

Disparities in Health Care – Where Do We Go From Here: Morning Session June 28, 2005

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JOY WHEELER: We have everyone take their seats. We are ready to get started. I want to welcome all of you. My name is Joy Wheeler; I am President and CEO of FirstGuard Health Plan based in Kansas City, Missouri. I also serve as chair for the Board of Directors of the Medicaid Health Plans of America. I am also happy to serve as co-chair of MHPA second health conference.

We have an exciting lineup today as we examine issues surrounding the disparities in health care that continue to exist. Recent studies have shown that despite the steady improvements in overall health of the United States, racial and ethnic minorities expend a lower quality of health services and are less likely to receive routine medical procedures and higher rates of morbidity and mortality than non-minorities.

There are continuing disparities in the burden of illness and death experienced by African Americans, Hispanic Americans, Asian American, Pacific Islanders, and American Indians and Alaska natives as compared to the US population as a whole. Disparities in health care exist even when controlling for gender, condition, age and socioeconomic status.

We are here this morning because we recognize that we are all committed to close this gap. The Centers for Disease Control sited a number of statistics that illustrate these disparities. Breast and cervical cancer, although death rates

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from breast cancer declined significantly during 1992 through 1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to received PAP tests and we will know these can prevent invasive cervical cancer by detecting precancerous changes in the cervix.

Cardiovascular disease, in 2001, rates of death from diseases of the heart was 30% higher among African Americans than among whites. And death rates from stroke were 41% higher. Diabetes, compared with white adults, American Indians and Alaska natives are 2.3 times, African Americans are 1.6 times and Hispanics are 1.5 times more likely to have diagnosed diabetes. HIV/AIDS although African Americans and Hispanics represent only 26% of the US population, they count for roughly 82% of pediatric AIDS cases and 69% of the both, AIDS cases and new HIV infections among US adults. In 2002 they accounted for 62% of all people living with HIV or AIDS in the United States.

Immunization: influence of immunization coverage among adults age 65 years or older is 69% from whites, 50% for African American and 49% for Hispanics. The gap for the pneumococcal vaccination coverage among ethnic groups is even wider, 60% for whites, 37% for African American and 27% for Hispanics.

Then finally infant mortality, although the 2001 US

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infant mortality rate of 6.8 deaths per 1000 live births was the lowest ever recorded. African Americans, American Indian and Puerto Rican infants continue to have higher mortality rates than white infants. In 2001, the black to white ratio in infant mortality was two to three.

We can and must do better to close these and other gaps that exist. I thank all of you for the courage and commitment in this room to address these challenges. This will be the focus of our discussions today. Now I want to introduce the Executive Director of the Medicaid Health Plans of America, Thomas Johnson.

[Applause]

THOMAS JOHNSON: Thank you Joy. Good morning everyone. Welcome to the second annual minority health conference. I am Thomas L. Johnson, executive director and first I want to take a moment and give thanks to my board of directors who give me a great deal of support and have done so since I started this job in September of this year to make sure that we remain a strong organization and move forward in representating the interest of the Medicaid health plans and what we can do for Medicaid members around the country. Let also thank all of the supporting members of the Medicaid Health Plans of America and I want to include our 2005 business partner, Adaptis, Incorporated. I want to note that not only do we have the chair of the board of directors

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Carlos Olivares speaking this morning, but I also want to thank Jim Anderson the present CEO of Adaptis who has joined as well. So, we thank Adaptis for your continued support. I want to also thank all of the corporate sponsors for this event this morning. They include Adaptis, Chartered Health Plan, LA Care Health Plan, Health Right, Pfizer, AmeriHealth Mercy, the Singting [ph] Corporation, TMG Health, and Aventis Pharmaceuticals. We also have an unprecedented number of organizational co-sponsors that have assisted us with this event this morning. The organizational co-sponsors include American Health Insurance Plans, The American Public Health Association, The Greater Washington Board of Trade, The DC Primary Care Association, The National Alliance for Hispanics Health, The Association for Community Affiliated Plans, The DC Asthma Coalition and The Pharmaceutical Research and Manufactures Association. So, I want to thank everyone for the support that they have given our organization today. I also want to thank my staff, Gail Greene and Joanne Williams. Yes, we have a staff of three people but they do a great job for us and as we move forward with more events that we will let you know about, they will continue to be a part of our team as well as the volunteers that have assisted us this morning and will assist us this afternoon and Well Done Solutions who has assisted us with the planning of this conference.

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The Medicaid Health Plans of America represents health plans that provide Medicaid managed care to its enrollees. Incorporated in 1995, as a national association for urban based maintenance organizations MHPA is a national organization sole devoted to representing all models of health plans participating in a Medicaid managed care. Our primary focus is to provide research analysis in organized forms that support the development of effective policy solutions to promote and enhance the delivery of quality health care. The association initially coexists around the issue of national health care reform and as the policy debate changed from national health care reform to national managed care reform, the areas of focus shift to the changes in Medicaid managed care.

Underscoring Joy's remarks, everyone in this room has a commitment and a responsibility to reduce health disparities. This issue knows no party or affiliation. There have been no 527s created to address health disparities. There is no catchy slogan and then there are no polls showing or gauging how proliferatively popular this issue is. There is however a mandate, a mandate to close this gap. That mandate must leave this room and at the end of today's program and it must incorporate it into our everyday lives. Instead of accepting the fact that people will inevitably become sick, MHPA believes that a strong, effective, and

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responsive public health system and safety net is about a prescription for preventing disease. Compromise on this issue is not an option. Achieving the outcome of eliminating health disparities is the only option. Our commitment must remain strong and true and must survive budget battles, federal or state Medicaid reform efforts, political affiliation, changes in the economy or the issue or medial event of the day. Failure to achieve these outcomes means that this country will never achieve its great potential because a healthy population is the core of a successful population.

At today's conference, we will hear from a wide range of speakers. Our speakers range from the former United States speaker of the House to a national advocate for ending racial and ethnic health care disparities. We will hear from the head of one of the most powerful trade associations in Washington as well as the executive director of a successful farmworker's clinic in Yakima Valley, Washington empowering the communities that they serve every day. We will hear from the administrator of both the Medicaid and Medicare programs who oversee great challenges in ensuring that these programs are sustainable, affordable and are of the highest quality as well as state and local officials who address the health care needs of their contingencies every day. Finally, we will not only hear from Medicaid and other professionals who will share their expertise, including one of the founders of this

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organization but we will also hear and hope to hear from you as well. We benefit from the fact that all of these individuals and institutions have one thing in common; they are all committed to reducing health disparities. And everyone in this audience not only paid to get in but they should feel invested to contribute their thoughts and opinions today.

With that, I am going to move to our first speaker. We were scheduled to hear from Congressman Eldolphus Towns this morning. Congressman Towns as I think many of you know has an outstanding record in introducing measures aimed at ending health disparities, specifically his measures in the last Congress centering about asthma and obesity set an example for all elected officials at either the federal or state levels. Unfortunately, there was a recent passing of the Congressman's Chief of Staff over the past few days, Brenda Pillars, who actually worked with us on putting this conference together in trying to secure his presence here. The Congressman will not be joining us this morning. Ms. Pillars was a shining example of the Congressman's commitment to ending health care disparities.

In the Congressman's place however, at the very last minute, we have secured Fredetta West, who is the founder of the African American Health Alliance and of FDWest Network Associates. Each of which is committed to the elimination of

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racial and ethnic disparities in health and health care and to ensuring access of quality of health care to all. In addition, she chairs the Racial and Ethnic health care disparities Coalition. She previously served as Chief of Staff to former Congressman Lewis Stokes, has CBC health grain trust coordinator and as associate staff for House, Labor health and Human Services in education appropriation subcommittee. She was a staff strategist and negotiator in developing and helping the CBC create and champion record funding for the minority HIV/AIDS initiative and achieving the renowned Presidential Tockusky [ph] apologize. During the Clinton administrations, Ms. West was at the center of countless health care policy battles and accomplishments. Ms. West has also drafted national legislation funding and policy measures ranging from those on health to those on education and employment. She was honored for her outstanding contributions in the fight against HIV/AIDS, receiving a disquisition Hero in the Struggle by the African American AIDS Policy and Training Institute, awarded the CBC's Hero in Health Care Award and earned the Hero's in Health Care awarded jointly by the Congressional Black Crocus, Congressional Hispanic Crocus, Congressional Native American Crocus and Congressional Asian and Pacific American Crocus. She also serves on a number of boards and served as a budget officer of the National Eye Institute and financial

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management officer of the National Library of Medicine. Will you all please join me in welcoming Fredetta West?

[Applause]

FREDETTA WEST: Good morning and thank you for the introduction and all that you all have done individually and collectively to helping eliminate the racial and ethnic health disparity. First, I would to extend greetings from Congressman Towns and his regrets that he can't be here with you today. But that fact that he wishes you a very successful and productive conference.

The focus for me today came from a number of points, as was mentioned while it was last minute, it is quite important, and that is the thing with health disparities in general. They have been with us a long time but far too often people of them at the last minute. They become that last comma on the page for funding requests and yet as spoken of as funding priority. You can't be funding priority if you are behind that last comma on the page.

As I talk to you today and as I have talked to other audience, my prayer is always that I provide the message that God has intended for you to receive. None of us know what that is. We can only pray and hope no matter who prepared we are. So I thought today - well the message that came back to me once my mind thought that was that this audience knows about health disparity. This audience even knows what they

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are and where they exist. The key becomes what are you willing to do about them, what will you do about them, and when. And only you can answer those questions. If you are already doing it, there are a number of us already are, what steps will we take to do more and to get others engaged and energized.

I will take my own health condition for a moment and along those lines, last year at this time, I was diagnosed with breast cancer but I do stand before you today and so thankful to God for that. As I look back over that period of time and being health care advocate, so much ran through my mind. Who missed it, when, how, why? Because I had gone constantly for breast mammograms, never stopped. I had in fact had one that November or December. As we do these events, there is also a time for educating and for prevention messages. So I found the mass myself, as large as a golf ball. Then when I went to the doctors I thought, how, how did it pop up this quick. So as I switched health care providers and health care systems, the answer then became I got to go back and deal with this but right now I got to deal with the condition. That is what we have to remember no matter who we encounter or what condition they maybe undergoing. To help them navigate and deal with what they have to deal with right now but then help them get further engaged in addressing and examining racial and ethnic disparities.

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Well when I got to the doctor, the second set of doctors, doctors that look like me, where I knew - and I can't say where I knew because just because a doctor looks like you isn't a guarantee they are call to competency either. And I find a lot of times when we talk about calling for competency too often white health care providers assume that we are talking about just them but we are talking about health care providers period. Because you are looking health care providers who have gone through the same systems of training. There were - pastimes there was but at least for right now and has been for a while, they are going through the same system of care. So somebody has made a decision somewhere along the line that its okay to have some degree bias against a person, a racial ethnicity. If for a moment, those are/those that are not, just close your eyes and picture yourself going into a doctor's office. That doctor sees just the back of you, he can't see your hands, nor your ankles nor anything but assumes that you are white, and you are Miss so and so or Mr. So and so and you get one degree of care. You turn around and they see the wrist or the face or the grain of hair and then you get another system of care. That is not just unfair, it is wrong. If we look at today's paper and again mind you, I asked the Lord what I should present today, I was going through the newspaper as much as I was running; I thought I got to check the newspaper. Okay,

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Washington Post racial disparities found and pinpointing them to illnesses. It could have said cancer, it could have said heart disease, it could have said AIDS, and it could have just shown my picture or yours.

