midst of a moment of heightened awareness where greater attention is being paid to health inequities. And so, I look forward to working with the Members of this Committee to leverage this unique time in history to achieve health equity in a very real and meaningful way, which requires our serious efforts to address the health workforce shortage and the lack of diversity in the health care and public health arena before things get worse. It is important to remember that most of the recent statistics I just mentioned happened against the backdrop of the ongoing COVID-19 pandemic and its stark, disproportionate, and disparate impact on Black, Latino, American Indian, Asian, Native Hawaiian, and Pacific Islander individuals and communities. In general, low-income Latino families had the highest numbers of full families in poor health, followed by Black/African American low-income families (Braveman & Barclay, 2009).

It is hard for me to overstate the reality that these disparities were brought to light as racial and ethnic minorities continued to suffer from less access to affordable, quality health care, and disproportionately higher rates of incidence and prevalence, as well as premature death, across every chronic and acute disease and condition. This includes cancers, diabetes, hypertension, heart disease, asthma, depression and anxiety, and obesity, just to name a few. During the pandemic, adults reporting symptoms of mental illness quadrupled, from one in ten prior to four in ten. COVID exacerbated isolation and stress for millions during a time when families and communities continued to grapple with social justice issues and economic stress. This impact affected Black, Latino, Native Americans, Native Hawaiians, Alaska Natives, and Asian American adults at a much higher rate than Whites in the United States owing to structural barriers to health care, public health, family leave, and economic opportunity.

For example, today, the maternal mortality rate among Black women is two to three times higher than that among White women. In fact, a Black woman with an advanced degree is more likely to die from pregnancy-related complications in the United States than a White woman with only a high school degree. Unfortunately, their babies do not fare much better: African American newborns, overall, are three times more likely than White newborns to die. In some communities, the number is even higher. Study after study confirms that racial and ethnic health disparities and inequities are so pervasive that they have – in some cases – widened over time and become the norm in the United States. Further adding insult to injury is a report from the

Commonwealth Fund that found that racial and ethnic health inequities not only are pervasive in this country, but some of the starkest and widest disparities are actually in states known for having high performing health care systems. However, according to a ground-breaking study, in situations where the physician was Black, the infant mortality rates dropped significantly.

These disparities carry a hefty economic cost. Research shows that health disparities amount to nearly $93 billion in excess medical care costs and another $42 billion in lost productivity each year (Laveist, et. al., 2009). In a study led by one of our researchers at Meharry to determine the economic burden of mental health inequities, the study showed that over a four-year period, $278 billion could have been saved and reinvested into the economy, and over 116,770 lives could have been saved had mental health inequities become more equitable - and this is a conservative estimate (Dawes, et.al., 2022). Han & Ku (2019) reported that over two-thirds of rural counties had no psychiatrists and almost half of rural counties had no psychologists. Additionally, Deloitte also released a major study showing that if we do not address health disparities in the U.S. by 2040, the top five costly chronic diseases today will cost us $1 trillion.

Consortium of Black Medical Schools Partnership

The historic halls of Meharry and its fellow HBCU medical schools are replete with professionals who have experienced the systemic problem of health disparities, have dedicated their careers to treating this systemic problem, and are prepared to solve the systemic problems relative to our national health care workforce shortage.

All four HBCU medical schools, including Meharry Medical College, Howard University College of Medicine, Morehouse School of Medicine and Charles R. Drew Medical School established the Consortium of Black Medical Schools (CBMS) initially to address the COVID-19 crisis, by providing expanded testing, contact tracing, surveillance, training of front-line health workers, research & drug development, and policy recommendations to address the unique needs of vulnerable, low income, African American, and other underrepresented communities that experienced disproportionate adverse outcomes due to the pandemic.

Meharry and the other HBCU medical schools are uniquely qualified to address the shortage of health care professionals for this population in a way that no others are. The Consortium brings together the cumulative expertise of the four HBCU academic health science centers in primary care and subspecialties which treat diseases that account for the disparities heavily impacting disenfranchised communities of all races and ethnicities. Together we have worked with the White House, the Centers for Disease Control and Prevention, the Department of Health and Human Services, state and local legislatures, local health departments, faith-based organizations, and other community stakeholders to reduce areas of disparity in vulnerable and marginalized communities across the nation.

The CBMS has the necessary history, organizational structure, deep relationships with national and international organizations dedicated to eradicating health care disparities, and credibility within disenfranchised communities to scale up immediately and rapidly. Crucially, Black health professionals are trusted in these communities - trusted because we have always been there

when others have failed them, forgotten them, or, with the best of intentions, misunderstood them and their needs.

As we have done this work, we also have been woefully underfunded for generations. Because of my 30+ years of experience at prestigious, majority institutions, I am aware of how federal funding is allocated to those who are deemed “uniquely qualified” to address a critical national need. This is entirely appropriate when it makes the best use of resources. And especially when and where a crisis is afoot.

We, the four HBCU medical schools, are asking for those same rules to apply to our work. We are without a doubt “uniquely qualified” to address this growing national health crisis.

