April 11, 2021

The Hon. Barbara Smith Warner
Chair, House Committee on Rules

The Hon. Christine Drazan
Vice-Chair, House Committee on Rules

The Hon. Paul Holvey
Vice-Chair, House Committee on Rules

The Hon. Daniel Bonham

The Hon. Julie Fahey

The Hon. Andrea Salinas

The Hon. Jack Zika

Re: **Opposition to House Bill 2337**

Dear Committee Members,

House Bill 2337 is set for a public hearing on April 15, 2021. As a private citizen, I write to ask that the Rules Committee reject the bill as it has been written.

Specifically, and as more fully explained below, Section 3(3) should be removed from the bill. This paragraph requires local public health authorities to make staffing decisions and to render healthcare services in a discriminatory and unnecessary manner.

Section 3(3) reads:

> Each mobile health unit [established by Section 3(2)] **shall be staffed by individuals who reflect the population they serve** and provide the following culturally and linguistically appropriate services, **prioritizing services to Black and indigenous communities and people of color**: […]

(emphasis added.)

1. It is wrong to require discriminatory hiring practices of LPHAs.

As written, this section would require the local public health authorities to hire healthcare staff not on the basis of their skill in medicine, or their knowledge and experience in providing healthcare services. The "shall be" language would mandate that staffing decisions would be based strictly on the immutable characteristics of personnel, to the exclusion of all else, to satisfy the appetite to "reflect the populations they serve." Local public health authorities would

therefore be commanded by this bill to act in contravention of constitutional and legal protections to workers that ensure that no one would be denied the opportunity for gainful employment simply because of their race, color, creed, gender, age, religion, disability, national origin, or other protected class statuses.

No public health director of principle would ever tell an employee that he or she cannot render healthcare services to patients because their characteristics do not reflect their community's characteristics, and the legislature should not pass a law that would command them to do so.

Some might object that this reads too much into Section 3(3), that this language does not explicitly state that hiring and staffing decisions must be limited on the immutable characteristics. But if that is not the motivation, why else include a statement that the staff must "reflect the population they serve"? Could not the described health services be rendered just as well regardless of whether the provider matches the characteristics of the community?

The answer is, of course, yes – skill in medicine depends not one bit on such categories. A young Sikh physician who emigrated from India can treat a Scotch-Irish grandmother no better and no worse because of these differences; a Hasidic Jewish male nurse can serve his neighbors who happen to be African Americans that attend a Methodist church with the same degree of care as he shows those of his own faith; and a healthcare technician processing electronic medical records can act with just as much professionalism and care regardless of whether the technician shares the gender, disability, age, or creed of any particular patient.

If the purpose of this language is to hold forth the idea that only those with the same race, gender, or ethnicity, or any other trait can be trusted to render healthcare services to atomized segments of communities, I ask the Committee to recall the Legislature's own statements on this topic:

> It is declared to be the public policy of Oregon that practices of unlawful discrimination against any of its inhabitants because of race, color, religion, sex, sexual orientation, national origin, marital status, age, disability or familial status are a matter of state concern and that this discrimination not only threatens the rights and privileges of its inhabitants but menaces the institutions and foundation of a free democratic state.

ORS 659A.006.

Segregating workforces or discriminating against employees based on demographic category is simply wrong. The Legislature should not try to create discriminatory sinecures, especially in the realm of public health.[1]

For these reasons, I urge the Committee to reject HB 2337 as written. Section 3(3) can serve just as well by removing the phrase "…shall be staffed by individuals who reflect the population they serve…" This will place the focus back on the provision of healthcare services, not on the question of what groups the service providers belong to.

[1] Section 3(4) of the bill also shares this problem. It reads: "The local public health authorities shall convene work groups to identify the number of mobile health units **and the diverse staff** needed for each region" (emphasis added). This phrase should also be removed, to focus the attention on skills and qualities of individuals, not on broad social demographics.

2. The communities served by LPHAs should not be bound to provide prioritization based on race or ethnicity, where there are more reliable correlations of negative health outcomes.

The final clause in Section 3(3) states that the mobile health unit staff must, without the possibility of challenge or dispute, prioritize services to specific communities based on race and ethnicity. This requirement seems animated by one of the bill's recitals, that incidents of racism create racial disparities in health outcomes. The Oregon Health Authority has reported that there can be a correlation between race and ethnicity on one hand, and less favorable health statuses on the other, for individual healthcare services.