Now this goes on to state that - and when my time is up just cut me off, I am fine - because there is a lot and I am that you are seated where you are because this is a kitchen table discussion that has to be dealt with. We can't just putting it on the back burner or after the last comma. This article reads the scientists found that blacks in the United States were more than four times as likely to be diagnosed with a disorder as whites, speaking of schizophrenia. Hispanics were more than three times as likely to be diagnosed as whites. Skip a few paragraphs, that US Department of Veteran Affairs found that differences in wealth, drug addiction and other variables could not explain the disparity and diagnosis. The only factor, again the only factor that was truly important was race. Yet, you still get enough people in organizations wondering if race matters. I mean give it up at some point. IOM proved the same thing. Again, the report is unnecessary when we all push for that IOM report. We knew it had to be done by renowned national and international organizations that the US Congress, the people in America, would listen to and believe. People of color could have written that report any day of the week.

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They are already living in it.

The article goes on to say the data confirm the fears of experts who have warned for years that minorities are more likely to be misdiagnosed as having serious psychiatric problems. Bias is a very real issue. Of course, it is but let's get to the action. Again, keep the reports going because clearly data matters also. Without data, you have nothing tying your hat on. Every company that is very successful does tremendous data collection, analysis and utilization. It should be no different for health.

One of the parts that did bother me was the same researcher that did the work later before the article closes he goes on to say we don't talk about it. It's upsetting. We see ourselves as unbiased and rationale and scientific. Physicians need to be treated in cultural competency. They say to prevent misdiagnosis and harm. And should go on to say and to prevent death. And I thought I had marked it but somewhere in this article, the researcher sort of sets back after he has already said clearly race matters and then goes on to say it appears that race matters. Either it does or it doesn't, by now you know that it does. Do something about it.

So the key for you today is to ask yourself what are you going to do about it and when. I would like to follow up with you after the conference and even some months later to find out what new is being done about it and where and when

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and what is to be accomplished. Thank you.

[Applause]

FREDETTA WEST: Can I say one thing, since this is a kitchen table discussion, the federal page EPA proposal would allow human test of pesticides. Ask yourself on who and when and where and what will that consent form read and how should it read and if it should even exist. Thank you.

THOMAS L. JOHNSON: Thank you. We are going to move forward in our program and I have the distinct pleasure of introducing our next speaker as President and CEO of American's Health Insurance Plans, Karen Ignagi is the voice of health insurance plans representating members that provide health care, long term care, dental and disability benefits to more than two hundred million Americans. HIP was formed in late 2003 as a result of a merger between the American Association of Health Plans and the Health Insurance Association of American. Ms. Ignagi led AHIP and since joining the organization in 1993, she has won many accolades for her leadership. Bostonians named her one of the top three top guns of all trade association heads. George Magazine placed her twenty-first on a list of the fifty most powerful people in politics. In a city teeming with health care lobbyists, Ms. Ignagi is widely considered one of the most effective. She blames a detailed knowledge of health policy with an intuitive feel for politics, wrote the New York Times

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in 1999. Fortune described the political program that Ms. Ignagi spearheaded at AHIP as worthy of a presidential election bid. In 2004, the Hill newspaper listed Ms. Ignagi among Washington's most effective lobbyists. Last year Modern Health Care named her the seventh most powerful person in all of health care. Ms. Ignagi recently testified before Congress on key federal legislation. In recent years she has appeared before Senate and House Committees on matters ranging from health plans in role of homeland security to Medicare reform to patient protection issues. She is authored more than ninety articles on a wide range of health care policy issues including pieces published in the New York Times, USA Today, New York Daily News, The Washington Times, Institutional Investor, New England Journal of Medicine, Health Affairs, Modern Health Care and Physicians Weekly. A recognized industry spokesperson, she appeared in the national network newscasts of ABC, CBS, NBC, and FOX. She has also shared her insights on leading cable shows such as CNN Inside Politics and MSNBC's Hard Ball, CSpan's Washington Journal and CNBC's Power Lunch and Capital Report.

Prior to joining AHIP in 1993, Ms. Ignagi directed the AFL-CIO's department of employee benefits. In the 1980's she was a professional staff member of the US Senate Labor and Human Resources Committee receded by work at the committee for national health insurance and the US Department

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of Health and Human Services. I want to also add that it is very fortunate that I have to be in the same building with somebody that I can consider a model role. My hope is that during my tenure at MHPA I can accomplish at least half of what Karen has accomplished with AHIP.

Ladies and gentlemen, let me please welcome Karen Ignagi.

[Applause]

KAREN IGNAGI: I never sound like a clump of elephants coming up I apologize for that. No one has ever noted my physical abilities. It is amazing my son can play anything in sports because I seem to have no ability in that arena myself.

I want to congratulate Thomas for just assembling a wonderful group of people here in the audience today. an outstanding group of speakers and nobody doubts that Thomas is going to get to the fifty percent level. He is clearly going to exceed anything we have done. He has done a fabulous job so far with very limited resources so I think Thomas you deserve a hand from everyone for pulling us all together.

[Applause]

It is wonderful to be here with all of you this morning. I want to take an opportunity to talk a little bit about what we are doing, which really much syncs up what you are talking about today; the challenges that we all face and

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where we are going collectively in our system. Joy I think started us off in just the right way with a real challenge. Thomas has challenged us also. I would like to continue on that vein because I think that we are on a presbyterous of a brave new world in health care, full of promise, full of excitement about the potential to cure disease, to make people healthier, improve their quality of life.

But just decades ago, Michael Herrington wrote about the other America. We are at risk of maintaining a two class system, not creating but maintaining because I think from all the data the institute of medicine has put on the table, we do have a two class system and we need to address. Its not just something in the future but it is something in the here and now that we need to grapple with. We need to prioritize as a nation and we need to get on with doing the job of addressing that.

Previous speaker did I think a very, very good job of personalizing the challenge and I want to try to do somewhere close to as well.

I think that by starting this morning, the most important thing I can do for you is to talk to you a little bit about who we are, who we represent, and what we are doing in this arena and talk about how we can do something together. First, as Thomas says, our members represents - we represent about 1,300 members providing services to over two

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hundred million Americans. We have long been working in the area of Medicaid, supported our Medicaid plans for a very long time because they have brought innovative tools and techniques to public programs which only now I think will, with the budget crisis the states are facing, will come into their own and they will be able to demonstrate in sort of the court of public opinion the fact that we are doing a better job for beneficiaries, for providing more quality, we are stretching health care dollars and we are addressing some of the challenges you have put on the table today. So, I think that for us we look forward to the coming discussions.

We also look forward to the fact that states that face a very, very difficult budget situation with respect to Medicaid can take a look at the tools and techniques our plans have developed and rather than moving in a direction of cutting beneficiaries, they can actually expand benefits, expand beneficiaries and categories of beneficiaries by turning to the private sector because we can do more with less. That is what the data say, that what the studies say, and the evidence is very compelling.

In addition we also have not only talked about the issue of disparities through the lens of the Medicaid challenges but we have deployed our resources across our entire health plan committee to try to figure out to address, how to move from here to there so not just have a discussion

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about the issue but try to train people to detect it, to address it and then ultimately try to do something about making sure that we make a dent in the situation we faced today with a very differential system. So, depending upon where you sit, that health care system is full of promise but for others it isn't and we need to address that.

Let me talk a little bit about how we are going about that and then if we have time, Thomas, I would happy to answer some questions if people would like to probe on any of this. Everything I am talking about I would delighted to make it available for folks.

We started about two years ago working with a number of our Medicaid plans and other plans who were providing services particularly in inner cities but also rural health care markets as well. They began to be concerned about this issue of disparities. So we were involved in the Institute of Medicine discussions from a cultural socioeconomic prospective. We began to put our heads together to say what could we do. So one of the first things we thought we could do is to create a tool kit to make people aware of what is the issue, what are the problems, what do the data say and then what we can, what part can we play in that. so in developing that tool kit, we put together a great deal of information on the importance of collecting data on race ethnicity and primary language. We talked about needing to

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have a communications strategy that helps people address cultural diversity.

We also talked about across cultural competency training module for the health care workforce recognizing everyone doesn't learn in the same way, they approach things differently, etcera. Then we want to develop a web-based clearinghouse of information so that not only could our members draw from it but also the public could draw from it, advocates could draw it and we could make it available in local communities. I am very, very pleased to say that we are well on our way to achieving these objectives. I want to talk to you exactly where we are.

First, we brought together back starting in January through the end of April, four regional workshops. One in Atlanta on January 21st, one in New York on March 16th, one in Albuquerque on April 6th, one in Chicago on April 20th. The idea was to take a look at four things. First of all an overview of current laws and regulations because often when you talk to folks who are on the front lines of health care about disparities and collecting information, the first response you get and I don't know whether this has been something all of you have experienced for very learned, experienced people, they say oh, we can't do that. We can't collect those data. We are prohibited by law or by regulation. So we thought in doing our due diligence and

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getting out we found that that was a major barrier. So number one we gave an overview of current laws and regulations to stimulate a discussion about what exists now and what can we do in the future.

Second, we wanted to educate people about the problem. Everyone in this room knows well about the problem and folks around the country do but we wanted to bring people together to look at the data together. So they could brainstorm about the best ways to address it. Third, we wanted to talk about ways to collect data and then finally talk about analyzing the data in light of what we can do with it.

So, the first thing that we did was to make the case about why collecting the data. We reviewed the Institute of Medicine discussions. We talked about age-adjusted death rates among various racial and ethnic groups. We have talked infant mortality rates. We did just a basic sense of the educational challenge. We also went into and we did a number of or a quite a lot of research about who is satisfied in health care and who is less satisfied. Generally, we found that minorities are less satisfied with the care and the quality of care they receive. We found reasons for that as we probed a little more deeply. We also found quite striking differences in racial and ethnic disparities with respect to quality of care in cardiac care, in asthma, in diabetes, some

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of the basic types of services that people rely upon as a trigger and key to deal with more complicated health care issues.

We found that Hispanics were most at risk for foregoing preventive care we also found that African Americans are most likely to go without need of care because of costs. So we put all of this together and we began to look and identify possible explanations for this situation. First at the patient level and this will be no brainers to all of you but to people who don't deal with this issue everyday who are focusing on it for the first time just to bring together the fact that socioeconomic status, it can be a challenge at the patient level. Language can be a challenge; cultural norms and I think we are just beginning to scratch the surface of cultural norms with respect to the challenges in prevention.

We all talk about diet and exercise and I always like to in some of these discussions, I talked a little bit about my family. As you can tell from my name, I am Italian. If you talk to my Italian relatives about diet and exercise and it involves not eating pasta or not eating things that aren't very good for you, they don't really like to hear it. That is the easy way to break down barriers as we get to other ethnic groups. It just breaks the ice and we can began to talk about that but we got into that. What are the norms,

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what are the expectations, what are the cultural traditions and what do we as clinicians and people who want to address the issue of disparities have to get our hands around. We also talked about attitudes in ways individual seek care and poor quality.

On the provider level, we talked about potential provider bias, stereotyping, lack of time, understanding, knowledge and sensitivity, to individual's cultural traditions, cultural competency and the kinds of the things that need to be addressed. At the institutional level of diversity in the workforce, lack of access to affordable health care, lack of cultural linguistically appropriate care and lack of cultural competency. We went on and had a much longer series of explanations. I am obviously giving you a top line sense.

Now the review of the laws and the regulations were quite interesting because as all of you talk about the need to address racial and ethnic disparities, I think you would be interested to know what you first already do, that there are no legal barriers to the collection of racial and ethnic data at the federal level. However, six states do restrict the collection of data with respect to health insurers as well as public sector activities. They are California, Maryland, New Hampshire, New Jersey, New York and Pennsylvania. I thought it would be really useful because it

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was for me to bring language that exists in stature and regulation so you could get a sense of what we are up against as we all talk here about needing to collect to the data as a trigger to do something about it.