We already are our country’s most reliable source for a well-trained, diverse health care workforce. And the value of a diverse workforce cannot be underestimated. Trust, cultural competency, and a strong background in social determinants of health are as crucial during these times as medical training. We must accept that, in order to successfully treat at-risk African Americans and other vulnerable populations, we must hire and deploy a workforce that is trained to implement a care plan for individuals and communities that addresses the social forces impacting and undermining their wellbeing.

Yet currently, HBCU medical schools - the most adept at training such a workforce - face the challenge of expanding our number of graduates in light of insufficient funding, an increasingly detrimental predicament for everyone, especially in a country whose population is ever-expanding and diversifying. A truly sustainable response to the shortage of diverse health care workers must include strategies to support HBCU medical schools.

To do this work, the CBMS requires an immediate infusion of significant resources in order to scale up quickly, efficiently, and comprehensively. The CBMS anticipates the cost to develop and implement our plan will be $5 billion dollars over the next five years. We are well-prepared and well-positioned to offer enormous benefit to the nation at comparatively little cost. We plan to use the infrastructure we build to begin addressing the structural barriers to health in minority communities. Our plan will therefore have benefits that should reduce the overall cost of health care for the nation.

Major Consortium Pipeline Initiatives

The Consortium is now leading the national drive for greater pipeline diversity and is engaged in multiple initiatives to ensure a more equitable health care workforce in the future. It has attracted the interest and investment of $100+ million in public and private funding to support current students, as well as longer term efforts to educate, train and employ more Black health care workers. Notable funders include the National Institutes of Health, Bloomberg Philanthropies and Mackenzie Scott.

- The Consortium convened a gathering of 166 representatives from 54 of the 99 HBCUs with undergraduate programs to develop a cohesive and aggressive program to increase

the number of Black or African American health science professionals and improve educational outcomes for both STEM and humanities students to ensure health science workforce diversity.

- NFL Diversity in Sports Medicine Pipeline Project to increase diversity in sports medicine by providing HBCU medical schools the opportunity to complete a clinical rotation with NFL club medical staff.

- Chan Zuckerberg Initiative to advance genomics research at the four medical schools by contributing $11.5 million per institution over the next five years.

- Two-year $100 million award to the Consortium from NIH's Advance Health Equity and Researcher Diversity (AIM-AHEAD) program.

- American Cancer Society's $12 million Diversity in Cancer Research institutional advancement grants to fund a four-year program to increase the pool of minority cancer researchers at the four HBCU medical schools.

- Partnership between the Consortium, the Organ Donation Advocacy Group and the Association of Organ Procurement Organizations to initiate programs to increase the number of US Black organ donation and transplant professionals across the nation.

- Beacon of Hope Partnership, a 10-year collaboration of the Consortium, Novartis, Sanofi, and Merck, to create programs that address the root causes of disparities in health and education.

As I testify today, I think of Samuel Meharry. His gift in 1875 was nominal relative to his total wealth. But he had been the beneficiary of selfless compassion from an African American family. He gave in order to allow that compassion to exert the maximum influence possible during that time and in that world, where slavery had been abolished in name only. I also think of my father, who - generations later - would succumb to health care disparities as much as he succumbed to cancer. I think of my mother, who urged me to respond by serving those who are perennially left out and left behind. I think of Black physicians and other professionals from the past who because of redlining and structural racism could not build wealth for their families and communities. I think of my colleagues across the nation who could share similar stories with you of family members and friends locked into legacies of poor health.

For more than a century, the responsibility for educating Black doctors, dentists, researchers, and health care professionals in the U.S. has largely rested on the institutions dedicated to that purpose: our nation's four HBCU Medical Schools. Charles R. Drew University of Medicine and Science in Los Angeles, Howard University College of Medicine in Washington, D.C., Meharry Medical College in Nashville, and Morehouse School of Medicine in Atlanta have long prioritized the need for more diversity in medical careers while other colleges and universities ignored the issue. For years, we have worked individually in our own communities and together, as a

Consortium, on larger initiatives in the United States and Africa to advance the diversity of the workforce and the health of the patients they served.

We, the Consortium of Black Medical Schools, are ready. We only need your endorsement and a modicum of the nation's resources to make a profound difference. Let us take our place in this fight. We already are well-prepared and well-trained. But we must be well-armed. Please arm us by supporting the policy recommendations outlined below. Thank you for your time.

Policy Recommendations:

- $5 billion for infrastructure for Improving Research and Development Infrastructure for academic health science centers at Historically Black Graduate Institutions as defined under Section 326(e) of Title III of the Higher Education Act.

- $500 million to maintain and expand programs to increase research capacity at minority-serving institutions (as described in sections 371(a) and 326(e)(1) of the Higher Education Act.

- Amend/Expand the Medicare GME policy to add a priority criterion for hospitals that have a sponsoring institution for their GME program/s that is a Minority-Serving Institution (to include Historically Black Graduate Institutions), as well as add "non-contiguous area" to the "rural" criterion.

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