As one example, OHA reports[2] that the immunization rate for 2-year-olds statewide varies depending on the ethnicity of the infant.

- American Indian/Alaskan Native: 68.6%
- Asian: 75.7%
- Black/African American: 61.4%
- Hawaiian/Pacific Islander: 65.1%
- Hispanic: 73.7%
- White: 72.0%

However, those disparities do not correspond to, or are reflected by, the statewide immunization rates for adolescents, aged 13-17.[3]

- American Indian/Alaskan Native: 67.5%
- Asian: 62.4%
- Black/African American: 59.2%
- Hawaiian/Pacific Islander: 61.8%
- Hispanic: 59.5%
- White: 56.1%

If the goal is to improve health outcomes, here is an example where the group needing the greatest improvement on a specific healthcare goal is excluded by the language of Section 3(3). The prioritization of healthcare resources should be aligned to the greatest healthcare need, irrespective of the race or ethnicity of the patients.

Further, those statewide rates do not reflect the rates found in individual counties. The immunization rates for adolescents in Clatsop County, for instance, shows that there is a higher rate for Asian and Black/African American residents, with the other racial and ethnic categories all clustered together:

- American Indian/Alaskan Native: 48.7%
- Asian: 60.6%
- Black/African American: 69.2%
- Hawaiian/Pacific Islander: 48.7%
- Hispanic: no data provided.
- White: 48.4%

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[2] See *Oregon Immunization Program Data and Reports*, "Child Immunization Rates" interactive data, available at https://www.oregon.gov/oha/ph/preventionwellness/vaccinesimmunization/pages/research.aspx (last visited April 11, 2021.) These charts show a variety of data on rates of immunization for a variety of diseases and age groups, broken down by statewide rates and the rate for individual counties.

[3] This data is taken from the same source.

This is an example of where local racial and ethnic categories may show a weak correlation to negative health outcomes. As such, it would be a waste of limited resources to require, as Section 3(3) does, that prioritization still be based on those correlations despite of the facts within that community. Section 3(3) would require local public health authorities to prioritize services based on a statewide correlation that may simply not exist within that LPHA's boundaries.

It is misguided of the legislature to insist that the correlation must nevertheless be prioritized, regardless of the individual circumstances in that local community and irrespective of any other circumstances (such as poverty or distance from healthcare services) which may show a far stronger correlation to negative health outcomes.

For this reason, I urge the committee to reject HB 2337 as written. If the bill requires local public health agencies to render services, it should empower those local agencies to address the specific health needs that exist locally. The bill should not require that public healthcare services prioritize any patient or group of patients based on immutable characteristics. Recall that OHA already acquires demographic information about patients and their health outcomes – if there is ever a concern that a local public health authority is providing services in a discriminatory manner, this data will allow the State to enforce the moral and constitutional requirement that public services must benefit all residents, regardless of who or what they are.

3. Section 3(3) of HB 2337 is causes avoidable harm, and could be modified to achieve benefits.

For the reasons described above, I urge the Committee to reject HB 2337.

This bill does many things – Section 1 declares racism a public health crisis. Section 2 grants rulemaking authority to OHA to proscribe the standards for the demographic data that state agencies and third-party service providers already collect. Sections 4, 6, and 7 require particular groups to make recommendations to the Legislature. Section 8 requires the employment of an Equity Coordinator to address language and other barriers faced by those who wish to present before the Legislature. Sections 9, 10, and 11 state that unspecified amounts of funding are allocated to advance these goals.

Whatever benefits there may be in the rest of HB 2337 are not outweighed by the harm of requiring unconstitutional and discriminatory hiring practices on local public health authorities, and the irresponsibility of requiring those local public health authorities to prioritize the provision of healthcare services based on unconstitutional divisions, especially when there may be no local disparity in health outcomes correlated to protected class status for a given service. HB 2337 can be altered to remove these flaws, and place the focus on addressing healthcare needs, rather than focusing on the immutable traits of those involved.

For these reasons, I urge the Committee to reject HB 2337 as it has been written.

Sincerely,

s/ Eric Blaine