Let me just read to you a couple of things. The California stature says, now recognizing this is legal because it is statutory language but I will try to cut to the chase. No application for insurance or insurance investigation report furnished by a such insurer to its agents or employees for use in determining the insurability of the applicant shall have any identification or requirement there fore of the applicant's race, color, religion, ancestry or national origin. That is California.

Maryland's: An insurer, dot, dot, dot, may not make any enquiry about race creed color or national origin in an insurance form, questionnaire of other manner of requesting general information that relates to an application for insurance. New Hampshire: this is the regulation not the statue, prohibits questions of race or color on all application forms used in connection with the offer and acceptance of insurance. Mew Jersey: prohibits applications forms from individual health insurance for including provisions statements or questions that pertain to race, creed, color and national origin. These is just scratching the surface but it occurred to me to read this to you because

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have collected it all in our training modules. This is something that folks all the around the country, both in our own community as well as in the advocacy committee had little knowledge about.

As we talk about the need to address racial and ethnic disparities, as we talk about the need to move forward and make sure that we are not creating and continuing to empower a two class system, we have got to get back to the basics to address something that all of us can do something about, number one. Number two, but then to talk much more broadly, about exactly why the data should be collected. Not because it is the right thing to do or some general thirty thousand foot purpose but how tangibly it can improve a persons health, any thing we can do to deploy better access, to get more prevention to make people feel more comfortable so they avail themselves of services that are there for them is something that will not only improve their health care but it will improve the strength of our nation. So we have go on a very strong education campaign to link what we are going to do with the data. For our part, for our members we have found we surveyed our members that roughly fifty percent of health plans are collecting racial and ethnic disparity data. What they are doing with it is using it to target disease management programs to improve health care. So to address these culturally challenging issues and arraignment. The

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other fifty percent, they were frankly concerned about the collection of data for fear it would be misconstrued for fear they might be validating a law statue and for fear that beneficiaries would think they were doing the wrong thing.

So I think as we have the opportunity, Thomas as you have pulled together this marvelous conference with all of this brain power, it really for me and maybe for you gets back to some of the basics. How can we deal with the stereotypes about data? How can we in the private sector both in the insurance side as well as on the clinical side, demonstrate that as we are collecting this data they are being used for the right purpose. They are being linked to health care and we are dedicated to approving people's health.

Then finally how can we all together get out into the community to raise awareness and ultimately to improve health? So when Thomas asked me to come here this morning I was excited to do it. It is a marvelous group of people you have brought together. All of you have done so much in your own arenas and we are delighted to be here with you. We would be delighted to make the modules, the training modules available to you, to anyone who would like them. We are going to continue to do a great deal with this work to reach out to communities to try to address some of these challenges and we can't do it alone. We want to be collaborative; we want to

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work with you with our member companies. The Medicaid arena is a focal [inaudible] international effort. [Inaudible] About later today of maintaining [inaudible] it continues to serve the needs of beneficiaries in the way that I think all of citizens [inaudible] help give you a little insight into what we are doing. We are very excited to be here today and we are very excited to collaboration with all of you. Thank you very much.

[Applause]

SOLOMON CARROSCO [ph]: I would like to ask you about any children's - most of the minorities, already three million they don't have insurance, almost 25 million most minorities that they can not pay. So approximately its going on almost 80 million in this country. Look, like they are watching the insurance, health organization going to the moon, US is number one so high, it is difficult to go today to doctors. What do you think about it, that is the - I think President Clinton in the first time proposed [inaudible] any insurance company completely, he put all Americans in one place, not two place as you explained today.

KAREN IGNAGI: well I think that you are right that and I think Unfortunately you are right about the problem. One of the Unfortunate aspects of this year is that with all the talk -

It is befuddling to me with all the talk about

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economic productivity and the importance of that to our country that very few leaders, economists link the issue of access to health care to that. Because without health care our nation cannot seek or hope to be as productive as it can be. It's a major hold back and I think everybody probably agrees with that. What we know since this conference is about Medicaid I can sort of start there, we know that ten million people are eligible for public programs and are not yet captured. We know that twelve million individuals are offered health care on the job and can't afford to take it. We know another eight million are not offered health care on the job. So if you disaggregate the population of people without health insurance, we think that there are some very definite, very strategically targeted solicitations that should be followed. We have a whole menu of those solutions and the major stumbling block and I hope that every - you ask every individual who come here from capital hill and is in the public arena, what the major stumbling block is Congress's refusal to prioritize. This is an issue. It's not a hang up about what to do on the policy side of it. I think that is fairly clear. The hang up is whether or not members of Congress are going to be willing to allocate the resource needed and to prioritize this issue.

We are seeing part of that in the view in the Medicaid debate and we will see more of it in the fall. But

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the issue of access to health care should be a number one goal for our society because it really relates to productivity, it relates to all of the aspirations that every member of this audience has but every individual in our country has. So I thank the gentleman for raising the issue. It's a terrible situation that people in our country and so many are without health care coverage because we have so much to give them. It's equally terrible that people who are covered who are not getting access to the right treatment because of cultural and ethnic disparities. So we have challenges on both fronts. The only way we know how to deal with that is to address them systematically and to do our fair share. That is what we are about.

FEMALE SPEAKER: [inaudible] support the data so necessary for [inaudible] but you mentioned that on fifty percent are actually doing it. What are you doing to encourage the other fifty percent because it is [inaudible]

KAREN IGNAGI: We are on a mission now. If the question was, if everyone heard. I had made the point that fifty percent of our members were collecting data. Frankly when we surveyed I was surprised that is was that high in light of what we had found that people were concerned about maybe it would be misperceived, they were doing the right thing. I was actually you know sort of for me the glass is really half full but maybe it relates to what I do everyday

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but -

FEMALE SPEAKER: I was there too until I heard the fifty and that -

KAREN IGNAGI: Yeah, well, okay. So fifty for me was a positive because I thought it would have been much higher. Now what we are doing now, we are on a mission. That is why we developed this training module. We are going out to the communities. We are working with our plans, we are getting the information to them about how data can be collected, making sure that they are educating their beneficiaries to address this reluctance and this concern that they would be misunderstood and to demonstrate how to demonstrate that they are linking the collection of the data to the disease management programs. So, we are doing a great deal. We have several people working devoted to this. And we are very excited about the educational campaigns that we are creating and the work that we are doing in the local communities.

FEMALE SPEAKER: I will just follow up on this.

KAREN IGNAGI: Yes, please. And Carmilla Bokeno [ph] on our team whom you may know is leading our efforts here.

MALE SPEAKER: [inaudible]

KAREN IGNAGI: Your response in terms of the federal government's responsibility of addressing a societal issue where all Americans need access to good quality health care insurance. So my question for you is what do you think is the

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role for private/public partnerships in addressing this issue in a country where consumerism is a priority for health care and not really a human rights health care.

I will just repeat, I won't do as well as you but I will paraphrase your question. What is the opportunity here to talk about private/public partnerships in the arena of the uninsured? And we are particularly excited. Medicaid for example, offers us a tremendous opportunity to demonstrate what we have been able to accomplish in our Medicaid plans in terms of both the cost effectiveness of the plans as well as the quality improvement. And in my view, it is the other way around the quality improvement leads to the cost effectiveness because if you are doing a better coordinating care, you achieve more cost integrity. The data say that. We are very proud of that.

Now what we are going to be doing, speaking of being on a mission, we are going to be moving to the NGA, the National Governors Association, and two those who are policy leaders bring this track record to their attention so they can see what has been accomplished so we can do our part in saying that you are at a fork in the road. You can move into a direction if you have budget pressures which most states do of cutting benefits, cutting beneficiaries or you can take a strategy where we move to the private sector to move to keep those beneficiaries on the rolls, to keep those special

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populations insured. Not to have anymore drop off in terms of increases in the numbers of people who are uninsured because of our ability to stretch dollars, to leverage those dollars that provide health care more effectively. But it is not just about financial effectiveness. It is about improving quality, which leads to financial integrity in terms of reaching the bottom line and saving states money. We have an excellent story to tell only 40% of individuals in the Medicaid program are fully Medicare, comprehensive Medicaid plans so that is a long way to go forty to a hundred. But we have an excellent track record; we have to have waivers now to move into the SSI population. We have a great study to tell there of ways to manage special needs individuals and so on so we are really on a campaign to bring this track record to people so they can get a look at it so that they can develop a comfort level in moving in this direction. Its one way to prevent more a significant increase in the number of the uninsured.

So that is a very example of public/private partnership. I think there are other ways we can have public/private partnerships similarly, in the Medicare arena we are demonstrating savings of the dual eligibles now. We have a great, not only a story to tell but a real opportunity to demonstrate what we can do but those who are in - who are low income but not the lowest in Medicare, we are going to be able to show that we can do more than the package that was

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legislated in the pharmaceutical arena by members of Congress. So, that is another part of doing our fair share. There are many other ESCHIPS programs, largely as you know private sector relying on private sector. Some states haven't moved as much as they should in terms of private sector opportunities so what we are trying to do is again, not expect that people should just systematically say we are in moving in your direction because you're there but because we have the data and the research to show we can do a better job for beneficiaries.

What we have been doing is going around the country working with key advocacy groups to let them take a look at the data, look at the track record so that they can make sure that they have their questions answered as well. So it is a collaboration effort. I think you have raised the right issue with respect to public/private partnerships.

I think health care policy tells us if I might, just a postscript. We have really moved from away from this bipolar public versus private to a much more nuance discussion about how can the private sector bring skills to the public sector and how can we create the best of both worlds. That is really what we are trying to do. So I appreciate the question.

ROBERT VALDEZ: I am Robert Valdez from Rand. Good to see you Karen.

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KAREN IGNAGI: Yes, how are you?

ROBERT VALDEZ: I am also looking for actions. You raised one with regard to insurance laws and regulations. But people may not recognize that the fix you are describing is a problem. Collecting racial data was the fix for redlining in other segments of the insurance industry. Health insurance and health plans are quite different. Insurance products if you want to use the term insurance but and in some states I guess they are regulated by the insurance commissioners, but did you come across other kinds of insurance related fixes or policies that seemed to inhibit or prohibit some of the kinds of actions that we might want to take to diminish health care disparity.

KAREN IGNAGI: Yeah. There are number of things that are in law and regulation. And I put them under the heading of unintended consequences. People who are trying to do the right thing - I am really glad you asked this question because I want to make sure that I am clear. I am not describing negative motivations to people that are trying to protect the population from folks inevitably doing the wrong thing but when things exist that are barriers to actually doing the right thing then we to point them out and we need to work on them.

I think what we have been trying to do is to say alright, if this is the example, if these are the barriers to

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actually moving forward in this arena, what could we offer by way of language, by way of specific recommendations that be targeted and it wouldn't be sort of a wide open door creating more concerns on the part of regulators but how could we target this for the collecting of this data for the purpose of disease management and being willing to demonstrate that clearly. So we are not necessarily coming to the states with problems, we are also coming with solutions and demonstrating why we want to do this.

There is a whole other arena, I am glad you asked the question of unintended consequences because a number of employers for example would like to encourage people to eat well, they would like to reward weight watching programs. They would like to reward people who are compilation with their disease management programs. I have asthma so on days like this, it is particularly for me as you can see to talk because it is just so humid out. But what a number of employers would like to do is to reward people like me to be on their meds and avoid being in the hospital emergency room. A number of our plans that our employers are very concerned about what are the legal barriers to do that is that put us afoul of the discrimination laws, so on and so far. So this is a whole new area that we have only begun to bring to life.

