

Oral Testimony to the Negotiated Rulemaking Committee for Medically Underserved  
Areas/Populations and Health Professional Shortage Areas

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First, thank you for giving us the opportunity to participate in this very important process. My name is Danielle Hawkes and I work as a policy analyst at the National Latina Institute for Reproductive Health. I am here today to speak on behalf of the Institute as well as our close colleagues The National Asian Pacific American Women's Forum (NAPAWF). NAPAWF is the only national, multi-issue Asian/Pacific Islander (API) women's organization in the country. Their mission is to build a movement to advance social justice and human rights for API women and girls. The National Latina Institute for Reproductive Health works to ensure the fundamental human right to reproductive health for Latinas, their families and their communities.

I will first discuss medically underserved areas/populations and then turn to health professional shortage areas.

**Medically Underserved Areas/Populations**

Medically underserved populations can be measured after they have been underserved using health outcomes such as infant mortality rates, but they can also be predicted using information we already know about barriers to access.

Barriers do not exist in a silo, and instead they are caused by real cultural and linguistic access issues. By studying these issues we can predict upfront who will be medically underserved in our communities. We know that for example race, culture, language, gender identity and sexual orientation play major roles in isolating certain populations from care.

The results of these barriers to access can be quickly identified by looking at cervical cancer. Latinas and women of color face disproportionately negative outcomes when it comes to cervical cancer. Black and Latina women are diagnosed with cervical cancer at twice the rate of non-Hispanic White women and have the highest cervical cancer death rates of any major group of women in the U.S. This is alarming on its own, but when you further dive into the problem you see that it is important to look at subgroups as well. For example, when we look at API women as a whole we see relatively positive cervical cancer outcomes, but when we look at Vietnamese American women we see rates that are

five times higher than non-Hispanic White women, a rate that is substantially higher than any other group. I am using cervical cancer only as an example, but this pattern can be seen consistently through all of the most pressing medical concerns of our day including heart disease, obesity, sexually transmitted diseases and more. In these groups preventive care is unavailable, diagnosis happens at a later stage and education is lacking. Issues such as language access, immigration status, racial & ethnic prejudice, and lack of cultural competency play key roles in perpetuating these unacceptable disparities and in making these groups medically underserved populations.

We also know that in the real world, these characteristics do not live alone. For certain populations they are multiplied and amplified creating an ever growing wall, preventing access and thereby a medically underserved area or population.

A low-income black Latino man who was born a female who speaks only Spanish will have significantly more barriers to care, often insurmountable barriers, than his fare skinned well to do Latina counterpart. It is critical, therefore, that not only the elements be considered but that their consideration be sophisticated enough to account for their escalating affects on one another. Conducting this analysis will be more than an academic exercise, and instead should lead to a dynamic calculation model that seriously considers those elements that cause populations to be medically underserved. This model should be straight forward and easy to use and transparent. This transparency serves two purposes. First, it lowers the burden on already underserved populations to demonstrate their plight. Centers in those areas should be focused on giving whatever care they can provide, not on complicated reports of under service. Second, it allows the public and advocates to understand the process and to provide feedback in the future on its success and areas for improvement.

### **Health professional shortage areas**

Turning now to health professional shortage areas: These dynamic issues of cultural and linguistic skill must also be considered at the foundation of the analysis of health professional shortage areas. An area, for example, may have a dentist for every 5 residents, but that information alone is not enough to determine whether that area is sufficiently staffed. We must know if there are doctors with other skills to adequately care for that population's health. These skills must extend beyond those traditionally evaluated in medical board exams because we know that to adequately prevent and cure disease doctors and medical staff must have cultural awareness and language capabilities. API and Latina women often delay care, not because of lack of a medical skill set, but rather because medical staff lacks cultural or linguistic capabilities. This is especially true for women seeking care for sensitive reproductive concerns or health concerns stemming from emotional or physical violence. Because these factors play a major role in the health of these populations, they must play a key role in the determinations of whether there is a shortage in any given area.

Another example of the need to have a detailed analysis here can be shown in a community that is served only by a Catholic hospital. While it may, in all obvious

measures, provide top notch care, when looking to women's reproductive health specifically you will likely find a severely underserved area. Women in that area may have nowhere to go to adequately care for their reproductive health and may have little access to education, contraception, or abortion.

We are not experts in statistical models, but we are experts in many underserved populations and we are happy to help the committee in anyway we can. On behalf of The National Asian Pacific American Women's Forum and the National Latina Institute for Reproductive Health, thank you for allowing us to participate in this process and for your service and expertise on this committee.

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