So the first area is to have solutions on this one. The racial and ethnic disparities because we know its key to

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treating patients well. And then as we move forward in the prevention area, we are trying to develop similar kinds of fixes that will allow the rewarding of positive behavior but not necessarily creating concerns on the part of legislators and regulators. We have solutions for the first so far but we are not yet there on the second. But we are working on it.

Thank you all. Thank you.

[Applause]

THOMAS L. JOHNSON: Karen, thank you. Thank you very much. And I want to ask people there are some extra seats up front so you should please be encouraged to come and take a seat.

We are moving forward to our next speaker. I am pleased to introduce to you all Carlos Olivares, executive director of the Yakima Valley Farmworkers' Clinic. He is also chair of the board of directors of Adaptis, Incorporated. When Carlos took over as executive director of the Yakima Valley Farmworkers' Clinic in 1986, the organization had about 150 employees working at small clinics in Topenish, Grand View and Cowenish Washington. Today more than twenty five years after it was founded in 1978, the Farmworker's clinic has over one thousand, two hundred employees providing medical, dental, mental health and social services at twenty two facilities in Washington and Oregon.

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Carlos grew up in La Paz Bolivar and graduated from Pepperdine University in California. Prior to coming to the Yakima area, he served in various administrative positions at health centers in California. Over the years he has gained a reputation as being a respected voice for the people who like access to quality health care, plus he is concerned an expert in the provision of cost effective medical services. He is a founding board member of the community health network of Washington/community health plan of Washington, a MPHA member, agencies that administer state subsidized medical insurance for over two hundred thousand patients. he is a founding member and chairman of the board of Adaptis, a Seattle company that provides computerized tracking of health insurance claims. He has been incrementally involved in promoting higher education for Hispanic people in the Yakima Valley.

He has been a member of HAAP, an organization that promotes and provides scholarships for Hispanic students to pursue higher education. He serves on the board of directors of Heritage College in Topenas [ph] Washington, a school that predominately serves Hispanic and minority students. In addition, he was appointed by Governor Gary Locke to the 2020 Commission, a body entrusted with reviewing the current higher educational system in the state of Washington.

Carlos's commitment to the health of farm workers and

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others have lead to positions on the National Association of Community Health Centers, NACHE Farmworkers Health Committee. He is currently chairman of that committee. The National Association of Community Health Centers helps policy committee and the Northwest Regional Primary Care Association. The NACHE awarded Carlos a Luis Gueriza [ph] award to recognize him as an outstanding administrator for a immigrant health center. He currently also serves on the Board of Directors of the Memorial Foundation which raises funds and allocates resources for health care in Yakima Valley area.

He has not only been involved in activities that are associated with health care education but has also been active in his community and church helping to improve the community that he resides in. he has been recently appointed to the Central Washington Affair Association Board of Directors and in 2003, he was honored by the Washington Health Foundation as a recipient of the Heroes of Health Care Award for Leadership.

My pleasure to present Carlos Olivaires.

[Applause]

CARLOS OLIVIAIRES: Good morning. Thank you very much for having me here. I appreciate the opportunity to talk a little bit about what we are doing in Washington and Oregon but most importantly, I am hoping to describe some of the

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aspects of the health care that we provide for our patients. So I would to divide this into two sections. The first one really tells you a little bit about our health center, what it does and how it is going. And secondly what lead us into the development of what we have now a very strong and health care plan that really addresses the needs of Medicaid clients as well other uninsured populations in the state of Washington.

As it was told earlier, the Farmworkers Clinic really is a community immigrant health center as many in this country who by way provide over fifteen million Americans with some health coverage and health care that otherwise they wouldn't get. But we in the clinics have made a commitment to be able to address the needs that farm workers, particularly farm workers in our area have. Most of us have very little concept and understanding about the lives of those people who provide the food that you eat every day and the wine that you drink every day, by those of you who do are really harvested by these folks and the needs that they have are tremendous in terms of health care but just social care in general.

We are finding ourselves on a day-to-day basis in a struggle to try to provide health services for these folks. As you can imagine most of the laws associated with farm workers really are exclusive of incorporating them into a health care environment. So Farmworker's Clinic for example,

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we provide - we have over forty thousand or so people enrolled in some management care environment. However last year we provided health care to over a hundred and fifteen thousand patients. So as you can imagine about half of our population is uninsured. So the question that we face ourselves is what do we do with people that are in those circumstances? You do I am sure as a managed care plan have patients that come in and out of the Medicaid system. So the question is what do we do with those folks?

In our system, we don't see them in the same way maybe as you do. We don't see them as an annual leave we see them as a patient. So therefore, when they come in and out of the system because they happen to buy a pick up truck this year or this month, they are no longer eligible for Medicaid. So the question is what do with them once they are out of that system. While in our organizations and most community immigrant health centers across the country, we continue to serve them because that is the mission that we have. There are many incidents and circumstances where patients are faced themselves with incredible barriers. The notion of insurance ability to begin with is a new one for most farm workers. I sort of try to think about what is it that I can tell you so that you can have a better understanding about what happens when I approach a migrant worker and say gee, why don't you buy basic health plan. Basic health plan by the way is a

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system that has been created in the state of Washington to deal with those who don't qualify for Medicaid but can't afford to buy private insurance.

What happens is that many of these farm workers are eligible for this program? We have a sponsorship program where the state contributes a little bit, we as a community of migrant health center contribute a little bit and the patients contribute a little bit. It is a wonderful partnership that we have that has allowed us to enroll over fifty thousand migrant workers into this program. However, that has not come very easily.

As you can imagine trying to sell insurance to a person that earns twelve thousand dollars a year and whose premiums are going to be fifty to a hundred dollars a month is like trying to sell insurance to my eighteen year old who is going to college and say you really need burial insurance. It's only going to cost you twenty dollars a month but you need it. How successful am I going to be at doing that?

Well it is the same concept that we deal with in terms of just the economics issues that are associated with trying to sell insurance to a migrant worker. Never mind the notion that insurability is not a concept that people are aware of. As you know in Mexico, which is where the majority of our farm workers come, a health care is not a luxury it's a right. People have it. They don't have to buy it. So when

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you come into here to this country and you try to sell that type of insurance to those folks the concept is absolutely foreign to them so that we need to work with them trying to make them understand what are the benefits of insurability.

So those are some of the challenges that we face with our farm workers, however there are other barriers to health care that are absolutely incredible. What I thought I would do today, instead of trying to sort of go through the pieces about data and information that relates to the health care disparities, which you have way more knowledge than I do because that is what you do. You look at information, you look at data, you understand what it is that you need to do in order to curve that utilization of your patients.

We look at it a little bit different and let me tell you some stories that I think will illustrate some of the challenges that we face and some of the challenges that our patients face on a day-to-day basis. We run a clinic Woodburn Oregon which is about I would say about twenty minutes south of Portland, for those of you who are aware of where that is. it is not unusual to see women drive four to five hours from the coast into Woodburn to get prenatal care. It is not unusual for that to happen. But most importantly it is not unusual for migrant pregnant women to come into our site within the last month or two of their pregnancy and rent a bed in a garage at \$250 a month in order to stay close to the

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hospital, the only hospital, the only provider who will take care of her for her pregnancy. That is a barrier that in my opinion, it is unthinkable in a country like this who has the kind of resources that it has. It is a shame that we still have to talk about that. Yet we do it and we see it every single day.

It is not unusual to find ourselves in a situation as I did visiting a migrant camp with one of my representatives, actually a Senator from my state who came in and looked at because we wanted to illustrate and show him the problems that exist with access to dental health care for our migrant children. As he approached a bunch of kids there were two or three that smiled at him and he looked at them and said well gee look he is getting his new teeth. And my dentist who was right next to him said Senator that is not new teeth, that is infection in his gums. That is not something that we think about in this country. You think about that when you go to Bolivia when you go to Africa, you go to different places in the world where you that that is an acceptable thing. But in our country that should never happen; yet, we see it every single day.

So when I look at these things they are just amazing to me and yet some of them are not always this way. In the mental health side, it is incredible to me as I was listening this morning over talk about the newspaper article about

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mental health issues. I got to tell you a story that I am sure some of you might have read or recognize or remember but in the state of Oregon we had a patient hospitalized in a mental institution simply because nobody could understand what he was saying. They thought he was just speaking in tongues. Therefore, they put in the hospital, in a mental health institution. After a year and a half in that institution somebody figured out that this guy was a native from a South American tribe who didn't speak Spanish, obviously didn't speak English and his language was so absolutely different and foreign to anybody else. This guy got put in for a year in a mental institution. How can we do that? How is that possible? Yet we live it on a regular basis.

So I think the question as you look at disparities in health care there are certain statistical information about diabetes, prenatal care, etcera, etcera, that need to be looked at and I have no problems looking at that because we do it as well on a regular basis. But there are other much more fundamental problems that we need to resolve in order to be able effectively address all of these issues.

As we move through our systems and as we move through the barriers that we see - you know most of the time when I talk to some of my good physicians in our communities, all they think they need to do is just simply put a little sign

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that says El hablo espaniol. And the reason that that is okay is because they got a janitor who can come in and interrupt for them. There are some many hospitals today where forty percent of population that they are serving is Hispanic, yet they don't have a translation system available for them. How is that possible?

It is okay to bring a twelve-year-old kid to be able to have translated for his father's procedure, a colonoscopy. How many of you would your daughter to come in and translate for you for that procedure? That is not okay. So the questions that I ask are much more fundamental than the data and information that we have in front of us. The questions that I ask is what do we have as a moral responsibility to provide health care and get rid of those disparities that we are talking about. All the way from training it is a shame in my opinion that dental school in this country only teach their dentists - I hope there are none here but if there are so be it - that they teach their dentist only to fill and drill. There is absolutely nothing in the curriculums that I have been able to see to talk about public health. And we know dental disease is certainly a preventable disease. So why in the world are we not dealing with the institutions that are teaching these guys to come out and fill and drill and make a million dollars on their first year out of dental school. Why are we doing that?

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So I know Clyde is the reverend over here and I shouldn't be preaching, [laughter] however, I am sure he is going to do better than I do however it is an important aspect of addressing the health care disparities in this country. As we begin our journey into continuing that health care delivery system and enhancing it because we found ourselves fighting with people who have consistently said, sure we care about you guys but never have done anything about it. We want to take care of the aspects of health care that relate to the people that we were serving. How are we going to do that?

Well we began with a wonderful movement, which was called a community migrant health center movement, which I am very proud of. We know its movement that works because it is grass root driven. We know its movement that delivers effective health care to our patients. We know it is a cost effective system however it wasn't enough. It wasn't enough because we have to compete with some of you and certainly some of the private health care insurances in my state.

So we began the journey of trying to understand what it is that we need in order to create the resources to be able to continue the health care for the uninsured. The people that cannot qualify for any of the services that are available either from a public sector or from the private sector. Therefore, we thought hell, if they could do it, we

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could do it. Why can't we have our own plan?

Well as I sat on the tables of wise men who have been doing this for many, many years and I was told repeatedly that I was ignorant fool that couldn't understand, began to understand, the managed care environment, therefore less began to think about the creation of a plan. I thought you know if you can hire them so can I. If you can build it, so can I. So a group of us got together and created what is today the community health plan of Washington, one of the largest Medicaid programs in the state of Washington. And I should tell you we really have kicked some butt out there in terms of the private sector. And we are proud of it. I know my CEO isn't here, but nevertheless we did create a plan. And the reason for that was we felt we had a strong network of providers who care about the patients. We knew that the level of quality of care that we were providing exceeded what some of the private sector was doing. We knew that if we created a system that was sensitive to the needs of our patients, accessible to them, and talk about a much more integrated model than the rest of what we were seeing in our counties, we would be successful.

So we proceeded to create that plan. Today as I said a little earlier, we have over two hundred thousand enrollees and we are doing well. It's a strong plan. It provides us with what we need. But most importantly let me tell you what

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it provides us as a community minded health center. It gives us the stability of a continuous source of funding that not only allows us to provide care for our Medicaid and basic health plan insurers but it also allows us to provide care to the uninsured. So we truly recycle that money. Imagine the concept that Medicaid is our private funding source. We don't have private insurance - well that's not true. We have some private insurance. They are finally some of the folks in our communities are learning that gee those people really do have real doctors and they really do provide good care. So we are beginning to see that we have started with a two percent of our total population being served were private insurance and now about 17% of the population that we are serving is private insurance. Why? Because in some communities we have managed to have a strong network of providers who can deliver the care to those folks.

As we begin through this journey, there were a whole lot of challenges that were important for us to overcome. As you know the issue of our money reserves, how you are going to deal with the insurance commissioners, how you going to deal with all the people who continuously said to us, you will be dead in six months. We are watching those people today exit our communities because Medicaid is not something they want to do anymore. And I am sad to report that a large number of private insurance companies are leaving the

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Medicaid programs in our state. Wonder why that is? But anyway.

Let me talk you about another aspect of our health plan that was important. We were contracting for some of our services meaning our TPA and information systems, etcetera, etcetera, with a private insurance company. One of the big ones. And as usual, we were not treated very well. Not treated very well because we are not very important because you know after all we were going to go out of business in about six months so what the heck, let's give them a little service and charge them the heck out of it so that they can you know they will be out of here.

Again, the question for me was if they can do it, why can't we do it. And therefore begin the process of understanding information systems, data processing and all, which was necessary to function and to operate a plan that could be successful. Therefore the creation of Adaptis. Adaptis was a sort of necessitate more than a well thought out business plan. I should confess that because we never went into with a notion that it was something that we were going to create valuable for our organization over time as it as by now but it also we just wanted to meet the basic needs that we had at the time. Today I think that Adaptis has served us well. We have a tremendous amount of well capable professionals in business who have are processing data and

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information to us. I pay Adaptis today, maybe I shouldn't say this but I pay Adaptis today the same amount of money I was paying the Blues ten years ago for better work, better information and by the way, having the ability to watch into Jim's office and say we want to get into the Medicare business next year, get going, we need some information, we need some work that needs to be done. And by god, since they work for us they got to do it. That is the wonderful thing about this.

I think that as you can see there is a whole lot of sense of control that comes along with these kinds of ventures. There is a whole lot of sense of possibilities that come along with this. Today I can tell you that in communities like Woodburn, we deliver over 70% of all migrant and seasonal farm worker women. You need to understand that in the state of Oregon, if you are a woman and you are pregnant and you are an immigrant or you are a farm worker and you are illegal, you don't quite exist. The state doesn't recognize you as a human being. So somebody has to take that responsibility. In the state of Washington, my organization alone has delivered over two thousand babies. In some of our counties, that is about 70% of all of the deliveries. We are also very much involved in the diabetes cooperative and we have a large mental health system. Our objective here is to integrate it all. We are processing and working on a new

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pilot that works around the mental health issues in an integrated primary care and mental health system.

Now those two like drug and alcohol and mental health don't talk to each other. They never have for some reason however in our system since they work for us, we have some little control. You will talk to the mental health therapist. You will talk to your primary care provider. You will integrate your electronic medical records so that when a physician sees that they have been treated in our mental health system he can understand or she can understand better what is happening to that patient. Therefore there is a tremendous amount of not only good care but cost effective care, which in turn generates revenue to keep going and doing the things that we need to do.

So we found ourselves, it is sort of ironic to look at the title of your conference, disparities in health care where do we go. Well I think you need to go in a lot of directions but certainly the primary question you need to ask yourselves is Medicaid your only mission. Are we solely and only dedicated to that group of poor people? What happens to the rest of them? What happens to Maria who can not qualify this month because the Medicaid system is asking her to show her papers two times, three times a year in order to make her eligible. What happens to her? How do we deal with her? And to me that is the challenge that presents itself. In terms of

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the private sector, all I have to say is you got to wake up. Because eventually it is going to cost you as much as it is going to cost anybody if these people are not treated. Eventually the health care costs systems of this country will continue to go up as they have been and then we are going to have an explosion and God knows you may be out of business pretty soon.

So that is the fundamental question for me is what do we do beyond the Medicaid population? So I ask you please to consider that as you deliberate today. And I ask you to keep in mind those kids that I see on a day-to-day basis because I do have a lot of Kleenex but I also put forty thousand miles on my car because I go to every one of them on a regular basis. I want to see my patients. I am not a doctor and people get offended at the fact that I say they are my patients. And I got to tell you they are just much mine as they are anybody's. You as a doctor sometimes you come and go. I stay. I am there; I have been there for twenty-five years. And I expect to continue to be there for the duration of my life. That is reason they are going to take me out in a stretcher or something.

The question is what do we do beyond the Medicaid? What do we do when the systems fail? What do we do when we have no resources because some politician has decided not to give it to us? That is the fundamental question. So, I thank

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you for your attention. And I will be happy to answer any questions you may have.

[Applause]

MALE SPEAKER: Mr. Olivaires, I would like to ask you your radical change because comparative study about medicine in Europe also in South America, 80% is public help. In Europe, it is almost 65%. In this country practically private, all of them is private. Hardly federal state has influence just 8%. So why not we change the system that President Clinton introduce [inaudible] any insurance company and take American people one system. That is the best solution I believe I think in my view of the subject with me.

CARLOS OLIVAIRES: There are a lot of questions about universal health care access and I think that you know I am not sure where I fall on that to be honest with you.

I don't know that I could do the care that we do with our patients by myself. I mean I need the help of everybody else that is around me. And I think the question is how realistic it is for me to think that we are going to have universal health care access in my lifetime. I don't know that. So I am not sure how to answer that question. I wish there was enough access for all and that we could provide as best care as we can. I think the key to all of this in many respects is prevention but most importantly before you do take name plates, studies and work around prevention, you

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need to get a sense of understanding how much does your community care about what happens because that is what drives people to do things. I don't know if statistics do. I do know that a person with a good heart will always endure and do the right thing than one with a lot of statistics in their hands. So I think it is a matter of caring for your neighbor and for your system.

FEMALE SPEAKER: Good morning. I already thought - I just wanted to congratulate for being with us here and I think your are really did articulate very well the situation that our migrant and farm workers go through every single day and what we have to deal as migrant as our Head Start where we are very committed to the well being not only of children and families and you are an inspiration for us and a model for other states. I would love to have you also sometime with us and extend your commitment and your vision for our families. Again, there was no other way to articulate it better than you did. I think there is hope for our other 37 states. We have families in Yakima so again just thank you.

CARLOS OLIVIAIRES: Head Start is a great program. We partner with them a great deal. We have mobile units that go to the Head Start programs in the schools to provide emergency dental care for them and also do all the physicals, immunizations and the things that kids need that you think are not there. Prevention of children in young kids for

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example sports is probably the best way that you can get these kids out of the streets, however there is very difficult to find a physician who will do free physicals for some of these kids. I mean that is all that is preventing them from moving into sports, yet we can't find anybody who will do physicals for these kids. So if your plan wants to do something real positive about this asking your schools, asking your Senators where are the kids whose parents don't care and who don't have the money to pay even the fifteen dollars that sometimes it cost to do a physical. Do a bunch of those. You keep a lot of those kids out of the streets and you put them into sports. So thank you very much again for listening.

[Applause]

THOMAS L. JOHNSON: Now we are going to move forward to our next speaker. We are going to change the order of the program slightly. I am about to introduce the former US Speaker of the House of Representatives.

Since retiring from Congress Newt Gingrich has worked extensively on the issues of health and health care devoting the majority to his time to advocating a transformation of the entire system. In 2003 Speaker Gingrich founded the center for health transformation, a unique collaboration of public and private entities dedicated to accelerating the adoption of transformational solutions polices and

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technologies to a twenty first century health and health care system.

In his book, *Saving Lives and Saving Money*, Mr. Gingrich described his vision of a twenty first century system of health and health care that is centered on the individual, prevention focus, knowledge intense and innovation rich. More over he makes the case for a market mediated system that will improve choice and quality while driving down costs. Secretary of state and Human Resources Tommy Thompson said this about *Saving Lives and Saving Money*, just as he has said time and time again; Newt Gingrich has taken on one of the biggest issues facing American today. This time it is the health care crisis. *Saving Lives and Saving Money* is welcome and necessary petition to the health care debate.

During his twenty years in Congress, including his four years as Speaker of the House, Newt Gingrich was committed to improving America's health care system. Co-chairing the Republican task force on health for four years prior to becoming speaker. Under his leadership as speaker Medicaid was improved investment in medical research was dramatically increased and FDA reform was enacted to allow for quicker approval and access to new medicines for those with terminal and degenerative illnesses. Mr. Gingrich is currently a member of the Advisory Board for the Agency for

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Health Care Quality and Research and sits on the Board of Regents at the National Library of Medicine. In addition, he co-chairs the National Commission for Quality Long Term Care. A long time advocate of people with diabetes he is an active member of the board of the Juvenile Diabetes Research Foundation. There are numerous honors listed that Mr. Gingrich has received through out his career. The list is very long for me to read. I just want to point out a couple of them. Just recently, he received the 2005 Veraldo Alberto Housse Award for outstanding contributions to the elimination of diabetes. This was at the National Minority Health Month Foundation meeting. In 2003 and 2004, he was named as modern health care top one hundred most powerful people in health care. He received in 1998 the National Association of Community Health Centers, Diabetes Health Care Advocate of The Year. In a998 also receiving the American Diabetes Association Charles Best Medal, the highest non-medical award bestowed by the ADA. He has also received awards from the Mental Health Association and the March of Dimes.

I want to finally read a quote that was given by a well known actress and disease advocate, Mary Tyler Moore who said shortly after Speaker Gingrich stepped down from Congress, - I am reading a quote - Newt Gingrich maybe many things to many people but to us he is a champion and a hero. His leadership in Congress will be sorely missed. Thanks to

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his leadership and reforming the FDA people with degenerative illnesses are receiving medications that allow them to live longer, healthy and more independent lives. Because of his work on behalf of medical research, we are closer to a cure for diseases like diabetes, AIDS, Alzheimer's and multiple sclerosis. And due to his tireless efforts in improving Medicare, senior citizens now receive the products necessary to control their diabetes so they are less likely to lose their eyesight, lose a limb or ultimately lose their lives to the disease. None of these successes would have been possible without the leadership of Speaker Gingrich. Hopefully, someday Americans everywhere will know about his efforts on behalf of people with incurable diseases.

I am proud to say that we both share roots from the great state of Georgia and I am proud to welcome to our program Newt Gingrich.

[Applause]

NEWT GINGRICH: thank you all very, very much I want to put that very kind introduction in context. Anytime I am getting that lengthy of an introduction I am reminded of many years ago when I was a very junior Congressman and not very well known, Congressman Bill Dickerson who was the ranking Republican from US Arms Services Committee invited me to come to his Congressional district to do a fund raiser, to try to give me a chance to prove whether or not I could make a

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speech and be effective and I said I would be delighted to do it and I was honored. Then he began to think about the fact that nobody in his district had a clue who Newt Gingrich was and so he decided he would make sure the fund raiser succeeded by calling a friend of his, Charlston Heston. So the next thing I knew I was going to be doing this fundraiser with Charlston Heston and Newt Gingrich. Then we both got there and we both made our speeches. Then they did a photo line. Congressman Dickerson would greet the people, he would place them between Heston and me, and we would get a picture. Then after that they sent me the pictures to sign. I had the humbling experience of learning that in 250 pictures there was not a single picture where the woman leaned towards me. [Laughter] so sometimes when I hear these really nice glowing introductions I remind myself and then there is reality. [Laughter]

I want to talk to you about reality and I want to tell you a second story which will help you understand where I am coming from. I have two grandchildren, Maggie who will be six this year and Robert who is going to be four next month. When Maggie was three, she came to visit me. We took her to the local toy store and we bought my first purse. Some of you may have seen this, its plastic and has plastic comb and plastic lipstick. It has plastic keys on a plastic key chain but they come with a clicker because you have to be

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able to unlock your car door electronically. It has a plastic cell phone. I carry a relatively modern cell phone. This is the older one, fairly big, open faced, buttons. She loved it. we went to the Hotel Washington right down here up on that top floor where you can have lunch looking out over the White House. She walks in talking on her cell phone because she wants to be like an adult. So, she sits across from me and she wants to talk to us. I said well then you got to punch in the numbers. Now I didn't say dial, dial is a good example of cultural exchange.

How many of you have dialed a telephone in the last year? Okay. I asked this question in Yancville California at a speech and several started laughing afterwards and they had said, they had taken their two children to their grandparents cabin in the Sierra Nevada Mountains close to the Nevada state line. And the kids came running out and they said this is so cool, grandpa and grandma have this phone and it goes round and round. {Laughter} the children thought it was boutique phone. That was a sign that they were really with it.

So anyway she would punch in the numbers and I did this and she would say no, you're cheating. You have to open your phone for it to work. Now at three she knew that because when she rode around with her mother, if she happened to be too impatient her mother would dial up grandpa and hand her

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the phone and she would talk to me on the phone. So she knew that this is how the phone works.

Everything was fine up to that point. At that point, she found that she had a change purse. And in the change purse, she had a credit card, at three years of age. It takes her about two minutes and she walks over and she says this white space this is where my name goes. So we wrote in Maggie and then tried to spend the rest of the day avoiding the Nordstrom.

The reason I am telling you this- think about this, here is a three year old, just a child, a three year old who understands electronic clickers, car keys, cell phones and credit cards. That very same summer the state of Florida adopted a law requiring doctors to print legibly when they wrote prescriptions. So here is a three year old who gets the future and the entire legislature focused on the past.

That is kind of the start of what I want to share with you. But I want to talk very quickly because I want to take questions for about fifteen minutes so I am really going to zip through this as an outline, not a speech.

We have founded the Center for Health Transformation. We can see it by going to healthtransformation.net. The Center for Health Transformation was designed to say that with 15% of the gross domestic product in health and with it being a matter of life and death, it is too complicated to

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plan how you are going to change it. But what you can do is you can get lots of people, it's like a beehive swarming. You can gradually get all the bees going in the same direction but you can never organize them. So if we can get everybody drifting in the right direction, they will apply it to their company or their hospital or their practice or whatever but it will be a movement, not a structure.

We have a very straightforward goal. And I give you this words very deliberately because I would love for you to use them and help us make them better understood. We believe that we can create a twenty first century, intelligent health system. The very specific set of words. First of all I talk about twenty first century because I want to go to the best of the breed, let's say the Mayo Clinic or Kaiser Permanente or I was at the Veterans Administration last week. And say terrific twentieth century model. Now what are you going to do in the twenty first century. Because this is a different era.

This is an era of automatic teller machines, - how many of you have a cell phone with a camera? Just raise your hand. When if I first encountered this, because I had a college student taking my picture during a meeting and sending the email to mom. You know click I am in a meeting with Newt. Followed by a second email a few minutes later, need thirty bucks for weekend.

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So think about all the potential inherently. One of the projects that we are working on with Bell South and we have been talking with the former head of Motorola is if you could take a cell phone with a camera, and you could develop a specialized optics and maybe an attachment. So for example, you could take pictures inside baby's ears at two in the morning. There are a million home health workers. There are a million nursing home workers, long term care workers. What if all of them were carrying just a simple commercial cell phone. But think of it as a health phone. But not some fancy system where you go out and find yourself a consultant and they charge you enough and you finally get the only one of its kind and it costs nine million dollars. I am talking about a \$135 phone except it would have all the right optics for health care. It would allow you to send the data straight to doctor office digitally. So you have just created a wireless system to wire people together. It could also be bought by parents who want to take care of their children and as I said, may not want to go to the emergency room at two in morning, if all they are going to be told, yeah they have an earache, put ear drops in. or maybe used by people who are taking care of their parents who are getting older.

I am giving you a flavor, I am not arguing for the details. But start by saying what is the twenty first century going to be like. Okay. Now what can we do about disparities.

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Now what can we do about home health. Now what can we do about independent living for people who are getting older. A very different model.

Second, I used the word intelligent. Twenty first century intelligent health system. I do it for two reasons. The first is I am a public figure. I am on television all the time. And I have a standard rule. I call it the Katie Couric Rule. Now 7:12 on Monday morning you are getting your coffee - How many of you get your coffee with Katie Couric? My wife has to listen to Katie every day and it is absolutely different to what I want to do. It is part of how she wakes up. So I understand the rule. At 7:12 on Monday morning while you are getting your first cup of coffee and Katie asks me a tough question, how am I going to answer it? So I wanted to be able to turn and say Katie, I am for an intelligent health system. Now my opponent has two choices. Well he can say well I am for an intelligent health system too. Or they can say I think the people should respect a dumb health system, I don't know why you are being - now that may seem small.

Now I want to tell you what I mean by intelligent and some of this you can do this afternoon for free. This is much more a part of your world than people realize. I want you to be able to get every morning, go online and pull up your health information. I want you to be able to measure it against what it should be. I want you to know what you need

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to do to get it fixed. I want you to be able to email your doctor if you have a question and do so in encryptive HIPPA compliant manner. I want you to be able to know what your doctors qualities and outcomes are and if the doctor you need is a specialist, I want you to know how to find that specialist and I want you to know what that specialist quality and costs are. And I want you to know that they have a twenty four/seven online real time continuing medical education so that you are getting the best, you are getting the best knowledge as of this morning.

That at is what I mean by intelligent. I am going to give you a couple of things, if you haven't done it. you should go do, today or tomorrow. Go to a website called realage.com - I am going to give you three websites. Go to realage.com for free you can fill out a questionnaire that tells you your real age. And I will give you an example. If you are a male who is over fifty-five and you take one baby aspirin a day, you take two and a half years off your age. Because one baby aspirin a day is that medicinal useful in avoiding heart disease. It's a fact. I mean its one of those things. If you use your seat belt more than 80% of the time you get to take time of age, on the other hand if you don't use the seat belt you add years to your age because you much more likely to die. Other than smoking, using a seat belt - if you can stop smoking and use a seat belt, it is amazing

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how much you increase the likelihood you will live a long time. Realage.com you can sign up for free as I did and they will send you a daily email reminder that tells you something interesting about your health. My wife's favorite last week, which I forwarded to her, she hasn't done this yet because she won't do her seat belt and she doesn't want to fill out the form. But one last week said if you eat one piece of extra dark chocolate a day, it improves your heart condition. Now it doesn't say seventeen pieces. [Laughter] I told somebody my heart has now been protected by chocolate up to year 2109. But this is something every day. This is a small thing actually learned thirty years ago. I am in a business that a lot of people think is stressful, deep breathing exercises lowers stress. So one of the ways of managing stress is just learn how to breath in for a while hold it, breath out. I mean you can learn this. This is - many of you probably do it automatically. But they had this little thing yesterday on how to manage stress and minimize the problem of stress giving you a heart attack. So realage.com is really worth looking at and here is my point for all the people who are in whatever network you are in. It's free. It's a free good.

It was created by a medical doctor, Dr. Royensin, [ph] because he suddenly realized in 1999, it's a great smart managed story I wanted to show you. It is so interesting

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about how America works. He realized that we were getting sicker because of cultural habits at a rate faster than he could fix us. He said if I don't change that common cultural of things like diabetes and obesity and exercise, I will never be able to really do what I want to do as a doctor. He lives in Chicago so he talked to some friends who said look you really want to change the common culture you have to get an Oprah. And he is a very clever guy; he said how could I get an Oprah. So he figured out who was the doctor for the producer of the Oprah show. He got to the doctor, the doctor got to the producer, the producer got to Oprah, Oprah called him. He and his colleague, Emmett Ozz [ph] a member of our center, is a cardiologist from New York Presbyterian, did the highest rated story Oprah had in 1999. So they go back every year, they do this show and they came out with a new book called You, the Owner's Manual, which was the number one best seller in the New York Times. And which puts in the one volume the kind of stuff they have on realage.com, but every person in the network can go to realage.com for free, fill out the form, get the daily email and at a marginal level start being reminded this is what it is going to take.

Second, ihealthrecord.com is something you should go to. It maybe dot net but I am pretty sure it is dot com. Ihealthrecord.com is a American Medical Association and I think forty seven state medical Associations and about twenty

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of national medical groups have come together and you can go on the site for free. But what is fascinating is a medical doctor and again think about this in terms of the networks you represent, a medical doctor enjoying ihealthrecord.com for \$25 a month and for that \$25 all of the patients can have a health record. So if you got 2500 patients, you are paying one penny per patient per month. You get two things - now this is not an electronic medical record. This is a health record you populate. It's all the stuff that you might fill out on a form at the doctor's office but it means it's all there electronically. If you are diabetic, you can put in your blood sugar every day and the system is basically infinite. You can keep your lifetime record of blood sugar. But in addition it has encrypted email so you send messages to your doctor that are HIPPA compliant that meet the privacy requirements and the doctor can respond. I believe one of the characteristics of doctors in the future will be that they will see six to ten patients a day but they will communicate with two to five hundred. A very different model than the model that we have today. So ihealthrecord.com exists, it's real, its available right this minute and \$25 a month per doctor any group that is in managed Medicare or managed Medicaid could actually have every one of your doctors providing records for patients who then by the way also be directed to realage.com for free.

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The third area is Medline Plus. Medline Plus is the national library of medicine. Your taxes paid for it, it is totally free. It is in several languages. One of the things they are saying it is the largest repository of health information in the world and the most accurate. Nobody doubts that it is the central repository of accurate information in the world. Medline Plus is available for free. And it starts with the most simple basic entry level and goes all up to what level of knowledge a Nobel Prize winner would want in their specialty. It's all in the system.

It is worth you looking at because they are now experimenting the concept of information prescriptions. That is you go to see the doctor, the doctor says here is what your problem is. Here is the prescription for a drug; here is the prescription for learning about it so that you understand what is happening to you. They are really having a very significant impact on people who now go and look at the material. Some of the material is written, some of it is audio/video, some of it is - almost all of it now is in both English and Spanish and they are gradually expanding the number of languages.

So now, what I have given you. Live today, not twenty years from now, not after five big government programs, live today you have a system that lets you assess your health concerns. you have a system that lets you track of your

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health and communicate with your doctor and you have a system which gives you information about your particular health needs. And all three exists for free that you can access tomorrow morning. Or at the most exist for something around a penny per patient per month.

So I want to give you a flavor of that because when we talk about an intelligent system we are much closer to that happening than people realize. If you look at the VA for example they are moving towards twenty four/seven real time continuing medical education online. I mean that is going to happen. You go to Scholar which is a Stanford product, the Stanford University, they have an online twenty four/seven continuing medical education that has been certified by the AMA.

So these things are all beginning to happen. The third part is health. If you notice, I talked about twenty first century intelligent health system. I don't talk about a health care system. The number one concern that I have is to postpone patient's status. I learned this by going to Nestle in Switzerland. Nestle is the largest food company in the world. And we at the time thought we were being bold because we talked about patients center systems. I met with them and they have the largest research laboratories in nutrition in the world. They have eighteen laboratories. Their budget is larger than the jet propulsion laboratory at CalTech. I met

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with 150 nutrition scientists. They said to me look you don't talk about the patient, talk about the individual. They said you have to affect three things, this is kind of fascinating. You have to affect attitude, activity and nutrition. If you affect attitude, activity and nutrition, you can postpone patients' status for twenty to forty years.

Now I will give you two examples. I am very much for public policy reflecting best scientific knowledge. I think part of the answer to the explosion of diabetes and obesity is simple. Get some exercise so I am for mandatory physical education K through twelve, five days a week, real activity. What it will do is it will overnight begin to change to outcomes because people will be exercising. So attitude, activity, nutrition.

Nutrition, they are actually working a preabar [ph] for people who have osteoporosis. Not a prescription drug just what you eat. So they are conscientiously trying to module and modify for different age groups for different health needs, what is the best package. We will presently start to be able to go and get a Lean Cuisine designed by diabetes versus a Lean Cuisine designed for people who need more calcium. There is a very different style of approach and the goal is to make it so tasty and so interesting you don't notice it and you don't care. You can actually eat healthy and be happy, its not one or the other. There is another

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part of what they are doing.

Its attitude, activity and nutrition. Well we worked with a firm called Silver Sneakers which is a marvelous, some of you may work with them. A marvelous firm they work particularly in the HMO Medicare space. They set out with a simple premise. They try to get senior citizens together three days a week to exercise and then they hang around and talk to each other. They get a 63% reduction in depression medication for women. Because it turns out a lot of women are depressed because they are alone. When you get them in a room with somebody else on a regular basis and they form friendships and they chat after exercise they are not depressed. So they don't need - I'm not talking now about bipolar disease or somebody that has biochemical pattern. I am talking about the number of people we treat medically for what are in fact social problems. So I recommend Silver Sneakers as an example.

So we want it to be health system with health care subsystem. And even in the health care system we want to focus on early prevention, early testing, wellness, self-management so if you learn that you are a diabetic, we want you to learn everything about taking care of yourself the first week. Because we know that that will postpone going blind, losing a limb, losing your kidneys or having heart disease. Very different model. Much less expensive because

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people are healthier so its not like you are going to get worse care because we are going to cheat you in the money, you are not going to need the care because you are healthier.

Lastly, it's a system. I have zero doubt that in the next few years, you will see a system in which we know about you from prenatal care until you pass away. So, it's a genuine system which means when you show up at the hospital, you won't be filling forms out for the two hundredth time. It means when a doctor looks at you they are going to know what drugs you are already taking, instead they are going to know what your allergies are, they are going to know what is contraindicated. We are going to know your lifetime experience and you are going to know your lifetime experience because you are going to own your own records and be in a position so that where ever you go in the world, an appropriate person can access those records with your permission.

That is the model we are developing. We are specifically applying it in Georgia and beginning to start a project on Rhode Island. Our goal is to create healthy Georgia project starting with diabetes and obesity and working with Dr. Satter [ph] at Morehouse Medical School, to actually develop it in such a way that one of our major goals is to eliminate any disparity in outcomes in Georgia by consciously design a system so that it reaches the individual

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so it changes the culture in saying where necessary changing the neighborhoods to maximize health outcomes so that every person in Georgia has access to a comparable level of health awareness and of good health outcomes.

It's a sweeping overview. I have got a few minutes I think on your schedule. I would just toss it open for questions for a few minutes I would be glad to.

MALE SPEAKER: [inaudible] access to technology for [inaudible]

NEWT GINGRICH: Okay. Three very, very good things. First of all, I am not totally sure I know what you mean about the retail versus services. My bias is through health savings accounts and health reimbursement accounts is that every small expenditure that I can get you to be personally responsible for I want to. And everything, which I can commercialize, I want to. If you notice, the reason I like the idea of a health phone is it would be commercially available system, not a siloed or very expensive system.

To me one of the great studies in preventive care is dentistry. Think about it. Somebody in the late nineteenth century invented the toothbrush. Somebody invented toothpowder, later they turned it into toothpaste then somebody invented flossing. Then the dentists took a very courageous decision and said that they were going to professionally be for fluoridation even though it would lower

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the number of people who came to them for cavities. When they began to have fewer cavities the dentist who were faced with the crisis financially did what? They invented braces.

[Laughter] I mean my two daughters had to have braces and couldn't be in their eighth grade picture, they would have stood, they were weird. So, it didn't matter how good their teeth were they needed the braces, right. Okay. so now they have braces and as I get older I am learning I have to take better care of my teeth and particularly my gums and it turns out by the way that is important because the germs that are in your gums are also the germs that give you heart disease so it actually does mean you ought to take care of your gums. But I don't like flossing but I found flossers, which is a commercial invention. I love flossers and I now use them every day. I went to a dentist recently, they said my gums got a grade A. I am still enough of the student I called my wife all excited and said I got an A in gums today. She thought I was a little weird.

But even that is not good enough. So, they thought well what is the latest dental opportunity. Whitener right. I am riding down the road, I am listening to Shawn Handerty [ph] one afternoon on his radio show and he is explaining to me that you too can get bright smiles. The thing I thought was this is really stupid. This goes on for three months and then my wife comes in and goes Hi, I am getting my brights

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done in the morning. I think well maybe it's not stupid. She comes home from getting her brights on and says to me you do television, you need brights on the smile too. It's not a bad deal, it is actually a pretty good procedure. Its takes about an hour. [Laughter]

Now the reason I am walking through this with you is that most of what I just described to you is commercial. We don't think of it as insurance. Nobody says oh, how much is my - what is my co-pay for my toothpaste. It is very important distinction being insuring my car and buying gasoline. If I can draw that distinction.

One other thing I just wanted to comment for just a second, I am going to get the hook here but - the only thing about - if we apply the travelocity and expedico model to selling drugs that is you go online and you see the whole range of choices, you see the real prices, I believe drug prices will drop by forty percent. We will be cheaper than Canada so I really advocate all of you look carefully at the traffic - and we have had one drug company actually work on this for us. You can go to our website and we will be glad to put you in touch with them. We really do believe you can bring down the price of drugs by forty percent and probably be a little bit cheaper than Canada. We are a bigger market.

On disparities, I just want to say two things. The first is virtually every African American church now has a

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computer. You go to any significant size church they actually have a church office a computer. We think there are ways between public library and church and other outlets to reach to the whole community. My personal bias, which I testified on in 1995 when I was speaker, is that I should give a laptop to every second grader. I think that eliminating information disparities will eliminate almost every other disparity but if you look at television and telephones, it is amazing the percent of penetration we have gotten. I have a strategy to get to one hundred percent penetration.

MALE SPEAKER: Thank you. I am very intrigued about your notion that a system with somewhat electronic information is going to allow people to see seven to ten patients during the day at their office but about two hundred to five hundred patients during that period of time. I am trying to do the math. I get about a hundred emails a day and there is no way in heck I could do that in eight hours or twelve hours for that matter. So I worry about that. But most importantly, what I am intrigued about is how do you deal with your friend the lawyers in this issue.

NEWT GINGRICH: Now listen I am for - this is going to sound like I am not very conservative. I am for passing a law that provides for retraining unemployed lawyers [laughter] and they are introducing either today or tomorrow of a concept of a health corp. it's a bill introduced by Senator

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Backus and Senator Ramsey and I really believe we ought to a system where if there is something wrong you go first to an expert court. If you don't like - you don't even need a lawyer to go there. If you don't like the outcome, you can then get a lawyer but you have to take the court decision with you. I think we can take 80 or 90% of the blackmail lawsuits. I also believe that you have an electronic health record system that the and this I got from a liberal Democrat who said that the very fact of following correct procedures should be a defense against malpractice charges. But all you have to say is look this is the procedure that I followed, it is the current best practice. Here it is. here is the record. That should automatically be a defense against the kind of blackmail charges we are seeing. But you got - I agree with you, you got to have dramatic ligation reform in this country. Or the lawyers are going to drive doctors out of business.

MALE SPEAKER: Mr. Gingrich, I would to ask you as a Politician, why not in this country we are so proud of, [inaudible] a developed country because our president has spent eighty billion dollars in war. That money they can put to health I think they can resolve. My question for you is how you currently solved said problem if you became president. You previously, they mentioned about that - how you can do it. What is your idea if you became president -

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how you resolve that problem?

[Laughter]

NEWT GINGRICH: Well that was really - let me say on the question, I am not going to get off on the second half of that although it is flattering. Let me just say, I think that we should have. We should vouchize Medicaid so that everybody is in the regular health system. We should have a very large tax credit for the working poor and we should have a mandate that requires people above \$50,000 a year to either buy health insurance or post a bond but our goal should be a hundred percent coverage inside the system so that everybody has access to health insurance and everybody is a part of a single system so we cut off both the cost shifting and the negligent in the preventive care of 44 million people,

CLARA FEINSTEIN: Hi my name is Clara Feinstein, I am from the DC Primary care Association. I just want to say first that I thought it was a very interesting talk despite all the discouraging comments about your wife. But I do have a question and that is just before you came we heard a very interesting about providing health care for farm workers in Oregon and given the intense poverty of many people in this country and the segadigitizital divide I was wondering how realistic it is to expect people to really hook up with websites like realage.com and how realistic it is to expect that to effect real problems of the health care

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disparities in this country.

NEWT GINGRICH: Well first of all in defense of my wife, I thought it was a funny comment. I was not trying to make fun of either my granddaughter or my wife in this conversation. I would not want either of them to feel the disparity.

The second in 1999, 14% of the country went online before they bought a car. On average two percent was saved which is a fair amount of money if you buy a car. In 2003, 64% of the country went online before they bought a car. The amount of penetration - if you look at the next generation cell phone which will begin to resemble a laptop computer the potential by the end of the decade for virtually everybody to be connected, I think is enormous. I think there are a couple of patterns of poverty that I don't frankly have a very good answer for. If you have people who are culturally outside the system, I think that requires almost a missionary approach because you are now asking people of such a very short time horizons and such very limited sense of connectiveness to undertake behaviors that are totally outside their being. I mean it's not just a question of if I hand you a laptop will you use it, these are people who literally don't understand the concepts that we are describing. I think that requires and somebody logged a welfare in '95. I really believe there is two sectors that really bother me. There is a sector of

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people who are culturally outside the system and they are often very, very poor. They often have a fairly large amount of violence in their life and they are often for their children represent a real risk. That group we have to have almost a missionary approach to rethinking. And then second we have to take much more serious than we have the challenge of the substantial number of young men who end up in prison and for whom we have no mechanisms of reintegration in this society that we give complete lives because that then becomes a significant factor in the first set in terms of having predatory behaviors of violence of people who are not able to control themselves and who had don't have any of the habits you need to have to being middle class man. Being what everyone in this room is being basically middle class, is a set of attitudes, values, time horizons, disciplines that are learned because we managed to learn them but we don't have very good mechanisms today for those communities. I would argue having watched for example Jimmy Carter's Atlanta project, having talked to people about native Americans on certain reservations we have had huge levels of depravation having talked to people who have been in New York City with drug addicted babies who were born drug addicted. That we don't today have a coherent strategy for the various pockets of people who are literally outside the common culture and it is not just a matter of money or its not just a matter of

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technology but it is a matter of really trying to think through how do you help those people make a transition in their personal lives into a different world. I think it's a very, very important question you raised.

MELVIN PENN: My name is Melvin Penn. First of all I am anxious to stand in front of somebody who has been in front of Congress all these years but I just want to bring this to your attention. One is health care is personal so in all of your transformation, please don't forget the doctor patient relationship. You know for twenty years, I practiced. David Saxton can tell and I am glad you got him on your team because he will bring you back to earth because he is a doctor first and everything else he has been second. But he will tell you please do not forget the doctor patient relationship. You know I would want to get up at two o'clock in the morning to look into a child's ear. I wouldn't want you to transfer something that I can't really see. I would want to talk to the mom who is sick of taking care of a baby that nobody else would see but give me the telephone.

Also this conference is about Medicaid not - I like your idea of giving the second graders computers. I liked all of your electronic modalities. Please remember Medicaid folks have other barriers that they always have to consider. I care for them in the inner city in North Carolina for over twenty years. so I am going to say something that you may not have

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thought about. Keep the doctors on your team and rewrite the songbook about American healthy. Start on his last chapter when you talked about how public health and things changed this whole country. I challenge you for your next book to start with his last chapter then go in the twenty first century. Thank you very much.

[Applause]

MALE SPEAKER: Mr. Speaker you were in the House when the Clinton health reform policies and practices descended upon the Congressional office. In your view what is government's role in terms of solving disparities in health care particularly in many.

NEWT GINGRICH: Well, let me say first of all, the women - when Ms. Clinton, now Senator Clinton, first began developing a plan she came up to see and I said at that time, do not write an autonomous bill. Don't write a bill so big that it can't pass, write a relatively small bill, get it through then come back next year with another relatively small bill, get it through and if you get eight years until you get reelected, you got eight years to get eight bills, you will be amazed how much you get done at the end of the time and that is part of what we formed the center for health transformation because I do national security for 40% of my time. I do health for 40% of my time. Health is thirty times harder. Three thousand percent more complicated probably for

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the reason that the doctor mentioned a minute ago. You take the complexity of learning to be a doctor multiply it by that complexity of that person who walks in the door, multiply by the complexity of their relationship with their family and their job and their neighborhood, you are dealing with just to get through one person you are dealing with layers of complexity that are really stunningly amazing.

I think that it is very important to approach health cautiously and to recognize it that we don't know enough to change the entire system in one sweep. We don't know what the second and third order of effects would be. I think that is a key component of it. I believe government's current role is to try to set up the incentives and the structures that enable us to maximize the health outcomes. I want people to live the longest lives with the greatest health with the greatest satisfaction at the lowest cost. It may sound like that is pie in the sky but I think that is in fact the American model of how we have always operated.

I may Theodore Roosevelt Republican. By that, I mean Theodore Roosevelt figured out one day that in the modern world, supposedly, he read Upton Sinclair's the Jungle shortly after eating breakfast and there is a scene Sinclair's book where a man falls into a vat and gets turned into sausage. And Teddy had supposedly eaten sausage that morning. That afternoon he sat up the Food and Drug Act to

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create the current FDA.

I like the idea that if I walk into a McDonalds, it is actually clean water and it actually beef in the hamburger. That may make me sound me like I am a lot more liberal than some of you thought but I think this kind, - so I want a system where every American has health insurance. I want a system where every American ultimately is going to have a DNA analysis so we know what they should be worried about. I want a system in which we also understand that different people have different cultural requirements and that means if you were born into a pattern where you are naturally diabetic you have a greater need to eat the right food and exercise. If you are one those lucky folks born into a pattern where you are going to live to be 95 under any circumstance unless you get hit by a car. As all you know, sometimes life is not totally fair. But we can make life a lot fairer by having the right kind of systematic approach and that is why we founded the center and that is why I was delighted to show you today. Thank you very, very much.

[Applause]

THOMAS L. JOHNSON: that was great commentary we got this morning and I also want to give special thanks to David Merritt who helped us bring this speaker together and someone who I have worked with over a period of years.

Next, we are going to look back to the past. I am

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very fortunate that sitting on our executive committee is someone who is a founder of this organization. It was incorporated in 1995, and it was called the National Association of Urban-based HMOs and we are very fortunate to have that person here with us. All the way from the west coast, from Los Angeles. He now is a minister in Los Angeles and I think he will give us a real prospective both on the industry and the road that we are taking this morning. I am very pleased to welcome the Rev. Dr. Clyde Oden.

REV. CLYDE W. ODEN, JR., O.D.: good morning. I want to thank my former friend Tom Johnson for having me stand before you. he use to be my friend, I was scheduled to speak before Newt, not after him. [Laughter] I was also concerned about my good friend the Rev. Carlos Olivares who I didn't know he was in the ministry but he certainly preached very well. And I appreciated that. I appreciate the opportunity to come before you today to see some of my former colleagues, to meet some of the board members, part of this organization, to see some old friends and to be here with all of you to talk this important topic.

I really want back and get things centered a little bit in terms of the issue about disparities and dealing with the issues of minorities in health care. I also started to get upset with Newt Gingrich when he started with his lawyer joke. My daughter is here, I spent a lot of money getting her

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into law school and I can't stand the idea of an honest for lawyer. [Laughter] But I am touched by this gathering and I am touched by the gathering because it represents the continuation of a legacy that start a number of years ago in wrestling with difficult problems in a way that is very personal.

I want to let you know how radical this gathering is. how revolutionary the ideas are and why it is important that the flame continue to burn, that leaders like Tom continue to lead this organization and that you really grasp onto the struggle about the real issue of disparity. How do you square this issue about disparities in our country when you look at one group of Americans that are doing very well and another group of Americans that aren't doing well at all.

I like to take you back down memory lane a little bit to understand a little bit why this gathering is so radical. I was there in 1981 when then Governor Reagan trying to save money in the state of California decided to let Medicaid members be served in a health plan. Their plans agreed to serve it at ten percent less than what fee for service was all about. I was there when they signed contracts up with providers who had no experience with Medicaid but had a lot of experience with Ronald Reagan and his party. They all got contracts. I was there when as one of the large community health centers we thought it was a good idea to serve

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Medicaid on a pre-paid basis and they told us no because there were too many Medicaid members in our plan and we were from Watts. I was there when we kicked at the door for eighteen months before they finally said yes. I was there when those same providers that knew nothing about Medicaid nearly messed up the program because they went after the money, didn't care about the people at all. I was there in 1973 when the Congress passed the HMO Act of 1973. Wonderful, wonderful piece of legislation that put into action having managed care to be part of the landscape of this country. I was there when organizations like ours that had come out of a experience of service that Medicaid were told that is a great idea but its not for you. You see managed care is for the middle class and that if you have too many Medicaid members in your plan you really can't operate as a managed care plan. I was there when they said that if you had 25% of your membership that was Medicaid that was too many. You had to fine a way to have more private sector members than you could Medicaid. I was there when Ellis Bonner was part of GHAA and kept pushing and trying to get that organization to begin addressing the issue of Medicaid because you may not recognize it but for many years when managed care plans got together and talked about the industry, what they didn't talk about was Medicaid because they just didn't consider it an important issue. But I was there when Ellis nearly kicked

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over the table until they listened and heard and he made it possible for me to be on the board and have a few other voices there to bring the issue of managed care for Medicaid to the surface. I was there when the industry began to consolidate and because of his efforts, the GHAA became AAHP and began to train minority managers to get involved in the managed care industry. I was there when the issue of cultural competency to began to be part of the conversation. I was there when governors would clearly would always try and balance the budgets of their states on the backs of Medicaid and poor people. I was there when in the conversations about putting together an industry, having something called the Medicaid health plans of America was their worst nightmare because it didn't seem to make sense.

But I am glad to be here right now with you because this organization continues its work in advocacy for Medicaid serving organization and because the values that you represent and addressing real problems for real people in real communities. There are real problems for real people in real communities in terms of Medicaid. But those real problems come because to a large extent many of those who set the policy with respect to how Medicaid serving plans ought to operate, they still put Medicaid as an afterthought. They don't deal with the issue of fairness or accrual somnolence of race. They don't really look at the populations that are

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being served. They ignore the issues about adverse selection but I am glad that this organization is here to continue to raise the issue and to raise the questions.

I think in order for the disparities the real disparities to be addressed and to be eliminated there are some things that you all must advocate for and fight for. One thing is for the industry so that the industry might be able to be fairly compensated for the care that they provide, that the industry should be able to have some assurance that the members that they are serving will be there for a while because this has always been a problem when you serve people one month but they are gone the next month and you want to invest in preventive care but the next month after you have done that they are no longer there.

I think it is important that the very core of managed care continue in terms of prevention and preventive health services and early intervention of care and timely and appropriate treatment. But I think it is also important that whatever plans are doing that the outcomes are measured and presented publicly so that we can see them, we as the public can see them. So that the base can really be held on real information and real data. It is important that [inaudible] competent providers and systems continue to operate.

You must advocate to that otherwise it will fall through the cracks. It is important that for managed care

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organizations that the effort on patient education continues to be a central part of the delivery system in order to reduce the disparity of health care because the members that are receiving the health care information must understand how to have better health seeking behavior and have more informed decisions about what is going on. I am not sure that will happen by just going to a website. I am not sure it will happen in situations in which you just assume that if people dial up a certain place they will get the information. Many of the people that you serve that Medicaid health plans serve are oral in nature. They like to hear stuff. If you tell them to read stuff, do you think their behavior is going to change? Its not. You need to make sure that point is made.

I think also thought in order to address the issue of disparity the Medicaid members have to be part of a partnership. Often the discussion goes on in talking about those people as if they don't really exist, they don't have hearts and minds and they can't really participate in their own well being. There has to be a partnership with three players, the providers who are getting paid appropriately, patients who are being informed and rewarded, patients who are being educated and patients who are being informed about what is going on with them and what is going on in the community around them.

Finally the third part of the partnership, if we are

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to address the issue of disparity and I didn't hear from our former speaker. Poor people have poor outcomes because they are poor. Yeah. They are. And if our nation wants to really address the issue of health disparity, you got to eliminate the issue of poor people. We've got to provide jobs that pay a living wage. We got to provide new opportunities for folks. While we are doing that, we also need to provide better schools, safer streets and cleaner water and cleaner air and better public health facilities. We need to do those things if we want to address the disparities because as long as there are two Americas and other Americas, as long as they live down there and we live over there, as long as mothers have to make sure they know how close they are to tub in their bathroom so when the gunfire starts they can run for cover, that is a reality for some communities but its not reality for others. Until we address those things the disparity as we look at in terms of life expectancy, well-being aren't going to be there. There has to be this partnership. There has to be a recognition. Those who are Medicaid recipients, beneficiaries, have to have a voice that is heard. They have to participate in the provision of care. They have to be part of the players sitting at the table. You need to know however, it won't be. Those that have been involved in setting policies for a long time would rather as one of our earlier speakers said, make the issue of Medicaid

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the last comma at the end of the discussion, make the issue of a population that we are serving actually as if they are really just objects and not real people. Unless you raise the question about cultural competency, unless you raise the question hearing their voice or the voice of their advocate and unless you also speak to the other issues that are real clear about having minority providers and minority administrators involved in all the decision making. The disparities will remain but the disparities can be addressed but we have to really provide a new twenty first century model that doe address some of these core issues. Thank you.

[Applause]

THOMAS L. JOHNSON: We are going to take a very short break. We are going to make it about five minutes because we are running a little behind. We are going to set up for the panel that will be coming on next. Feel free to socialize and there are some exhibits out in the hallway as well. Thank you.

[END RECORDING]